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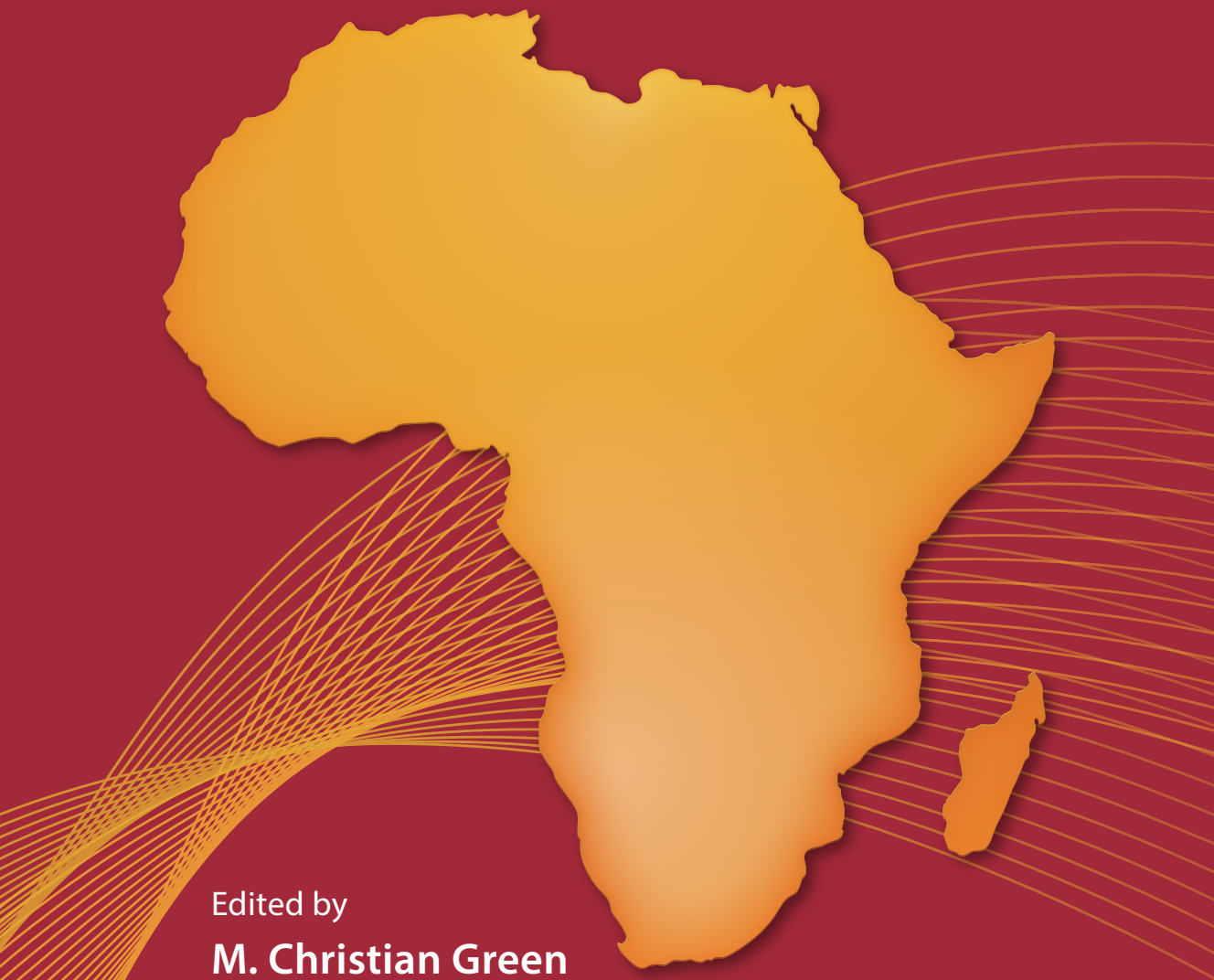

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17 Pushed to the margin: the rights of women living with HIV and AIDS during lockdown in Zimbabwe

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INTRODUCTION

Covid-19 has been a global challenge, with developing countries such as Zimbabwe being the most vulnerable. Zimbabwe recorded its first Covid-19 positive case on 20 March 2020, involving a male resident of the town of Victoria Falls who had a travel history to the United Kingdom and South Africa. The second Covid-19 case was recorded immediately afterwards. It involved a journalist who also had a history of travelling to several countries.[2] The World Health Organization (WHO) encouraged countries to adopt concerted measures to prevent and contain Covid-19.[3] As a result, Zimbabwe implemented measures, such as lockdowns, that were targeted at containing the virus's spread and its effects. The objective of this chapter is to discuss the manner in which the rights of women with HIV and AIDS were affected during lockdowns with a particular focus on Zimbabwe.

Statutory Instrument 83 of 2020 introduced the first lockdown in Zimbabwe.[4] In Section 2, the statute provided that: "'National lockdown' means the restrictions on the movement of persons and on intercity, terrestrial, airborne and cross-border traffic prescribed by this Order." This definition of lockdown emphasises the restriction on the movement of people. However, it should be noted that Zimbabwean lockdowns came in different levels, with level one being the most restricted one and level five the least restricted. The first lockdown in Zimbabwe was implemented on 30 March 2020, when the country had recorded only one death and nine confirmed cases.[5] The first lockdown was a level one lockdown. A second-level lockdown was then imposed on 14 April 2020, following the provisions of Section 4 of the Statutory Instrument 110 of 2020.[6] According to the Statutory Instrument,

1 Law Lecturer at Herbert Chitepo Law School, Great Zimbabwe University.

2 Chipenda C and Tom T. 2021. "Zimbabwe's Social Policy Response to Covid-19: Temporary Food Relief and Cash Transfers" (CRC 1342 Covid-19 Social Policy Response Series, 23). Bremen: Universität Bremen, SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik / CRC 1342 Global Dynamics of Social Policy.

3 Xiong J et al. 2020 Impact of Covid-19 pandemic on mental health in the general population: A systematic review", *Journal of Affective Disorders* 277:55-64.

4 Statutory Instrument 83 of 2020 [CAP. 15:17] Public Health (Covid-19 Prevention, Containment and Treatment) (National Lockdown) Order 2020.

