'*HIV/AIDS, HUMAN RIGHTS AND THE LAW – OPPORTUNITIES, CHALLENGES AND THE WAY FORWARD FOR SOUTHERN AFRICA*'

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Speech given at the ***Launch of HIV/AIDS Human Rights Charter***

Zimbabwe Lawyers for Human Rights
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1. It is an honour that you have asked me again to be involved in this launch of the Zimbabwe HIV and AIDS Human Rights Charter. I thank Zimbabwe Lawyers for Human Rights and the other partner organisations for inviting me.
2. And it is with the driving spirit behind today's event, Zimbabwe Lawyers for Human Rights, that I want to start. The fact that an organisation devoted to human rights and the rule of law has sponsored the process leading to the Charter says critical things about the way we have to frame our epic battle with this epidemic – namely, by emphasising and respecting the rights of all affected by and at risk from AIDS. I will return in a moment to how important the 'rights-centred approach' to HIV/AIDS is.

3. But first I want to make a connected point. It is this. While you cannot ignore rights when you approach health and healthcare and human well-being, this means equally that cannot ignore elementary principles of sound government when you speak about any healthcare issue.
4. Zimbabwe is currently cursed with one of the lowest, perhaps *the* lowest, life expectancy in the world. According to the World Health Organisation,[1] a male Zimbabwean can expect to live only to the age of 37. For women, life expectancy is even lower – only 34.
5. These shocking figures are a direct outcome of the ghastly nightmare of mis-governance that has afflicted Zimbabwe for the last eight years. They are a consequence of the misrule, tyranny, brutality and regime-led thuggery that has led many hundreds of thousands of Zimbabweans to flee their own country – and that has imposed on those who remain, misery, hunger, beatings, oppression and disease-afflicted mortality.
6. I would show less than ordinary human decency if I failed to express my remorse and shame at the part my own country, South Africa, has played in condoning, colluding with and supporting this state of affairs.

7. To be healthy, to be well, to be able to face this epidemic with strength and will, Zimbabweans need good government – wise, democratic, just, people-led government based on the rule of law.
8. The world waits and watches as Zimbabweans continue the struggle to secure these fundamental rights in their own country.
9. Last year in September, during the opening of the Commonwealth Law Conference, the biggest cheer came when the outgoing president paid tribute to what he called 'the world's bravest lawyers' – those who are opposing tyranny in Zimbabwe.
10. My point is that opposition to tyranny is an indispensable part of our struggle to create a sound and just system of governance that includes a healthcare-system favouring vigorous engagement with the AIDS epidemic.
11. The mis-governance in Zimbabwe has exacerbated the crisis of AIDS in many ways:
    - It has caused the collapse of health structures.
    - It has led to shortages of anti-retroviral drugs.

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[1] http://www.who.int/whosis/mort/profiles/mort_afro_zwe_zimbabwe.pdf, accessed Friday 29 August 2008.

- And it has impeded sound and effective prevention policies.

12. Hence, when your Charter in clause 4.6 demands that 'access to treatment, care and support must be reinforced by the provision of health services by properly trained and well-resourced professional and competent service providers', how can this be realistic unless there is a commitment to good, honest and effective governance in Zimbabwe?

13. That is why ZLHR's human rights commitments cannot be sub-divided. The struggle for a just and well-ruled Zimbabwe is also the struggle for sane and effective AIDS policies, and the Charter we are launching today forms an integral part of that struggle.

14. As I said in this same venue more than two years ago (in May 2006), your invitation to me, a non-Zimbabwean South African, emphasises how we on this sub-continent must face this epidemic together:

AIDS does not yield to borders or nationalities or to ethnic or racial or language sexual differences. In AIDS, no less than in opposing tyranny and misrule, we need to think together and plan together and act together. And if we are to surmount the daunting challenges of sickness and death and discrimination

the epidemic presents to us, we have to pool our ideas and strengths and resources.

