Zimbabwe Lawyers for Human Rights

Launch of HIV/AIDS Human Rights Charter

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‘Rights, responsibilities and building an effective response to AIDS’

by

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1. It is an honour for me to be with you this morning to launch the Zimbabwe HIV/AIDS Human Rights Charter. I thank the organisers from Zimbabwe Lawyers for Human Rights for inviting me to join you and to say a few words on this important occasion.
2. Their invitation to me, a non-Zimbabwean South African, recognises that on this sub-continent we’re in this epidemic together: that the epidemic does not bow before borders or nationalities or to language or ethnic or racial or sexual differences, and that in AIDS, as in other matters, we need to think together and plan together and act together if we are to surmount the daunting challenges of sickness and death and discrimination it presents to us.

3. I am particularly honoured and pleased to be asked to speak at the launch this morning. The Charter you have drafted is a significant and enlightening document. I say this for the following reasons:

- First, the Charter unashamedly embraces human rights, and 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, a human rights approach constitutes good 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. This is because it is well documented that, in complex related ways, human rights violations against people with HIV or AIDS enhance the spread of HIV and exacerbate the epidemic. As the Chief Justice of South Africa, Justice Pius Langa, recently observed, this approach 'must be used by all sectors of society who are actively engaged in fighting the epidemic':

> The rights-based approach to HIV/AIDS recognises that violations of fundamental rights such as the right to non-discrimination, the right to health, the right to food and water, the right to social security, the right to privacy and the rights of women are all contributing factors that exacerbate

the spread of HIV/AIDS and its consequences. It therefore aims to deal with the problem at a multi-sectoral level by ensuring that all rights are recognised and protected in all spheres of life.[1]

- Second, the Charter recognises the responsibilities of government. It declares that 'government must ensure that treatment is accessible and affordable to all'. This provision of the Charter constitutes plain speaking. And it is correct. 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 a necessarily fatal condition, but is now chronically manageable with relatively straightforward healthcare interventions. The Charter's focus on government's responsibility to provide treatment is therefore well-directed.
- And in doing this the Charter also shines an unavoidable light on the question of good governance and how it affects the management of AIDS. It is obvious that without good government we cannot respond effectively to the devastation of AIDS. This lesson is emerging painfully in Zimbabwe. It

[1] Keynote address at HIV and Access to Legal Services Conference, AIDS Law Project, University of the Witwatersrand, Johannesburg, 17-18 February 2006.

requires no particular desire for controversy to note that issues of governance, economic policy and international relations are directly affecting those living with AIDS in Zimbabwe. Widespread reports reaching South Africa suggest that life-giving supplies of anti-retroviral medication have been interrupted, that these drugs are unaffordable even to those who have jobs, and that this is a direct consequence of political instability in Zimbabwe.

- Over the last quarter-century, the AIDS epidemic has shone a remorseless light on every moral issue in every society it has touched. It has exposed hypocrisy and double-dealing and unjust privilege; it has accentuated inequality and injustice; and it has revealed misrule. All South Africans, of all political persuasions, profoundly yearn for an end to the controversy that has beset governance in Zimbabwe over much of the last decade. The destructive effects of misgovernance in the management of the AIDS epidemic acutely underscore this wish.
- Third, the Charter is important because while it emphasises government's duties, it also rightly understands that government cannot be expected to deal with the epidemic single-handedly. Individual response to AIDS is a duty that each of us bears,

inside and outside government, in each of our homes and communities and workplaces.

- In particular, effective responses – in awareness, education, prevention and in treatment access and literacy – require a vibrant, strong, unafraid civil society. 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 learnt this lesson very valuably, when some years ago we went through a painful period of governmental denialism about AIDS. From the end of 1999, until 2003, our government seemed unwilling to accept that HIV was the cause of AIDS. This entailed the horrendous consequence that government seemed to doubt the medically established fact that AIDS, as a virally caused condition, can be effectively treated with anti-retroviral medication. The result was that an effective national response to the illness and suffering of the epidemic became paralysed. Fortunately powerful voices in civil society, including the Treatment Action Campaign, the South African Council of Churches, and the Congress of South African Trade Unions, expressed profound and vigorous opposition to the

government's stand. This, combined with pungent media criticism, pressure from business, a Constitutional Court ruling, and our governing party's long tradition of internally reflective debate and dissent, led to a salutary change in government's approach. We now have a national treatment roll-out that promises every South African with AIDS access to anti-retroviral medication at public health facilities. Last week, government announced that nearly 140 000 South Africans are receiving free anti-retroviral treatment through public health facilities – a significant achievement, on which we need urgently to improve.

- The lesson from South Africa is this. An assertive, articulate, well-informed, well-organised, rights-conscious, unafraid citizenry is indispensable if we are 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.

4. Some of this may sound controversial. But fortunately – since judges should generally avoid controversy – it is not. Almost all I have said is deeply embedded in official policy of the African

Union. A remarkable document emerged from the Special Summit of the African Union in Abuja, Nigeria, held a few weeks ago from 2-4 May 2006. This contains the Common Position that Africa as a continent will present next week to the UN General Assembly's Special Session on AIDS in June 2006. The document –

- repeatedly acknowledges the role of civil society, and emphasises that national governments must be 'supported by partners including civil society';
- commits Africa to fostering leadership and strong political commitment that builds on and 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;
- understands the central importance of a holistic response to AIDS, including the vital role that poverty alleviation, good

nutrition and food security play in HIV prevention, treatment and care.

