NATIONAL ASSEMBLY OF THE FIRST SESSION OF

THE NINTH PARLIAMENT OF GUYANA (2006-2011)

REPORT OF

THE SPECIAL SELECT COMMITTEE

OF THE NATIONAL ASSEMBLY

ON THE

CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010)

PRESENTED TO THE NATIONAL ASSEMBLY

BY

THE CHAIRMAN OF THE COMMITTEE

ON

1ST SEPTEMBER, 2011

REPORT OF THE SPECIAL SELECT COMMITTEE OF THE NATIONAL ASSEMBLY ON THECRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010)

Appointment of a Special Select Committee

1. On the 29th July, 2010, the National Assembly passed Resolution No. 129 of 2010 which reads as follows:-

WHEREAS the first fight against HIV and AIDS has been relentless especially during the past 15 years;

AND WHEREAS some success has been recorded throughout the country in reducing the instances of infection and transmission of HIV and AIDS;

AND WHEREAS educating the population is of utmost importance in the arsenal of weapons and/or measures required to combat this dreaded disease;

AND WHEREAS despite the best efforts of health care officials, religious organisations and NGOs in educating the population with respect to AIDS and HIV, infection rates are still disappointingly high;

AND WHEREAS persons, some knowingly, still infect others with the Human Immune Deficiency Virus, causing immense suffering and pain to the infected persons, their families, community at large along with increased cost to the health care system;

AND WHEREAS persons are not held responsible by law for knowingly transmitting this deadly virus to innocent victims;

AND WHEREAS the confidentiality and non-discriminatory laws in place which protect persons affected with HIV and AIDS prevent disclosure of their identity, these persons are free to have unprotected sex with unsuspecting partners, thus further spreading the disease.

NOW THEREFORE, BE IT RESOLVED:

That the criminal laws of Guyana under all relevant sections be amended, to make it an indictable offence for any person to transmit the virus to any other person, when they would have had prior knowledge of their infected status;

BE IT FURTHER RESOLVED:

That non-disclosure laws or guidelines be so amended to allow information to be used by the prosecution if so required;

BE IT FURTHER RESOLVED:

That all agencies, clinics, hospitals which have the results of tests and other vital information be bound by law to release such information to any court engaged in a matter; and

BE IT FURTHER RESOLVED:

That the manner in which society and law treat with persons who willfully transmit HIV be taken to a Special Select Committee to examine this issue comprehensively, drawing from other countries' experiences which have criminalized this offence and those which have not, taking into consideration experts' and the public's views, as well as examining the present laws of Guyana and return to the National Assembly with considered opinions and recommendations on this issue.

Committal to Select Committee

2. Following its tabling and debate, the Resolution was committed by the National Assembly for consideration by a Special Select Committee on Thursday, 29th July, 2010.

Members of the Special Select Committee

3. At a meeting held on Thursday, 21st October, 2010, the Committee of Selection nominated the following Members to comprise the Special Select Committee to consider the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010).

Members of the People's Progressive Party/Civic (PPP/C) (6)

The Hon. Dr. Leslie S. Ramsammy, M.P.
The Hon. Dr. Jennifer R. A. Westford, M.P.
The Hon. Dr. Frank C.S. Anthony, M.P.
The Hon. Manzoor Nadir, M.P.
Dr. Vishwa Deva BudhramMahadeo, M.P.
Rev. Dr. Kwame Gilbert, M.P.

Members of the People's National Congress Reform – 1 Guyana (PNC/R-IG) (3)

Dr. George A Norton, M.P.
Mrs. Volda A. Lawrence, M.P.
Ms. Africo Selman, M.P.

Member of the Guyana Action Party/Rise, Organise and Rebuild (GAP/ROAR) (1)

Mr. Everall N. Franklin, M.P.

First Meeting of the Committee – Election of Chairman

4. At its first meeting held on Thursday, 10th March, 2011, the Committee elected the Hon. Dr. Leslie S. Ramsammy, M.P., Minister of Health as Chairman of the Special Select Committee.