15. The revised Charter you have drafted is a significant and enlightening document. I say this for the following reasons:

- First, as I mentioned earlier, the Charter strongly endorses the human rights approach to HIV prevention and care. It adopts a dignity-based approach to dealing with the epidemic. This is correct in principle – since human rights violations, even in pursuit of public health policy, are hard to justify. But, in addition, the human rights approach constitutes sound strategic thinking, since it is only by protecting the rights of those with HIV/AIDS that we can hope to curtail the effects of the epidemic. It is now well-established that, in complex related ways, violating the human rights and dignity of those living with HIV or AIDS enhances the spread of HIV and makes the epidemic worse..[2]
- Second, the revised Charter recognises the importance of governance, and with it responsibilities of government. Clauses 4.6 and 5.1 require that government should ensure

[2] See the keynote address of Chief Justice Pius Langa of South Africa at the HIV and Access to Legal Services Conference of the AIDS Law Project, University of the Witwatersrand, Johannesburg, 17-18 February 2006.

that treatment is accessible and affordable to all (the state is obliged to 'provide anti-retroviral drugs to all who need them'). This provision is imperative. Public provision of health care is a governmental responsibility, and no more clearly so than in a continent-wide emergency such as the HIV/AIDS epidemic. The public provision of anti-retroviral medication in particular is a vital governmental duty – one that has become especially urgent since AIDS is no longer an inevitably fatal condition. Provided relatively straightforward healthcare interventions are made, AIDS is now a chronically manageable illness. The Charter's focus on government's responsibility to provide treatment is therefore well-directed.

- Third, the Charter is important because while it emphasises government's duties, it also recognises that government cannot deal with the epidemic on its own. Each of us carries the duty, inside and outside government, to respond with humanity to AIDS in our homes and communities and workplaces.
- An especially important point is that good AIDS interventions – in awareness, education, prevention, promotion of testing, and in treatment access and literacy – demand vibrant,

strong and unflinching civil society organisations. That means organisations like Zimbabwe Lawyers for Human Rights, who monitor the response of government, intervene when violations of rights occur, and press vigorously for equality, dignity and treatment access.

- We in South Africa experienced this the ghastly nightmare of government denialism about the causes of AIDS afflicted us. From the end of 1999, until 2003, our government seemed unwilling to accept that a virus caused AIDS. This had the ghastly consequence government initially refused to accept AIDS could be effectively treated with anti-retrovirals. So our national response to AIDS was paralysed, as illness, anguish and death mounted. Fortunately powerful voices of principle in civil society, including the Treatment Action Campaign, the South African Council of Churches, and the Congress of South African Trade Unions, too on the government. The media was not far behind. And the courts eventually became involved: the Constitutional Court ruled that government had to provide mothers with HIV access to ARVs to lessen the chances of transmitting HIV to their new-born infants. Government had to yield. South Africa now has the world's largest publicly provided ARV programme. More than 400

000 people are receiving ARVs through public clinics – and another 100 000 through private healthcare schemes. We have to do much more – since nearly 1000 people a day are dying of AIDS. But we have come far.

- The lesson is that principled, outspoken, well-informed, well-organised, citizens must be involved to deal effectively with AIDS. Democracy, constitutionalism and respect for human rights are necessary in Africa. They are necessary in Southern Africa. They are necessary in South Africa. And they are necessary in Zimbabwe. They enhance our dignity and our capacities as human beings, not least because they enable us to deal better with one of our generation's major moral challenges, AIDS.

16. As I emphasised last time I spoke here, none of this should be controversial. Almost all there principles are official policy of the African Union. The Special Summit of the African Union in Abuja, Nigeria, held in May 2006, produced a remarkable document, reflecting the Common Position that Africa presented to the UN General Assembly's Special Session on AIDS in June 2006. The Common Position –

- emphasises the role of civil society, and asserts that national governments must be ‘supported by partners including civil society’;
- commits Africa to fostering leadership and strong political commitment that strengthens civil society organisations;
- recognises that human rights violations against women and others exacerbate the effects of the epidemic and impede prevention and treatment efforts;
- emphasises the susceptibility of vulnerable groups such as women children and uniformed services to the spread of HIV, and the need to scale up the response to under-served and marginalised groups, such as people in conflict situations, displaced persons, sex and migratory workers;
- reflects and appreciates the vital importance of a holistic response to the epidemic, including the pivotal role of poverty reduction, nutrition and food security in HIV prevention, treatment and care.