5 Mavhunga C. 2020. "Zimbabwe Begins Lockdown to Fight COVID-19", *VOA*, 30 March.

6 Statutory Instrument 110 of 2020. [CAP. 15:17] Public Health (Covid-19 Prevention, Containment and Treatment) (National Lockdown) (Amendment) Order, 2020 (No. 8).

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the level one lockdown of March 2020 meant that everyone would stay home and would only go outside for food and health reasons within their neighbourhood. This lockdown saw the erection of numerous checkpoints and roadblocks to regulate the flow of people. A curfew from 6:00 pm to 6:00 am was put in place. It is in the context of this first-level lockdown that women with HIV and AIDS faced surmounting challenges that violated various constitutionally enshrined human rights.

While everyone was vulnerable to Covid-19, people were far from equally affected by the pandemic responses. There were stark gendered disparities, and women with HIV and AIDS already among the most marginalised people in a patriarchal society, were hit the hardest in Zimbabwe. Stigmatisation, coupled with intersectional discrimination, has always been exerted towards women living with HIV and AIDS. Their challenges are a mirror to stark inequalities and injustices, which were intensified by Covid-19 responses.[7] As the Covid-19 pandemic exposed entrenched inequalities and gender power dynamics, women living with HIV and AIDS experienced the greatest health and human rights impacts.

With the above factors in mind, this chapter focuses on how women living with HIV and AIDS were affected by the curtailment of certain rights during lockdowns in Zimbabwe. These realities suggest recommendations that may be useful in future measures against emerging pandemics. This research used a qualitative mixed method of legal doctrinal approach. S.N. Jain, a legal researcher, defines doctrinal research as analysis of case law, arranging, ordering and systematising legal propositions and study of legal institutions through legal reasoning or rational deduction.[8] This approach helps one to understand the legal framework and judicial precedent relevant to the plight of women living with HIV and AIDS. According to Amrit Kharel, another legal researcher, availability of the reliable data is the biggest challenge in conducting legal doctrinal research.[9] To bridge this gap, semi-structured key interview questions were devised for five key non-governmental organisations dealing with women living with HIV and AIDS. This research also used a human rights-based approach. Human rights theory requires governments and authorities to focus in their programmes on the rights of those who are most marginalised, excluded or discriminated against in society, in order to ensure that they are not deprived of their rights.[10] The broad objective of the lockdown was to guarantee Zimbabweans the right to health by harnessing the spread of Covid-19. However, in the process, the government took away more rights from women living with HIV and AIDS than they gave them.

7 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

8 Jain SN. 1972. "Legal research and methodology", *Journal of the Indian Law Institute* 14(4):487-500.

9 Kharel A. 2018. "Doctrinal Legal Research", *SSRN Electronic Journal* January:12.

10 United National Population Fund. n.d. "The Human Rights Based Approach", *UNFPA.org*. [Accessed on 31 March 2022].

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RIGHTS CURTAILED DURING THE LOCKDOWNS

Right to health

The right to health care is enshrined in the Constitution of Zimbabwe.[11] Section 76(1) provides that "every person living with a chronic illness has the right to have access to basic health care for the illness". This section directs the state to accord the right to health to people with chronic diseases, such as women with HIV. Numerous international instruments to which Zimbabwe is a signatory recognise the right to health.[12] Equally binding on Zimbabwe are regional instruments that also recognise the right to health.[13] Under Section 46 of the Constitution, Zimbabwe is obliged to abide by these international and regional instruments, since this provision requires domestication of international instruments and treaties.[14] According to Admark Moyo, a human rights lawyer, this provision mandates the consideration of the norms and values of the international community, as given in international treaties and customary international law and general principles of international law.[15] Moyo further points out that Zimbabwe's obligation to observe and apply international and regional law is apparent by the virtue of it being a member state to international and regional human rights treaties.[16] On the basis of the established Zimbabwe's international obligations, the importance of the right to health as elaborated in General Comment 14 to the International Covenant on

11 Constitution of Zimbabwe Amendment (No. 20) Act 2013, s 76.

12 Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810at 71 (1948), art 25. (Article 25 affirms that: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."); International Covenant on Economic, Social and Cultural Rights, GA Res. 2200A (XXI), 21 UN GAOR Supp (No 16 at 49, UN Doc A/6316 (1966), 993 UNTS 3, *entered into force* 3 Jan 1976, art 12.1. (Article 12 provides the most comprehensive article on the right to health in international human rights law. States parties must recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while Article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties … to achieve the full realization of this right"). See also International Convention on the Elimination of All Forms of Racial Discrimination of 1965, 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969, art 5 (e) (iv); Convention on the Elimination of All Forms of Discrimination against Women of 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, *entered into force* Sept. 3, 1981, art 11.1 (f) and art 12, Convention on the Rights of the Child of 1989, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), *entered into force* Sept. 2, 1990, art 24.

13 African [Banjul] Charter on Human and People's Rights adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58(1982), *entered into force* Oct 21, 1986, art 16.

14 Constitution of Zimbabwe, 2013, s 46(1)(c) provides that when interpreting this Chapter [The Bill of Rights], a court, tribunal, forum or body must take into account international law and all treaties and conventions to which Zimbabwe is a party.

15 Moyo K. 2019. "Socio-Economic Rights under the 2013 Zimbabwean Constitution", in Moyo A (ed). *Selected Aspects of the 2013 Zimbabwean Constitution and the Declaration of Rights*. Lund: Raoul Wallenberg Institute, 163-181.

16 Moyo "Socio-Economic Rights under the 2013 Zimbabwean Constitution", 168.

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Economic, Social and Cultural Rights (ICESCR) becomes instructive.[17] This general comment, first and foremost, appreciates that "health is a fundamental human right indispensable for the exercise of other human rights and that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life with dignity".

In accordance with General Comment 14, the realisation of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, the implementation of health programmes developed by the World Health Organization (WHO) or the adoption of specific legal instruments. Zimbabwe has put in place legislation and policies for the realisation of the rights of people living with HIV.[18] These legal frameworks generally posit and accept the vulnerability of people living with HIV and appreciate the need for their protection. These legal frameworks signal an intent to protect both men and women living with HIV.