Statutory Meeting

5. At the second meeting held on Friday, 3rd June, 2011, the Committee agreed to meet on Mondays at 3.00 p.m. with a minimum of two hours deliberations. However, the day and time of the Committee meetings were changed consensually to meet the convenience of Members.

Other Meetings of the Committee

6. The Committee met on four (4) other occasions as follows:-

3rd Meeting held on 27th June, 2011;

4th Meeting held on 13th July, 2011;

5th Meeting held on 3rd August, 2011; and

6th Meeting held on 10th August, 2011.

(See Appendix I for the Attendance Record of the Committee.)

Mandate of the Committee

7. The Committee's mandate was guided by Resolution No. 129 of 2010, that is, to examine this issue comprehensively, drawing from other countries' experiences which have criminalized this offence and those which have not, taking into consideration experts' and the public's views, as well as, examining the present laws of Guyana and return to the National Assembly with considered opinions and recommendations on this issue.

Consultation Process

8. At the second meeting, the Committee agreed on the methodology to be used in the consideration of the Resolution. It was agreed that:-

(i) in keeping within its mandate, the Committee would establish a process whereby the members of the public would be able to comment on the Resolution;

(ii) the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of

2010), would be made available to the members of the public via the Parliament Office and Parliament Office website; and

(iii) in order to obtain widest consultations on the Resolution, invitations would be posted in the print media inviting members of the public to make both written and/or oral presentations before the Committee.

9. In this regard, advertisements were placed in the media on the following dates: Wednesday, 8th June, 2011, Sunday, 12th June, 2011 and Monday, 13th June, 2011, extending invitations to members of the public – individual/s and organizations – to submit written and oral presentations to the Committee not later than 22nd June, 2011.

(See Appendix II for specimen of advertisement in the print media.)

Response to Invitations

10. The Committee received a total of nine (9) written submissions, four (4) from individuals and five (5) from organisations. The individual submitters were not interested in making oral presentations, hence, the five (5) organisations were invited to make oral presentations in support of their written submissions.

11. The Committee scheduled Wednesday, 13th July, 2011, for oral presentations.

(See Appendix III for submissions received)

Hearings

12. The oral presentations were held as follows on Wednesday, 13th July, 2011:-

- Artistes In Direct Support (AIDS)
- Society Against Sexual Orientation Discrimination (SASOD)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- National AIDS Committee (NAC)
- United Nations Development Programme (UNDP)

13. Details of the presentations including the questions asked and responses given can be found in the Record of Proceedings at the aforementioned date appended to the Report. (See Appendix IV for Record of Proceeding dated Wednesday, 13th July, 2011.)

Review of Recommendations from Hearings

14. Following the hearings the Committee met on Wednesday, 3rd August, 2011 and discussed the issues highlighted and the practicality of the recommendations made by the stakeholders from both the written submissions and oral presentations.

Observations

15. The Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010), notes the following:-

(i) that there is no need for an HIV-specific Criminal Law

Persons who maliciously transmit HIV with intent to harm others should face appropriate criminal prosecution. For these cases, there is no need to create HIV-specific legislation. Instead, existing laws relating to assault or criminal negligence must be invoked.

In determining whether an act of transmission should attract criminal penalties the complexities of human sexual behaviour must be carefully and fairly discerned. There are several circumstances in which an HIV positive person does not present a significant risk of transmission or does not have criminal intent.

A criminal law specifically related to HIV would cast all persons living with the virus as potential criminals and intensify the hysteria surrounding the virus.

(ii) that Criminalisation is counter-productive

The stigmatisation of people living with HIV has implications for the society as a whole. There are serious repercussions for public health when constructive responses are undermined by ineffective laws. Our legacy of legislating human sexual behavior, from sex work to same sex relationships, bears out that statutes are often irrelevant to individual decision-making surrounding sex. The proposed legislation does not stop an individual from engaging in risky activities before or after conviction, in or out of prison.