17. The Charter we are launching today rightly enunciates many of these themes. This is commendable. And the Charter has caught up with international principle by now – unlike two years ago – expressly mentioning sex and sexuality.

18. Vulnerable groups must lie at the centre of Africa's response to AIDS. And our response must recognise the particular susceptibility of 'sex and migratory workers'.

19. Your Charter is no longer silent on vulnerable sexually defined minorities. This is a great advance. In the overwhelming majority of cases – more than 9 out of ten – HIV is transmitted by sexual intercourse. Sexual transmission is explains much of the reason for the enormous stigma that continues to surround HIV infection.

20. Even though the fact that AIDS is now medically manageable is reducing stigma, it is still central feature of this epidemic. Stigma is fuelled by sexual shame, sexual silence, sexual exclusion. So in talking about AIDS we cannot ever keep quiet about sex. If we do, we add to stigma. We add to the burden that everyone infected with HIV and everyone affected by the epidemic carries. We increase the isolation, despair and fear that too many continue to feel in this epidemic.

21. And we must deal with the sexual subordination of women and gender based violence – issues your Charter rightly emphasises focuses on.

22. But we must do more. We must also talk about the legal position of commercial sex workers, and the continued

criminalisation of private consensual acts between adult men. In accordance with the UNGASS principles of 2001, we must identify the legal provisions that continue to contribute to stigma and that impede access to prevention and treatment.

23. We must speak about the fact that, in Zimbabwe and elsewhere in Africa, continued criminalisation of sex acts between consenting adult men, and continued governmental rhetoric against them, impedes prevention messages and delays access to life-giving treatment.

24. It puzzles me in this regard that your revised Charter speaks about LGBTI and other sexually vulnerable groups – but doesn't specially mention men who have sex with men (MSMs).

25. This in my respectful view is an unwise omission. Not all men who engage with sex with other men identify themselves as gay or bisexual. This is especially the case in Africa, where prejudice and discrimination are still rampant. Your Charter fails to identify and protect those outside the LGBTI community who are at risk of infection and at risk of transmitting HIV – and who are especially under-served with educational and prevention materials.

26. In response to a query I sent during the drafting process, I was told that 'There have been strong indications from a lot of

AIDS service organisations in Zimbabwe that we [should] use 'LGBTI', partly because of the government's attitude; and that 'in Zimbabwe, 'LGBTI' has been accepted as a term to include also MSM according to persons I have spoken to from government agencies like the National Aids Council'. If this reflected the attitude of MSMs themselves, it would greatly surprise me.

27. Another reservation I have about the Charter as redrafted is that it states (clause 4.13) that children 'have the right to request information' including 'information on prevention, VCT, confidentiality, access to treatment, care and support, including the provision of condoms for the sexually active'. By contrast, clause 5.1 asserts that the State 'must ensure that everyone, including children and young persons, have access to correct, accurate and age-specific information on HIV and AIDS prevention, treatment, care and support and mitigation interventions'.

28. There seems to be some dissonance between these provisions. Why does clause 4.13 insist that this information must first be 'requested'? We know that children – often far too early – are sexually active. In the case of prisoners, who we know are also sexually active, the Charter insists that they be

afforded access to condoms (clause 4.14). This is correct. The logic should be carried through and made unequivocally clear in the case also of sexually maturing or active children.

29. One final comment is that the Charter doesn't speak directly about the role of the criminal law. Clause 5.1 urges that the government 'should review and reform public health, criminal laws to ensure that they are consistent with international human rights obligations and are not misused in an era of HIV or against targeted groups'.