However, the right to health requires more than simply putting a legal framework in place. The provision and access to the treatment form part and parcel of the obligation of the state to provide the right to health.[19] In *Minister of Health v Treatment Action Campaign*,[20] a South African case which has a persuasive value in interpreting Zimbabwean law,[21] the court made it clear that the unavailability of nevirapine drug in hospitals was unreasonable, given that they had a policy in place. In this case, justifications for the failure to provide a comprehensive programme for the prevention of mother-to-child transmission were found by the court to be inadequate to meet the tenets of the state's obligation to provide for the

17 Convention on Economic Social Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4).

18 Health Service Act Chapter 15:17 of 2018 s 37 gives guidelines regarding health services operations that include:

(a) the types and availability of health services
(b) the operating schedules and timetables of visits
(c) procedures for access to the health services
(d) other aspects of health services which may be of use to the public
(e) procedures for laying complaints.

This is of importance to people who have HIV as it helps to inform them about where they can get treatment. See also the National Aids Policy of 1999, which introduced the Aids levy was introduced by the government. Also, the Statutory Instrument 202 of 1998, which was enacted under the Zimbabwe Labour Relations Act, was regarded as a giant stride in protecting employees with HIV.

19 *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 para 17 (CC).

20 *Minister of Health v Treatment Action Campaign*, para 17.

21 Constitution of Zimbabwe, 2013, s 46(1)(e) permits the consideration of relevant foreign law when interpreting the Bill of Rights.

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right to health.[22] This is buttressed by the General Comment 14 on Paragraph 12 of the ICESCR, echoing the need of accessibility to treatment and drugs as a crucial component of the right to health.[23] The general comment further states that accessibility must be nondiscriminatory, thus health facilities, goods and services must be accessible to all, especially the most vulnerable and marginalised sections of the population, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons living with HIV.[24]

While lockdown was a health measure implemented to prevent a health disaster by harnessing the spread of Covid-19, it also compromised the right to health of women living with HIV by limiting their access to healthcare facilities and anti-retroviral (ARV) medication. It is argued that the Zimbabwean government failed to ensure access to both medication and health facilities by women living with HIV during the lockdown. The results were a two-dimensional violation of the right to health.

Access to drugs

With respect to access to drugs, lockdowns brought about travelling restrictions across borders and between cities. For example, if A from Bindura decides to visit his uncle in Marondera and the lockdown goes into effect before he can return home, then he must stay there until the end of the lockdown. Travelling from one city to the other was only allowed where there was a letter from the police, which was not easily obtainable. Even though movement for medication purposes was allowed,[25] the effect of these difficulties and undue delays in obtaining police clearance letters was to render the authorisation unhelpful.

These travelling restrictions, as Nyashanu and fellow researchers have shown, led women to miss appointments because of the difficulty in travelling to health facilities to collect their supply of antiretroviral drugs (ARVs).[26] Women living with HIV in Harare had to negotiate with police officers so that they could be let into town to collect ARVs.[27] These women were not always successful in such negotiations, and some were turned back to their residential areas. Furthermore, upon the pronouncement of the lockdown, some people collected the ARVs for

22 Currie I and De Waal J. 2017. *The Bill of Rights Handbook.* Cape Town: Juta and Company (Pty) Ltd, 578.

23 CESCR, General Comment No. 14.

24 CESCR, General Comment No. 14.

25 See Public Health (Covid-19 Prevention, Containment and Treatment) (National Lockdown) (Amendment) Order, 2020 (No. 5) Section 4(1).

26 Nyashanu M, Chireshe R, Mushawa F and Ekpenyong MS. 2021 "Exploring the challenges of women taking antiretroviral treatment during the Covid-19 pandemic lockdown in Peri-urban Harare, Zimbabwe", *International Journal of Gynecology and Obstetrics* (154):222.

27 Nyashanu et al, "Exploring the challenges of women taking antiretroviral treatment".

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3-6 months, and when others went to collect, the clinics had run short.[28] The police clearance letters also did not serve any legitimate governmental purpose in fighting the spread of Covid-19. The issuance of these letters at police stations was not pre-conditioned by any medical examination of the intended travellers, hence there was no guarantee that they would not spread the coronavirus to other areas. Such medical examinations are the sole domain of the country`s health profession and not the police.

The unavailability of public transport in remote areas also forced women to miss their treatment. A rapid HIV-specific assessment from Zimbabwe found that 19% of people living with HIV were unable to get antiretroviral therapy (ART) refills.[29] In an interview, Samuel, the Director of Tariro Youth Development Trust, whose organisation was serving young people living with HIV before and during the pandemic, noted that in Zaka District, Masvingo Province, some women living with HIV resorted to walking long distances to get their ARVs refilled.[30]

Access to healthcare facilities

Many women living with HIV have other comorbidities and require regular access to healthcare facilities for clinical treatments. They require constant viral load checks, routine tuberculosis (TB) checks and cervical and breast cancer screenings, as they are more susceptible to these cancers. Lack of access to health facilities due to travel restrictions accelerated the deterioration of their health conditions. Opportunistic Infection Centres were closed in many places and there were reduced clinic hours.[31] It was also reported that women living with HIV who had underlying cardiac or respiratory conditions and older women living with HIV may be at higher risk of acquiring the coronavirus and developing more serious symptoms.[32] These problems prevented women from accessing care for HIV-related conditions thus left them much prone to contracting coronavirus itself.

Right to water

Another right that was tempered with during lockdown is the right to water. According to General Comment 14 to the ICESCR, Paragraph 11, the right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and

28 Nyashanu et al, "Exploring the challenges of women taking antiretroviral treatment".

29 Cairns G. 2020. "Disruption to HIV treatment in Africa during Covid-19 during Covid-19 pandemic could double HIV deaths, modelling studies warn", *Aidsmap.com*, 13 May.

30 Interview with Samuel, Director of Tariro Youth Development Trust, by P Vengesai. Zaka, Zimbabwe, 14 April 2022.

31 Universal Health Coverage (UHC) Partnership. 2021. "Zimbabwe: Data-driven decisions maintain availability and access to essential health services during the Covid-19 Response", *ExtranetWHOint*, 31 March.