5. The Charter we are launching today is prescient in that it adopts and enunciates many of these themes. This is commendable. But the African Union's Common Position to UNGASS does one thing that your Charter fails to do. It expressly mentions sex and sexuality. It repeatedly emphasises that vulnerable groups must lie at the centre of Africa's response to AIDS. And in doing so it unequivocally recognises the particular susceptibility of 'sex and migratory workers'.
6. More importantly, even, the African Union's Common Position to UNGASS sets out explicitly the groups that it includes within the category of those especially vulnerable in this epidemic. These it names as 'the poor; women, young people; orphans and vulnerable children; men who have sex with men; migrants; prisoners; sex workers; the disabled, people affected by conflicts and injuring drug users (IDUs)'.
7. The Zimbabwe Charter is signally silent on vulnerable sexually defined minorities. This is a disappointing omission. In about 95% of cases HIV is transmitted sexually. Sexual transmission is one of two principal reasons behind the enormous stigma that continues to surround infection with HIV. The other –

association with debility and death – is fortunately beginning to ebb, as the good news that AIDS can be successfully treated is spreading throughout our continent, even in under-served rural and urban communities.

8. But stigma is a still pervasive and oppressive and life-threatening dimension of this epidemic. That 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.
9. So we must talk fearlessly and boldly and bravely and clearly about sex. We must talk about the sexual subordination of women (an issue your Charter does address); 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 heighten stigma and preclude access to effective prevention and treatment. 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, is impeding prevention messages and delaying access to life-giving treatment.

10. Naturally, I speak of these matters with some personal intensity. I come to speak to you this morning, not only as a lawyer and a judge, and as one who has been involved in AIDS policy formulation for many years: but in all my human capacities and vulnerabilities. I speak to you as someone –

- who was infected with HIV more than twenty years ago;
- who lived for years in the paralysing fear and silence and isolation that stigma brings;
- who fell desperately ill with AIDS in 1997;
- who was saved by the near-miraculous availability of anti-retroviral medication; and
- who is now privileged to live a healthy, full and productive life because of the blessings of good medical care and access to treatment and because of the support and affirmation I receive not only from my friends and family, but also from my colleagues in the judiciary and throughout the legal profession.

11. So I come to speak to you of hope in action and the real possibility of survival in productivity in an epidemic that all too

often and unnecessarily continues to signal suffering and debility and death.

12. But I speak to you also in a further capacity. I speak to you as a proudly and openly gay man. Why am I proud to be gay? Because, like being white and being male, my gayness is an unavoidable and integral part of what makes me human: it is constitutive of my humanity. (For those who are religious, it is the way God made me.) I am also proud that President Mandela appointed me, as an openly gay man and a full and equal South African, to the High Court in 1994, and that President Mbeki appointed me in the same capacity to the Supreme Court of Appeal in 2000.

13. But a more urgent reason for me to speak about being gay is that homosexuality occurs in every sector of every society on earth – including in Zimbabwe. Homosexual transmission of HIV is a known but often under-stated fact, and men who have sex with men are a desperately ignored and under-served community in Africa.

14. Your Charter flinches from addressing the position of sex workers and gay men. We do candour about stigma, candour about HIV transmission, and candour about prevention and

access to treatment no service when we omit to talk openly and clearly about sex.

15. We do our own commitments an injustice when we are silent about commercial sex workers and men who have sex with men. We undermine those commitments when we omit these groups from our urgent insistence on equality, justice, dignity and access to prevention and treatment for all in this epidemic.

16. I have a further reservation about the Charter. This is a matter that at present is the subject of intense debate within the human rights AIDS policy community in South Africa. It concerns the pre-conditions for HIV testing. Your Charter –

- suggests that 'effective pre- and post-test counselling must be provided at all sites where HIV testing is conducted'; and
- requires that before anyone can undergo HIV testing, he or she must sign a written informed consent form.

17. 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 al too often only confirmed an intent to discriminate.

18. But these conditions have changed. Treatment now exists, and increasingly it is becoming available throughout Africa, even in its least-resourced areas. 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.

19. This is a fearful and complex problem, and in my work, I have started questioning these special protections:

- I have come to wonder whether the special protections and barriers that surround HIV testing do not add to stigma.
- I have come to doubt whether, where treatment is available, the extra prerequisites that surround testing for HIV are necessary or useful or justifiable.
- I have come to wonder, where health care resources are desperately strained, whether counselling is not a luxury that our continent can not always afford.
- I have come to wonder whether, instead of exceptionalising AIDS – as we have done for the first 25 years of the epidemic –

we should not begin to re-medicalise its diagnosis and treatment.

20. These are difficult questions. But I would raise the question whether your Charter should be quite so unequivocal about requiring that consent to an HIV test must be specific and express and written, and about whether counselling should be imposed as a prerequisite to testing.

21. I would ask whether you might not rather wish to adopt a formulation that suggests that counselling 'should' be provided where possible; and that informed consent to HIV testing may properly be included as a routine part of medical diagnosis where treatment, as opposed to discrimination and stigma, will be the result.

22. We have come a long way these last 25 years. We have learnt sad and bad and hopeful truths about ourselves in this epidemic of grief and loss and suffering. But the most important lesson we have learnt is about our own capacity for action. In North America, Western Europe and in Africa, it is the principled, thoughtful interventions of activists who have repeatedly changed the course of the epidemic. Without determined activism –

- we would not have had treatment for AIDS;

- we would not have had affordable medication prices, and
- we would not have had a world that recognises that it is immoral and unacceptable to contemplate the death of millions of African from AIDS simply because they have no access to care and treatment.

23. The most important lesson of the epidemic is one of hope. AIDS is now medically manageable. My own life – eight and half years after I start on anti-retroviral treatment – is only one case in point. We can change the course of the disease through constructive, careful, thoughtful action.

24. It is our duty to build on this rich and inspiring history of action and activism. Your Charter points in the right direction. Let us take it further purposefully.