The most powerful tools for promoting disclosure and safer sex are initiatives such as voluntary counseling and testing and community engagement, including with and for persons who are living with HIV. Criminalization will certainly reduce people's willingness to learn their status and access treatment, care and support.

Guyana has made great strides in the areas of HIV-related treatment, care and support, and its successes in the prevention of new HIV infections are lauded regionally and globally. Voluntary counselling and testing services are accessed freely and without hesitation or fear by hundreds of persons weekly.

The Treatment Programme ensures that Guyana achieves universal access to HIV treatment with the most efficacious regimen based on current science.
Persons living with the disease across the country benefit from psychosocial, nutritional and other forms of support.

(iii) that Criminal Laws dealing with HIV transmission are often unfairly and selectively enforced

Where they exist, these laws are often applied to people who are the socially or economically marginalised. Women are especially are more vulnerable to prosecution under such laws because they access health services more frequently than men and are therefore likely to find out their HIV status sooner. Infidelity, rape, sexual coercion and

unequal power relations are among the dynamics that increase women and girls' vulnerability to both HIV infection and prosecution under such laws.

(iv) The Special Select Committee believes that Criminalisation places responsibility solely on the HIV positive person.

Guyana's estimated HIV prevalence is 1.5 percent. Exposure to the virus is a risk that every sexually active individual has a personal responsibility to manage. A law relating to general HIV transmission places responsibility for risk-reduction only on the HIV infected person.

Additionally, criminalisation may create a false expectation that the law has eliminated any danger from engaging in unprotected sex. Not knowing a partner's status or assuming that he or she does not have a disease are not sufficient reasons for neglecting to use protection; discussing each other's status and getting tested are behaviours that will lead to a decline in HIV.

Guyana needs to continue to combat stigma and its often resulting discrimination, so that people can make healthy, responsible and safe choices about their sexual and reproductive lives.

Several other issues have to be addressed such as prior knowledge and consent and whether or not there was deceit or coercion. Willfulness and intent also have to be proven, and if proven, the existing laws of Guyana are sufficient to take such cases to justice. Overall, the negatives of criminalising HIV exposure and transmission far outweigh the benefits.

Recommendations

16. The Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010), recommends that:-

(i) The State must take action in a manner that ensures compliance with the laws governing the International Human Rights Conventions on Equal and Inalienable Rights of Human Beings, specifically those related to health, education and social protection of all people, including people living with HIV.

(ii) The Committee commended the passage of laws in the National Assembly addressing sexual offences and other forms of violence against women and recommends that the National Assembly direct legislative reform at discrimination and other human rights violations against people living with HIV and people most at risk of exposure to HIV.

(iii) The National Assembly should support the Government of Guyana's Program to expand its proven programmes to achieve HIV prevention, including programmes with people living with HIV, and support voluntary counselling and testing for couples, voluntary disclosure, and ethical partner notification.

17. The Committee believes that the adoption of overly broad legislation criminalising HIV transmission or exposure will be a major set-back in the country's existing national HIV response, and would undermine the excellent work that is currently being done locally to address HIV.

Report of the Special Select Committee

18. At its meeting held on Wednesday, 10th August, 2011, the Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010), agreed that this Report on its consideration of the Resolution be presented to the National Assembly.

19. The Report is accordingly hereby submitted.

Minutes

20. The Minutes of Proceedings of the Committee are at Appendix V.

Verbatim Records

21. Verbatim Records of the proceedings of the Committee would be available at the Parliament Office.

Hon. Dr. Leslie Ramsammy, M.P.,
Minister of Health,
Chairman

Committees Division
Parliament Office
Public Buildings
Brickdam,
Georgetown.

10th August, 2011.