32 UNICEF. n.d. "Technical Note on Covid-19 and Harmful Practices", UNICEF.org.

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potable water.[33] While the committee on the ICESCR frames the right to water as right to health, this is not the case with Zimbabwe. The Zimbabwe Constitution, in Section 77(a), makes the right to water a stand-alone right. It unambiguously states that "every person has the right to safe, clean and portable water".

The importance of the right to water in the Zimbabwean context can be derived from its wording. The relevant section provides for the *right* to safe, clean and potable water, as opposed to the *right of access t*o water in other constitutions.[34] Zimbabwe is therefore obligated to guarantee the right to water, and not merely the right of access. The right to access to water was explained by Gabru to mean that the state's obligation is to provide the means to ensure access to water.[35] It can be argued that this may not be the case where the state must guarantee right to water.

The court in *City of Harare v Mushoriwa* noted that Section 77 of the Zimbabwe Constitution is a fundamental human right, such that the state is enjoined to take reasonable legislative and other measures to achieve the progressive realisation of this right.[36] The brief facts of the case are that the City of Harare issued a water bill of $1700 to Mr Mushoriwa who disputed the bill on the basis that it was a bulk water bill and not for his premises, leading to the disconnection of the water. Mr Mushoriwa made a chamber application for the restoration of the water supply pending the resolution of the water bill dispute, which interim relief was granted by the court *a quo* on the basis that the disconnection of the water was in violation of the right to water.

In interpreting Section 77, the court stated that:[37]

> Possible violation of its provisions is only implicated where the State or a local authority fails to provide any or adequate water supply to any given community or locality. It might also arise where, as appears to have been recently admitted by the appellant itself, having afforded an adequate water supply to most inhabitants, it is then discovered that such supply is in fact contaminated and therefore only potable at great risk.

It is argued that the government of Zimbabwe failed to provide adequate water during lockdowns. The Women's Coalition of Zimbabwe reported that women were "beaten and barred" by law enforcement agents from accessing water at communal boreholes. This was particularly reported in Masvingo in the Aphiri area.[38] There

33 CESCR, General Comment No. 14.

34 Constitution of the Republic of South Africa, 1996, s 27 (provide for the right to access to water, as opposed to the right to water as provided by the Constitution of Zimbabwe).

35 Gabru N. 2005. "Some comments on Water Rights in South Africa", *Potchfstroomse Elektroniese Regsblad/Potchefstroom Electronic Law Journal* 8:12-14.

36 *City of Harare v Mushoriwa* 2018 ZWSC 54 at 27.

37 *City of Harare v Mushoriwa.*

38 Parliament of the United Kingdom. 2020. "Womankind response to IDC inquiry on the impact of corona virus (Covid-19) on developing countries". Online at: https://committees.parliament.uk/writtenevidence/1931/pdf

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were reports of men using violence and force against women queuing at water points in attempts to jump the queue.

Right to food

In the same section as the right to water, the Zimbabwean Constitution, in Section 77(b), provides for the right to sufficient food and mandates the state to take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of this right. The right to food has been described by Kirsteen Shields, a lawyer, as a right that is corporeal, intimate and essential to all of life.[39] The focus on assessing whether this right has been met must be on the adequacy of structures surrounding the production of and access to food as opposed to the metrics of physical access and consumption.[40] Since it is an internationally recognised right, the scope of the right to food can be found in international law.[41] An interpretation of the international right to food is given in General Comment 12 of the Committee on Economic, Social and Cultural Rights to the ICESCR.[42] It defines the right to food as: "the right of every man, woman and child alone and in community with others to have physical and economic access at all times to adequate food or means for its procurement in ways consistent with human dignity".[43]

The heart of the right to food is access to food that is adequate in terms of both quality and quantity.[44] The threefold obligation of government is to respect, protect and fulfil the right to food.[45] This threefold obligation is corroborated by Section 15 of the Zimbabwean Constitution, which requires the state to encourage people to

39 Shields K. 2017. "Methods of Monitoring the Right to Food", in Andreassen BA, Sano H-O, and McInerney-Lankford S (eds). *Research Methods in Human Rights: A Handbook*. Cheltenham: Edward Elgar Publishing, 333-353.

40 Shields, "Methods of Monitoring the Right to Food".

41 Universal Declaration of Human Rights, G.A. res. 217A(III), U.N. Doc A/810at 71 (1948), art 25(1). (Article 25(1) provides that: "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."). See also International Covenant on Economic, Social and Cultural Rights, GA Res. 2200A (XXI), 21 UN GAOR Supp (No16) at 49, UN Doc A/6316 (1966), 993 UNTS 3, *entered into force* 3 Jan 1976, art 11(1). (Article 11(1) states that: "The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing. Moreover, article 11(2) recognizes the fundamental right of everyone to be free from hunger.").

42 Convention on Economic Social Cultural Rights, General Comment No. 12 (1999) (on the right to adequate food as set forth in Article 11 of the Covenant).

43 Convention on Economic Social Cultural Rights, General Comment No. 12.

44 Zimbabwe Human Rights NGO Forum. 2009. "Human Rights Bulletin No. 42: The right to food and Zimbabwe", *Reliefweb*.

45 HRForumZim, "Human Rights Bulletin No. 42: The right to food and Zimbabwe".

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grow and store adequate food, secure the establishment of adequate food reserves and encourage and promote adequate and proper nutrition through mass education and other appropriate means. It is this threefold obligation which the Zimbabwean government failed to accord its citizens, and women living with HIV and AIDS suffered the most.