30. That does not seem to me clear enough. You must be well aware of the 26 year old woman from a township near Bulawayo who was arrested last year for having unprotected sex with her lover. She was living with HIV. The crime of which she was convicted was 'deliberately infecting another person'.

31. The strange thing is, her lover tested HIV negative. The woman was receiving ARV therapy, so that is not surprising.[3] Before sentencing her, the court tried to get a further HIV test from the lover – even though reportedly he didn't want to

[3] Swiss HIV clinical specialists recently released a consensus statement 'that individuals with HIV on effective antiretroviral therapy and without sexually transmitted infections (STIs) are sexually non-infectious'. See Vernazza P et al. 'Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitment antirétroviral efficace ne transmettent pas le VIH par voie sexuelle', *Bulletin des médecins suisses* 89 (5), 2008,
available at http://www.saez.ch/pdf_f/2008/2008-05/2008-05-089.PDF (accessed 21 July 2008).

proceed with the charges at all.[4] She was eventually sentenced to a suspended term of five years' imprisonment.[5] The threat of imprisonment, and the shame and ordeal of her conviction, will continue to hang over her.

32. The statute under which she was convicted, s 79 of the Zimbabwe Criminal Law (Codification and Reform) Act 23 of 2004 is an extraordinary piece of legislation. It doesn't make it a crime merely for a person who knows that she has HIV to infect another. It makes it a crime for anyone who realises 'that there is a real risk or possibility' that she might have HIV, to do 'anything' that she 'realises involves a real risk or possibility of infecting another person with HIV'.

33. In other words, though the crime is called 'deliberate transmission of HIV', this is a misnomer. For you can commit this crime even if you do not transmit HIV. In fact, you can commit the crime even if you do not have HIV. You merely have to realise 'that there is a real risk or possibility' that you have HIV – and then do something – 'anything' – that involves 'a real risk or possibility of infecting another person'.

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[4] Reported in the Zimbabwe *Herald*, 2 April 2008, http://allafrica.com/stories/200804020011.html (accessed 21 July 2008).
[5] Zimbabwe *Herald*, Tuesday 8 April 2008.

34. Stranger upon strange, this statute offers a defence when a person really does has HIV. In such a case, if the other person knew this, and consented, then the accused is exempt. But, the way the statute is drafted, this defence can not apply where the accused does not in fact have HIV, or does not know that she has HIV – by definition, in that case she cannot engage the informed consent defence by telling her partner she has HIV!

35. In short, this law creates a crime not of effect and consequence, but of fear and possibility.

36. What is more, the wording of the law stretches wide enough to cover a pregnant woman who knows she has, or fears she may, have HIV. For if she does 'anything' that involves a possibility of infecting another person – like, giving birth, or breast-feeding her newborn baby – the law could make her guilty of 'deliberate transmission – even if her baby is not infected.

37. In all cases, the law prescribes punishment of up to twenty years in prison.

38. These are misguided, counter-productive and wrong-headed laws. Far from protecting women, they target and victimise them – as the Bulawayo prosecution did.

39. The AIDS community in Zimbabwe should take a clear stand against laws of this sort, and seek the repeal of the relevant provisions of Act 23 of 2004.

40. As last time, I do not speak in the abstract about the issues of prevention, treatment and care. I speak with personal passion, for –

- I have myself been living with HIV for more than twenty three years;
- For many years after my diagnosis in 1986, I lived paralysed by the fear and silence of stigma;
- I became severely ill with AIDS in October 1997;
- But because I could (on the salary of a judge) afford the expensive anti-retroviral drugs, I was given my life back; and
- I am now privileged to live a vigorous, health-filled and engaged life because I have good medical care and access to treatment.
- In addition, I feel blessed to receive support and affirmation from my friends and family, as well as from my colleagues in the judiciary and the legal profession.

41. So I come to speak to you about hope. We do not need to fear this epidemic. By taking action – in our own lives, and for the lives of others – we can ensure survival amidst death.