APPENDIX I

SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS (RESOLUTION NO. 129 OF 2010)

ATTENDANCE RECORD (2011)

NAME	March	June		July	Aug.	
	1st	3rd	27th	13th	3rd	10th
The Hon. Dr. Leslie S. Ramsammy, M.P.	Pr.	Pr.	Pr.	Pr.	Pr.	Pr.
The. Hon. Dr. Jennifer R.A. Westford, M.P.	Pr.	Pr.	Pr.	Pr.	Pr.	Pr.
The Hon. Dr. Frank C.S. Anthony, M.P.	Pr.	Pr.	Pr.	Pr.	Pr.	Abs.
The Hon. Manzoor Nadir, M.P.	Abs.	Ex.	Pr.	Pr.	Ex.	Pr.
Dr. Vishwa Deva Budhram Mahadeo, M.P.	Pr.	Pr.	Abs.	Pr.	Ex.	Ex.
Rev. Dr. Kwame Gilbert, M.P.	Pr.	Ex.	Pr.	Pr.	Pr.	Pr.
Dr. George A. Norton, M.P.	Abs.	Pr.	Pr.	Pr.	Pr.	Abs.
Mrs. Volda A. Lawrence, M.P.	Abs.	Ex.	Ex.	Pr.	Pr.	Ex.
Ms. Africo Selman, M.P.	Pr.	Pr.	Ex.	Pr.	Pr.	Abs.
Mr. Everall Franklin, M.P.	Pr.	Ex.	Ex.	Ex.	Ex.	Ex.

Pr. - **Present**
Abs. - **Absent**
Ex. - **Excused**

Committees Division
Parliament Office
Public Buildings
Georgetown

APPENDIX II

PARLIAMENT OFFICE

SPECIAL SELECT COMMITTEE ON

CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS,

(RESOLUTION NO. 129 OF 2010)

INVITATION TO THE PUBLIC FOR WRITTEN SUBMISSIONS

Resolution No. 129 of 2010 on Criminal Responsibility of HIV Infected Individuals has been committed to a Special Select Committee of the National Assembly. This Resolution seeks to institute legislation to hold persons criminally responsible for willfully infecting others with HIV.

The Committee has begun its work but wishes to receive from members of the public, professional individuals, and organisations, their views on the above mentioned Resolution.

The Committee is, therefore, extending an invitation to members of the public for written submissions on this matter not later than **Wednesday, 22nd June, 2011.**

Copies of the Resolution can be obtained from the Parliament Office or via the Parliament Office's website: www.parliament.gov.gy.

Individuals and organisations who are willing to appear before the Committee to give oral evidence should indicate this in their submissions.

All written submissions and requests to give oral evidence can be sent to committees_division@yahoo.com or must be addressed to:

The Clerk of the Committee
Special Select Committee on
Criminal Responsibility of HIV Infected Individuals,
(Resolution No. 129 of 2010).
Committees Division,
Parliament Office,
Public Buildings,
Georgetown.

Mr. Sherlock Isaacs

Clerk of the National Assembly

8th June, 2011.

APPENDIX III

The Clerk of the Committee
Special Select Committee on
Criminal Responsibility of HIV Infected Individuals
(Resolution No. 129 of 2010)
Committees Division
Parliament Office
Public Buildings
Georgetown

committees_division@yahoo.com

One of the things we have to understand about HIV is that the one thing that gives us pleasure is the one thing that can kill us-SEX. There are campaigns on sexual behavior, the effects of having unprotected sex, having multiple partners, sharing needles and abstinence but we are still facing the problem of a rising number of HIV infections each year. This makes us ask the question, "Are our efforts really reaching the targeted audiences?" Yes, the message is getting out there. One can get graphic and show horrifying pictures of what HIV and other STDs develop into, but this generation has a short attention span. It will affect us for that particular point of time and we will talk about it, then the memory of it fades.

No one, no matter how hard we try, can prevent anyone from having sexual intercourse. It is an act of nature. The only thing we can do at this point is encourage responsible behavior.

To the topic at hand, holding persons criminally responsible for infecting others has been an issue that has had my attention for years. There are some countries who imprison people for this act. There are countries that mark people who are HIV positive. But how can one measure justice from imprisoning someone who has infected others?