Covid-19 had drastic impact on food consumption and nutrition security as households lost income while food prices went up due to the inflationary shocks of the pandemic.[46] This scenario came in the midst of a situation where women with HIV and AIDS are economically disadvantaged more than men. Women living with HIV aged 25-34 years are 22% more likely than men to live in extreme poverty.[47] This economic inequality increased further during the Covid-19 pandemic and its aftermath.[48] The Zimbabwean economy, which is largely informal, could not sustain livelihoods of those who make a daily living off the streets. In a report, UNAIDS indicated a great concern for the worsening humanitarian situation in Zimbabwe, where people living with HIV are disproportionately affected by food insecurity and shortages of essential medicines.[49]

Right to privacy

A pertinent section of the right to privacy as provided for in the Zimbabwean Constitution is Section 57(e), which clearly forbids unwarranted intrusion into a person's health condition. The right to privacy is a civil and political right, and its wording in the Constitution is even clearer in its intention to protect the privacy of a person's health condition than it is in the international law.[50] General Comment No. 16 and Article 17 of the International Covenant on Civil and Political Rights (ICCPR) require member states to take effective measures to ensure that information concerning a person's private life does not reach the hands of persons who are not authorised by law to receive, process and use it, and is never used for purposes incompatible with the Covenant.[51]

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46 Zimbabwe Peace Project. 2021. "The impact of COVID-19 on socio-economic rights in Zimbabwe", *Reliefweb*, 18 May.

47 McCarthy J. 2018. "Women Are More Likely Than Men to Live in Extreme Poverty: A Report", *Global Citizen*, 16 February.

48 Ferreira FHG. 2021. "Inequality in the Time of Covid-19", International Monetary Fund, Summer.

49 "People living with HIV face major challenges in Zimbabwe", UNAIDS, 8 March 2019.

50 UDHR, art 12 (Article 12 states: "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks." See also International Covenant on Civil and Political Rights art 17 which states that "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.").

51 UN Human Rights Committee (HRC). 1988. CCPR General Comment No. 16: on Article 17 (Right to Privacy), The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, 8 April.

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In order to enforce travelling restrictions, Zimbabwean roadblocks, especially on roads entering the major cities, were manned by soldiers and police.[52] As people would try to make their way to health care centres, they would inevitably encounter these roadblocks. Confidentiality in this regard was breached in two ways. Women with HIV were asked to present medical cards to the police at the roadblocks to prove that they were HIV positive, hence their intention to visit health facilities, or they would be required to disclose their status in order to be issued travelling letters at the police station. The breach of confidentiality is confirmed by reports of public health researcher Mathew Nyashanu and colleagues that police would ask to see hospital cards from women living with HIV if they alleged that they were visiting a hospital for medical treatment.[53]

Freedom of religion

The Zimbabwe Constitution does not provide for a stand-alone right to religion. However, it is included in the guarantee of freedom of conscience in Section 60(1)(a), which provides: "Every person has the right to freedom of conscience, which includes freedom of thought, opinion, religion or belief. In the same fashion, this right is provided for in both the African Charter on Human and Peoples' Rights and the ICCPR.[54] General Comment 22 of the Committee on Civil and Political Rights interprets the right to freedom of thought, conscience and religion in a far-reaching and profound manner.[55] In its interpretation, the Committee emphasised that the right to religion encompasses personal conviction and the commitment to religion or belief, whether manifested individually or in community with others.[56] The same general comment further provides that the freedom to manifest religion or belief may be exercised "either individually or in community with others and in public or private." A South African case of *S v Lawrence*, which has a persuasive value to Zimbabwe, established the scope of the right to religion as: "The right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs

52 Nyashanu et al. "Exploring the challenges of women taking antiretroviral treatment".

53 Nyashanu et al. "Exploring the challenges of women taking antiretroviral treatment".

54 See African (Banjul) Charter on Human and Peoples' Rights (Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *entered into force* 21 October 1986, art 8 (providing for freedom of conscience); International Covenant on Civil and Political Rights, GA Res 2200 (XXI) of 16 Dec 1966, 21 UN GAOR Supp (NO 16) at 52, UN Doc A/6316, 999 UNTS 171 *entered into force* 23 Mar 1976, art 18:1 (provides that: "Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.").

55 UN Human Rights Committee (HRC), CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion), 30 July 1993, CCPR/C/21/Rev.1/Add.4.

56 UN HRC, CPPR General Comment No. 22.

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openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination."[57]

The right to gather for religious purposes can also be found in the right to freedom of assembly and association.[58] In another South African case, *Minister of Home Affairs v Fourie and Another*, the role of religion was perceived to have the capacity to awaken concepts of self-worth and human dignity.[59] Section 58 of the Zimbabwe Constitution provides for the right to freedom of assembly and association, and if this right is read together with the right to religion, then the right to religion would guarantee a degree of autonomy for religious groups to run their affairs without interference.[60] This view was corroborated by legal scholar Pierre De Vos and colleagues, who highlighted that freedom of religion includes also the right to act in accordance with those beliefs and to organise one's life in a manner that demonstrate allegiance to one's beliefs.[61] Thus, where a certain religion believes in congregating and is banned from gathering, it means that their right has been violated.

During lockdown, women with HIV were deprived of this right, despite its benefits to their status and healing process. Research has shown that spirituality and religion play an important role in women living with HIV.[62] Churches in collaboration with community-based organisations (CBOs) have been known to hold special programmes at clinics and in the communities to encourage adherence to medication. Some CBOs also belong to churches. As well, spirituality has been defined by sociologist Magdalena Szaflarski to be the "internal, personal and emotional expression of the sacred and often assessed by spiritual wellbeing, peace/comfort derived from faith, and spiritual coping", while religion has been defined as "the formal, institutional and outward expression of the sacred, and has been measured by importance of religion, belief in God, religious attendance, and prayer and meditation".[63] Szaflarski appreciates the interrelatedness of religion and spirituality. The importance of spirituality and religion to women living with HIV is centred on the fact that they slow disease progression.[64]

According to theologian Francisco Dimitre Rodrigo Pereira Santos and fellow researchers, "the moment that a woman receives a positive diagnosis for HIV, she experiences fear, not only the fear of death as a result of the disease, but also fear of prejudice, fear of not receiving social support, and fear that other people might

57 *S v Lawrence* 1997 (4) SA 1176 (CC) para 92.

58 Currie and De Waal, *The Bill of Rights Handbook.* 317.

59 *Minister of Home Affairs and Another v Fourie and Another* 2006 (3) BCLR 355 (CC) para 89.