42. I am pleased that the new Charter reflects progress on the normalisation of AIDS in Zimbabwe.

43. What does ‘normalisation’ mean? It means that we strive to get to the position where infection with HIV is treated as no more than just another

44. It is of course true that all life threatening conditions demand an abnormal response – breast cancer, high blood pressure, insulin-dependent diabetes. But we must guard against any interventions that increase the stigma surrounding HIV.

45. The Charter no longer insists that there must be pre-test counselling. It says in clause 4.7 that counselling ‘must always be available’. That is right. It should be available, but it shouldn't always be insisted on. [Give Durban 2007 AIDS conference example.]

46. Unfortunately, your Charter still seems to insist that there must be written consent for a test (clause 4.7). This seems to be wrong in principle, counter-productive and liable to increase stigma.

47. I realise that many wish to include such protections from a desire to protect the human rights of those at risk of HIV.

48. But the result may be the opposite. Such provisions drive people away by emphasising how different HIV is. We do not

insist on written consent for blood pressure testing, diabetes monitoring or liver function tests or platelet counts. Why do we insist on written consent to HIV testing? Only because we continue to fear discrimination and stigma.

49. But where these protections themselves emphasise the differentness of HIV in the mind of the person who is considering whether to be tested, they increase stigma – and drive people away from testing altogether.

50. These provisions reflect safeguards that were fought for and attained in the 1980s. That was before HIV could be treated. At that time, the main object of administering an HIV test was all too often to identify and isolate and to stigmatise anyone found to be HIV positive. Treatment did not exist, and a positive test too often simply gave health care providers and others a chance to discriminate and exclude.

51. But conditions are now different. Treatment for AIDS is now available, and is becoming increasingly accessible even in our continent's poorest countries.

52. And what we are finding is that, despite the availability of treatment, many people are still reluctant to be tested for HIV. They refuse an HIV test even when they know that they will be offered treatment and support and solidarity. All too often, they

take these fears with them in isolation to the grave. In their loneliness and anguish, they appear to 'choose' death rather than to be diagnosed with HIV.

- This is a profound and difficult problem. As I mentioned last time I have become sceptical because I suspect that the special impediments surrounding HIV testing increase stigma. We have to ask:
- Where treatment is available, are the extra prerequisites that surround testing for HIV necessary or justifiable?
- And where health care resources are severely stretched, is counselling not a luxury we can ill afford?
- We must ask ourselves whether, instead of making AIDS different from other life-threatening medical conditions – as was necessary for the first 25 years of the epidemic – we should not start re-medicalising HIV diagnosis and treatment.

53. These are difficult but important questions. They light our way forward in dealing with AIDS. And your revised Charter in my respectful view has a number of positive features here.

54. The objective of 'normalising' HIV and AIDS matches the revised Charter's emphasis on 'shared confidentiality' (clause 4.8), which is rightly says 'should be emphasised and reinforced'.

55. The same clause rightly encourages openness about HIV status – which is ‘strongly encouraged’.

56. We have come a long way these last 25 years. We have learnt sad and sore and illuminating truths about ourselves amidst the grief and suffering of this epidemic.

57. But the most important lesson the epidemic has taught us is what we can do about it. In North America, Western Europe and in Africa, it is the principled, unflinching campaigns of activists who have repeatedly changed the course of the epidemic. Without determined activism –

- There would have been no treatment for AIDS;
- ARVs would still have been unaffordable; and
- we would not have UNGASS, the Global Fund, and a world that recognises – at least in principle, though still too little in practice – that it is immoral and unacceptable to stand passively by while millions of African men and women die of AIDS because they have no treatment and health care services.

58. The most important lesson of the epidemic is one of hope. AIDS is now medically manageable. My own survival – nearly eleven years after starting on ARVs – is just one example. It is within our power to make this epidemic smaller and lest hurtful to us and our communities by taking effective action.

59. It is our duty to build on this rich and inspiring history of action and activism. Your revised Charter points in the right direction. That is an encouraging and inspiring portent.