Scenario

John finds out the he is HIV positive, he becomes furious. He says to himself, someone has given it to me; I will give it to others. John did not think at the time that it was his responsibility to protect himself. Maybe the person who infected him did not know of their status either. John becomes promiscuous and starts acting irrationally. The only thought he has is that he will die soon. He doesn't think that he can still live a long life with the right attitude, diet and medication. He just thinks death. He becomes a bioterrorist. It becomes an obsession. He doesn't realize that he has developed a mental illness from this obsession. John had slept with at least twenty women since finding out about his status. This issue somehow reaches Public Health and John is tried and imprisoned. John refuses to state the names of the persons he has infected. What do we do? We publish John's name or picture and asking for anyone who has come in contact with this man to come into the clinic for counseling and testing. Human Rights intervenes and states that this is invasion of privacy and an act of discrimination. Women or men who have come in contact with John are then scared to get tested. Some were known to be affiliated with John. What does this lead to? People continue with their lives and live in fear of it or denial and others who are not strong enough commit suicide, while some become vindictive and start to spread it as well.

But you imprison John and what justice is there? The damage is already done. John has already infected dozens of men and women. We may have prevented him from being in contact with people in society, but think of the continuum and all the people who are now infected by John. The ones he has infected start to infect others who then infect others. Then when John is imprisoned, do you isolate him from inmates? Because it has become a widely known fact that men do involve in same sex behaviour in prison. How do you protect the inmates from infection? Do you give John a chastity belt or put him in confinement or under quarantine?

Some people who are living with HIV develop mental illnesses. How do you deal with this individual then? You institutionalize them, but where? A mental institution or a prison? Anywhere you place them; they still put others at risk with their behaviour.

But then, if you place a law on HIV infected persons who willfully infect others, what happens to the rest who willfully infect others with other STDs such as Chlamydia, Gonorrhea, Syphilis, Herpes etc? Don't these people deserve protection under the law as well?

There were cases in the United States where HIV infected individuals purposefully place infected needles in the seats at movie theatres so as to infect others. That is criminal too, but we don't know who the perpetrators are. We had media attention given to two men in society years ago who willfully infected others. What has become of these men? So does criminalizing individuals who spread this virus serve any purpose? No, the onus is on us as individuals to protect ourselves.

How do we find the persons in society who are willfully spreading this virus? How do we tract individuals who have tested positive? What satisfaction do we give to the victim? We cannot un-infect someone.

You want to educate people on what irresponsible behavior can lead to. In a moment of passion, some people become irrational thinkers and just think for the moment. Some people become forceful and say that they are allergic to condoms or want to have a baby.

What we need to do as a society is try to combat the spread of HIV/AIDS, even if our efforts seem futile. When we criminalize infected individuals we are also rebuilding that stigma already attached to HIV/AIDS. You don't want to institute a law that is useless. Yes we need laws to protect persons against being willfully infected.

Criminalizing infected individuals who willfully spread this disease leaves us with other social issues. We face stigmatizing individuals (discrimination), HIV infected persons still having the opportunity to infect others, the intervention of Human Rights, homicide, suicide and a long list of social ills.

The problem with this resolution is that we face having to ask more questions than actually coming up with answers.

Nevica Wray

Email: nevica.wray@yahoo.com

Re: Public submission for motion on criminalizing willful HIV infection

With vested interest I am sending this response. There is no doubt in my mind that Mr. Everall Franklin means well. However Mr. Franklyn's may have overlooked the complexity of the public health issues particularly regarding the sensitivities of HIV/AIDS.

While Mr. Franklyn has legitimate concerns that moved him to the point of making a motion to criminalize willful HIV infection, there are a number of factors if this motion is passed , this will impede and also retract progress that have been made regarding HIV/AIDS in Guyana.

Voluntary counseling and testing (VCT) is a huge success in Guyana, there are major successes in the prevention from mother to child transmission (PMTCT). As a result of these two major HIV/AIDS programs in conjunction with other HIV/AIDS prevention initiatives taken. Guyana has seen significant decline in HIV prevalence rates. However history has taught us that sex and sexually transmitted infections are taboo issues and as such carries a high level of stigma and discrimination. Criminalizing HIV can only add to further stigmatizing HIV in Guyana. Therefore we can experience regression of successful anti stigma campaigns. These are just a few projected likely consequences if HIV transmission is criminalized.