60 Currie and De Waal, *The Bill of Rights Handbook*, 317.

61 De Vos P. and Freedman W. 2017. *South African Constitutional Law in Context.* Cape Town: Oxford University Press, 484.

62 Szaflarski M. 2013. "Spirituality and Religion among HIV-Infected Individuals", *Current HIV/AIDS Reports*, 10:324-332.

63 Szaflarski, "Spirituality and Religion among HIV-Infected Individuals".

64 Szaflarski, "Spirituality and Religion among HIV-Infected Individuals".

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know her condition. The patient then begins to re-evaluate her life and goals."[65] Santos and his research colleagues posit that religious groups and spirituality are among the means by which people living with HIV cope with the condition.[66] Many women living with HIV use spirituality as a fundamental resource for overcoming the stress and demands associated with disease.[67] In many cases, spirituality can enhance the lives of women living with HIV, as such women seek spirituality as a coping mechanism for their illness, entrusting to God all their chances for cure.[68] In this way, women can cope with the negative thoughts brought about by illness, as well as the stressful situations brought on by the disease, maintaining calmness even in the face of adversity.[69]

The lockdown brought a ban on religious gatherings to Zimbabwe. Religious leaders switched to online church services. Online conduct of business has been found to be exclusionary on its own due to lack of resources such as devices and data required for online engagement. Therefore, the banning of church gatherings impeded stress management of women living with HIV. These women were left in the confinement of their homes, where they were also susceptible to gender-based violence (GBV). Globally, women living with HIV experience higher rates of GBV than the general population.[70]

For women living with HIV, gender-based violence can hinder HIV prevention and access to services.[71] The fear of violence makes it difficult for women to decide whether and with whom they will have sex or to be able to negotiate safer sex. Violence and the potential for it, discourages many women living with HIV and AIDS from disclosing their HIV positive status to their partners, families and health providers, making it more difficult for women to stay on HIV treatment. Thus, the ban on religious gatherings exacerbated and increased other social problems especially GBV.

HOW WOMEN LIVING WITH HIV WERE AFFECTED BY THE CURTAILMENT OF THESE RIGHTS

Based on the interviews, challenges faced by women with HIV during lockdowns are several. According to one of the interviewees, Ottinah Matafi, a Community

65 Santos FDRP, Gurgel do Amaral LRO, Dos Santos MA, Ferreira AGN, Ferreira de Moura J and Brito LB. 2019. "Repercussions of Spirituality in the lives of women living with HIV", *Revista Cuidartre* 10(3):71.

66 Santos, "Repercussions of Spirituality in the lives of women living with HIV".

67 Szaflarski, "Spirituality and Religion among HIV-Infected Individuals".

68 Szaflarski, "Spirituality and Religion among HIV-Infected Individuals".

69 Ironson G, Kremer H and Lucette A 2016 "Relationship Between Spiritual Coping and Survival in Patients with HIV", *Journal of General Internal Medicine* 31(9):1068-1076.

70 Orza L et al. 2015. "Violence Enough already: Findings from a global participatory survey among women living with HIV", *Journal of the International AIDS Society* 18(5):20285.

71 "What is the link between HIV and gender-based violence?", *ReliefWeb*, 1 December 2014.

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Adolescent Treatment Support mentor from Zimbabwe Young Positives (ZY+), young women living with HIV were forced to disclose their statuses.[72] The confidentiality of the women's HIV status was compromised when they had to show hospital cards to police officers to show that they were travelling to collect ART. Some of the women were denied access at roadblocks despite showing hospital cards. This was made worse by the fact that most of the police officers at roadblocks were from the same communities as the women. Most feared it would end up being a topic of gossip with their neighbours. According to an interview with Charmaine Matanda a monitoring and evaluation officer with ZY+, "Some of the women had to suffer accidental disclosure at home as families began to see that a family member was constantly taking medication as people had to spend more time together at home than before. These disclosures came with a lot of mental challenges which caused some to abandon their medication."[73]

People living with HIV must also constantly access medical facilities for other medical service, according to an interview with Fadzai Tawonangwere the advocacy and communications assistant for ZY+.[74] This include, viral load checks, cervical cancer screening and general medical check-up, so that practitioners may know if the women are experiencing challenges with their health. Some clinics had to be closed in Shamva District, as cited by Wellington Bakaimani, the Director for Simukaupenye Integrated Youth Academy, which is working with young women living with HIV, especially single mothers.[75] There arose gaps in medical treatment with more people skipping appointments, as some were locked down in other places far from their local clinics with their medical records elsewhere. This led to some women who had low viral loads ending up with high viral loads, as well as opportunistic infections and death for some.

This prompted most women to travel long distances to access their medication. They had to walk, because in their area was not served by the Zimbabwe United Passenger Company (ZUPCO), which was the transport service that had been exempted from Covid-19 restrictions. If they boarded unregistered taxis, at some point they would be ordered to disembark on the way. The women from the rural areas were hit doubly, as their local facilities were closed with no alternative transport. The transport challenges faced by urban women were generally among the few who used facilities outside of their local communities, as was noted by Yvonne Shumbanhete of Africa Asia Youth Foundation in an interview.[76]

72 Interview with Ottinah Matafi, a Community Adolescent Treatment Support mentor from Zimbabwe Young Positives (ZY+), by P Vengesai. Harare, Zimbabwe, 2 May 2022.

73 Interview with Charmaine Matanda, a monitoring and evaluation officer with ZY+, by P Vengesai, Harare, Zimbabwe, 2 May 2022.

74 Interview with Fadzai Tawonangwere, the advocacy and communications assistant for ZY+, by P Vengesai, Harare, Zimbabwe, 2 May 2022.

75 Interview with Wellington Bakaimani, the Director for Simukaupenye Integrated Youth Academy, by P Vengesai, Shamva, Zimbabwe 5 May 2022.

76 Interview with Yvonne Shumbanhete, the Director of Africa Asia Youth Foundation, by P Vengesai. Masvingo Zimbabwe, 20 April 2022.

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Shumbanhete further noted that "these women resorted to defaulting because most of them opted for out of community facilities as they shun nursing staff who live within their communities for fear of being known".[77]

During the pandemic, they reduced the meals to one due to financial hardship. This resulted in malnutrition and mental health challenges. According to Shumbanhete, malnutrition and mental health challenges have a relationship with a high viral load.[78] The right to food was thus not respected during the pandemic, as even the safety nets offered by government could not last a family a fortnight. Shumbanhete further noted that women are already economically marginalised in many different ways and particularly noted that traditionally women cannot own the means of production like communal land. Many traditional leaders are sceptical to give land to women. Traditionally, the inheritance of deceased spouse's estate is handled by the family and husband's families disregard the widowed wives. Many women living with HIV are widows and single mothers. They are living in poverty. Before the pandemic, they were living on two meals a day. As Shumbanhete put it, "When we say meals, we are not talking about the substance, but just something to eat. It may be a whole carbohydrate meal only or something. During the pandemic, some barely had a single meal, though they still had to take their medication."[79] Tafadzwa Mupfumi, a programmes officer at the Africa Asia Youth Foundation, emphasised the exacerbation of economic hardships during lockdowns and linked it with gender-based violence.[80] Of this connection, Mupfumi said, "We saw more cases of gender-based violence during the pandemic, some of which culminated into domestic violence as the women turned to victimise children due to the GBV. One case in Chivhu was recorded where a woman murdered four of her children because of their father's infidelity."[81]

Due to the financial challenges posed by the Covid-19 pandemic, many households could not afford to pay for their water bills. Many households saw their safe, clean water being disconnected. Generally, the right to water has been questionable even in the pre-Covid-19 era, with taps only having water very early in the morning and going the rest of the day without. During the pandemic, most people faced water disconnections, such that they relied on boreholes which are far from where they were residing. Angeline, as a woman living with HIV, had this to say:

> My worst nightmare during the pandemic was a time I could not even pay for my rent. My landlord wanted at least money to settle the bills, which I didn't have at that time, and she insisted I leave if I could not raise the money. I had to move to another area where rentals are much cheaper but there is no water connection. People there rely on boreholes. There is no

77 Interview with Yvonne Shumbanhete.

78 Interview with Yvonne Shumbanhete.

79 Interview with Yvonne Shumbanhete.

80 Interview with Tafadzwa Mupfumi, a programmes officer at the Africa Asia Youth Foundation by P Vengesai. Masvingo, Zimbabwe, 20 April 2022.

81 Interview with Tafadzwa Mupfumi.

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> electricity. They rely on gas, but I still couldn't afford it. So, I had to use fire, but I cannot really go out to look for firewood due to my health condition. I have a heavy chest, which is why I can't opt to use paraffin for cooking. It has been difficult to access water, but I have to go to fetch water several times, as I can only use a smaller container. I do not have anyone to help, so I have to do it myself.[82]

When asked to clarify on what a heavy chest would mean, Angeline indicated that it is a respiratory problem. The problem of water and other utilities was affecting everyone; however, women with HIV, because of their underlying conditions, were affected more than others.

The cessation of gatherings, including religious gatherings and all forms of clubs, affected many young women who relied on these to relieve their stress and get inspiration from others. Clinics relied more on giving lessons when people came to collect medication. In these lessons, they reminded everyone to adhere to medication and other ways of living positively. It is in these lessons that experts were called to teach on other ways to live positively. Church attendance also helps people to remain positive – and without it, many lost hope. Jacqueline, another woman living with HIV had this to say:

> Closing of churches during the pandemic was not for anyone's benefit. I love church, and I have always found solace in church since I found out I was HIV positive. The very week I discovered my status I went to a new church. I was looking for healing from HIV, but I found something better than a healing. It became family and it has helped me stay positive. Online services were not accessible to many, as it required data at a time when money was hard to come by. For most of us, online services were difficult to follow, though it became normal.[83]

Many of the women could relate to this reality. Non-organisations serving these women also experienced hurdles in delivering services to their beneficiaries. Total lockdown meant that they could not help women living with HIV directly, since there was no physical access to them. Some women living with HIV became reluctant to collect ARTs, leading to high viral loads and low CD4 count.[84] The organisations could neither provide counselling services, nor make follow ups with women who had been recently tested positive for HIV. They also could not conduct CD4 counts on women living with HIV.

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82 Interview with Angeline (not her real name) by P Vengesai. Masvingo, Zimbabwe, 15 September 2022.

83 Interview with Jacqueline (not her real name) by P Vengesai. Masvingo, Zimbabwe, 15 September 2022.

84 A CD4 count tells you how many CD4 cells there are in a drop of blood. The more there are, the better. A healthy immune system normally has a CD4 count ranging from 500 to 1 600 cells per cubic millimetre of blood (cells/mm^3), according to *HIV.gov*. When a CD4 count is lower than 200 cells/mm^3, a person will receive a diagnosis of AIDS. AIDS is a separate condition that can develop in a person with HIV.

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Most medical facilities working with people living with HIV rely greatly on volunteers from different organisations to complement their programmes' efforts. During the programmes is where much advocacy is done to encourage people to get tested and adhere to medication, as well as on ending stigmatisation and discrimination. In the absence of these organisations, facilities became overwhelmed with just a few people. According to Sam Mzenda of Tariro Youth Development Trust, it was very hard to keep working in the pandemic, thus he observed, "We had members who were working directly from the medical facilities. They had to struggle as the nurses there did not have enough PPE; hence, we could not even think of having it. There was general fear among the staff members, especially at a time when medical staff was hard hit and were dying from the pandemic. It was a difficult time. Organisations could not keep encouraging the staff to face the danger. It was a trying time."[85]

Above all, the findings from the interviews emphasised the way in which the rights of women living with HIV were violated. One dimension of the violation of the right to privacy arose from the home visits that the organisations initiated in trying to reach out to their patients. These visits had the effect of informing other family members about the client's HIV status. Also, when they sent personnel to an area for purposes of collection and treatment, the client's status was exposed to the person bringing the treatment. This then amounts to violation of medical confidentiality.