1. Fear of testing for HIV
2. Fear of accessing care and treatment for HIV.
3. Possible migration of person who can help to build our country
4. Regression of our PMTCT progress.
5. Decline in VCT
6. Unknown prevalence rates
7. Partner violence and abandonment
8. Great burden on the social welfare system of the country
9. More legal resources being channeled regarding punitive sanctions (can our current judicial system be able to accommodate an already over burden judicial system)
10. Possible separation of families with children once punitive sanctions are done.
11. Children can possible be orphaned if proper family support is there (wife not working ect.)
12. Increased infection of persons of unknown HIV sero status (person will boast to be negative since they never had a HIV test to prove their HIV sero status).
13. Increase in domestic violence for persons who feel that they are unable to access care if they felt they were exposed prior to the law being enacted.
14. Persons who were previously promiscuous will not willingly engage in HIV/AIDS awareness session since they cannot be held accountable if they are ignorant of the subject.
15. Violence against groups suspected of transmitting the virus will be targeted (Most at Risk populations can be targeted)

We can learn from our international neighbor Uganda who has criminalized willful infection of HIV/AIDS. It is estimated that 80% of people living with HIV is unaware of their status directly related to their punitive laws. Guyana has moved from being second highest prevalence within the Caribbean now Guyana is not longer even within top ten country in the Caribbean.

Additionally myths can possible be perpetuated similarly in Uganda anti homosexuality bill mandating the death penalty for persons who are HIV positive and engage in homosexual activity. This certainly perpetuates stigma and fear. This can create a public health crisis and nullify all the campaigns that have brought our general prevalence rate to 1.2 % since the advent of HIV/AIDS.

As a person living with HIV I do not see Mr. Franklin concern as illegitimate but I do believe the methodology can be more devastating. We have seen the benefits of partnerships, if you do not have people living with HIV as part of prevention process, this does not constitute a partnership. Thus much cannot be accomplished by criminalizing HIV but rather bringing people to a level of consciousness. This can only be won through reduced stigma and discrimination and recognizing that we are all human worthy of consideration and respect to live with dignity.

I have a mother, brothers, sisters, nieces, and nephews I would like them to be free of HIV and I am sure this is the sentiment of most people. However Criminalizing willful transmission of HIV will be difficult to be established since a negative sero status may be hard to establish particularly if a person never had a HIV test. Hence HIV persons will be viewed as criminals in light of that inability to prove ones negative status if a HIV test was never done. Assumption will be the law of the day. Let us think hard and long before we act least we blunder.

June 21, 2011

The Clerk of the Committee
Special Select Committee on
Criminal Responsibility of HIV Infected Individuals
Resolution 129 of 2010
Committee Division
Parliament Buildings
Brickdam
Georgetown

Dear Sir

Thanks for the submission of **RESOLUTION NO. 129 of 2010**

I am quite sure that there will be far and wide consultations and discussions on this issue and I do sincerely hope that good sense will prevail for not having this passed into a law of the Cooperative Republic of Guyana.

Honourable members, it must be noted, for it has been written that "From the UK to the USA, from Sweden to Australia, criminal laws are increasingly being used to prosecute HIV transmission or exposure, even if evidence shows that what we really need is increased investment in HIV prevention, treatment, care and support, and the elimination of stigma and discrimination – not criminalization – as the effective way to address the epidemic."

Jan Albert, Professor of Infectious Diseases at the Karolinska Institute, Sweden, says :

"Since I've been an expert witness in court trials, my personal opinion regarding people living with the virus has changed. In my experience the accused are seldom 'criminals'. There are many reasons for neglecting to inform sexual partners about HIV status, including denial. None, or very few, have had the intent to transmit HIV, which is how these acts often are described by the media. There will be more and more HIV infected people living in Sweden, and the rest of the world. Do we want to turn a proportion of our population into potential criminals every time they have sex ?"