All the research participants agreed that society should have some understanding of the plight of those suffering from other chronic diseases and that people should not suffer any stigma or stigmatisation when they discloser their health status in a bid to look for health assistance. Women with HIV or AIDS are perceived by the society to have contracted it through promiscuity. For that reason, women with HIV and AIDS felt that they should not have disclose their status to police for the purpose of obtaining travelling letters. One woman living with HIV said, "Telling the police that I need a letter to visit clinic to collect my treatment was a major challenge, because my condition is different from blood pressure, sugar diabetes or any other disease which people consider to be of natural cause. If you tell people that you have HIV in my society, you will be considered to have contracted it through sexual promiscuity."[86] Mary T. Bassett, an American public health researcher who has administered HIV/AIDS programmes in Africa, buttresses this position in arguing that the emergence of AIDS pandemic in the early 1980s was gendered and those women who were positive were perceived to have contracted it through sex work. This kind of discrimination and stigmatisation persisted in the Covid-19 pandemic and led to women living with HIV to avoid seeking assistance, as that was only possible after disclosing the status. This fear of disclosure of health status resulted in women living with HIV suffering in the confinement of their houses.

85 Interview with Sam Mzenda of Tariro Youth Development Trust by P Vengesai. Zaka, Zimbabwe, 14 April 2022.

86 Interview with a woman with HIV by P Vengesai. Masvingo, Zimbabwe, 2 October 2022.

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Globally, women carry the burden of domestic work at the rate of 2.5 times more than men.[87] Women generally have borne the brunt of house chores, coupled with the need to help their children with schoolwork, among other domestic tasks. Due to the increased care responsibilities during the Covid-19 pandemic, all women were hard hit. However, women with HIV, like other patients with chronic diseases, needed to work less and find some rest. Because of their fear of disclosing their condition to their family members so that they could be relieved of domestic duties to nurse their health conditions, they had to endure the burden of domestic work. Maria, a community care supporter and peer counsellor interviewed in Masvingo, had this to say, "Through my counselling sessions, I discovered that most of my HIV patients went through traumatisation and stress due to the burden of domestic work, as they did not disclose their status to family members in fear of stigmatisation."[88]

Maria indicated that, by the time that the Covid-19 restrictions were relaxed, most of their women patients had run out of treatment due to lack of accessibility. She indicated that most men would find their way to the centres to collect their medication, yet women found it very difficult to negotiate with police at the roadblocks. As Maria described it:

> In the second phase of the lockdown, when we had processed the paperwork to open the centre, most of our male patients would come to collect their medication, and when I asked them how they would have passed the roadblocks, they would say "I am a man I know how to find my way out." Yet it was very unfortunate most women could not visit us for their treatment and our efforts to visit their homes were hampered by their fear of stigmatisation and discrimination.[89]

These contentions were backed by another women living with HIV, who was asked if she managed to consistently take her medication during the Covid-19 lockdown. In her own words Maria in an interview said, "At some point I went for a week without medication, as there was nowhere to find the treatment in my suburb. I tried to go to town to get my medication and the police sent me back indicating that I did not have a letter to go to town."[90]

Some of the research participants indicated that they run out of medication during lockdown. Generally, most people living with HIV could not afford to buy medication in pharmacies, and the pharmacies generally do not stock ARVs, as they are free in public institutions because of health aid offered by international organisations, such as the Global Fund and PEPFAR. But even if the medication was available in pharmacies, it was difficult for them to buy over the counter with their cards, as any

87 UN Women/Women Count. 2021. Progress on the Sustainable Development Goals: The Gender Snapshot 2021. New York: UN Women/ UN Department of Economic and Social Affairs, 16.

88 Interview with Maria by P Vengesai. Masvingo, Zimbabwe, 2 October 2022.

89 Interview with Maria.

90 Interview with Maria.

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other patient with a chronic disease would do, because they did not want the local pharmacists to know their conditions. The idea of having the ARV bottle thrown on the counter and having to pick it up and walk out was too farfetched. In clinics, people living with HIV have long battled the need to be assisted in rooms that are secluded, especially the back of the facilities where they are not seen by others. As Ivy in an interview said, "I waited for an opportunity to access the clinic so that I can get my medication instead of me going to the pharmacy and be known by the whole suburb that I am positive."[91] Agreeing with Ivy, Angeline said, "At the pharmacy you will see a board written 'we check BP and sugar', but they won't include HIV, because it is a sacred disease that one cannot disclose in our culture. Even bringing the medication from the local pharmacy with your card is not something I would do. Besides where would I find that kind of money to purchase the drug for about US$30.00."[92]

CONCLUSION

In light of the above, it is recommended that the Government of Zimbabwe should improve drug restocking at all health centres, allowing patients to access medication and needs locally. It is essential that ARV stocks and prevention supplies are prioritised. It is also important for the government to provide for training and deployment of larger numbers of village healthcare workers, peer counsellors and ART counsellors who bring all the HIV and opportunistic infections (OI) clinic services into the communities. Many women living with HIV and AIDS need constant counselling and frequent check-ups in order to prevent and overcome depression, stress, anxiety and psychosocial challenges. Portable water must also be made available to communities through the use of increased number of boreholes and mobile tanks. Municipalities must be assisted to increase their capacity in water provision to avoid cut offs and interruptions. Social assistance funding must also be increased and be extended to women living with HIV and AIDS. This will help them to secure food and be able to participate in church services that are done online for instance through WhatsApp and Facebook.

While it is accepted that Covid-19 epidemic affected everyone, vulnerable groups within communities, such as people with chronic diseases, were the most affected. People with chronic diseases need to have access to health care systems, sanitation and hygiene, safe water and a healthy food supply. As discussed above, during lockdown, access to such critical services was limited. Although both man and women with chronic diseases were affected due to lockdown, women living with HIV and AIDS suffered the brunt of the challenges. Public health researchers and clinician Mathew Nyashanu and his fellow researchers posit that HIV and AIDS still has the status of a global health challenge despite numerous efforts, at international,

91 Interview with Ivy (not real name) by P Vengesai. Masvingo, Zimbabwe, 2 October 2022.

92 Interview with Angeline.

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regional and national levels, to contain it.[93] The gains realised from these efforts faced setbacks in the Covid-19 era. Women with HIV and AIDS suffered more because of the factors identified in this chapter.

93 Nyashanu et al, "Exploring the challenges of women taking antiretroviral treatment".

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