Honourable members, the criminalizing the transmission of HIV will undermining in a major way our efforts in Guyana to prevent the spread of HIV. Fear of prosecution may deter people from coming forward for testing and counselling, and from disclosing their status to sexual partners and advising those partners to have an HIV test. Policing the bedroom will effectively drive the HIV "problem" underground. Guyana has made tremendous gains in getting people to be tested during the National Week of Testing, just imagine what will happen when this law comes to past.

It should be noted that in some countries, such as Canada and the USA, laws have been used to send mothers to prison for transmitting HIV to their child.

In Sweden a mother has been separated from her children and sent to jail for not disclosing her HIV status, even if she did not transmit HIV to anyone

In Portugal a cook was fired because he is HIV positive even though medical expert advice ruled out the possibility of onward transmission

In Greece a blood donor was sentenced to imprisonment for transmitting a girl and a man with HIV even if he did not know about his status when he made the donation.

It has been reported that in recent years, there has been substantial evidence that prosecutions for HIV transmission have been on the increase across Europe – most noticeably in a series of cases in Finland, the Netherlands, Sweden, and the United Kingdom. At the same time, HIV incidence and prevalence has continued to increase, particularly in Eastern Europe and Central Asia. '

Criminalization of people living with HIV is against a human rights approach towards the eradication of HIV/AIDS. One of the leading Organizations in the fight against HIV/AIDS summarized in the most distinguished manner, and I quote

" The criminalization of people who have transmitted HIV is both a moral and a practical minefield. The very fact that the sentences received by the individuals in the past vary from a small fine to life in prison reflects just how difficult it can be to legislate and deliver a ruling on an issue where individual viewpoints, emotions, stigma and the good of public health are so inextricably mixed.

According to UNAIDS there is no evidence to suggest that criminalising HIV transmission is an effective means to prevent the further spread of the virus or achieve criminal justice. If governments wish to make a dent in their countries' epidemic, far more effective prevention programmes exist such as testing, counselling and general awareness campaigns. Where criminalisation laws have been proposed as a means of protecting vulnerable women and girls from their HIV-positive partners, a more effective approach would be to address gender-related violence, inequality and sexual coercion, as well as stigma and discrimination.

While it is perhaps an understandable reaction on the part of individuals to want to seek redress through the courts for becoming infected, on an epidemic-wide scale criminalisation could do more harm than good. The potential disincentive to testing, stigmatisation of HIV, misapplication of the law, prosecuting people unaware of their status, as well as other possible pitfalls mean criminalisation may be counterproductive.

What should ultimately be remembered is that HIV is an infectious disease - every single person who is accused of sexually transmitting the virus by whatever means, will at some point have been the victim of a 'transmitter' themselves. Replication and infection is the primary objective of any virus. The real criminal is perhaps not the human host therefore, but HIV itself.

Thank you for reading my submission

Respectfully

Nasimul Hussain
348 East Street
Georgetown

Telephone 699-6411

Hampton Court
D.Town.Po
Region 2, Essequibo
18-6-2011

Clerk of Committee
S.S C- HIV Infected Individual
Parliament Office. Public Building
Georgetown.

Dear Clerk,

Subject to add appearing in the Daily press, about intended legislation about HIV scenario, I am submitting some proposals. However, it is a very sensitive issue, which legislation can only be recorded and very much controversial to be executed.

Proposals Attached.

Regards

Isahak Basir. Isahak Basir CEH

Tel: 771-4024

PROPOSAL BY I.BASIR FOR H.I.V LEGISLATION

(1) A special court must be established to deal with offenders and press coverage must not be permitted as well secession to be held in camera.

(2) The offender if found guilty must not be imprisoned, but monitory fine can be established.

(3) The offender must make financial compensation for the affected person.

(4) The offender when found guilty (a) must be confine to community work. (b) He or she must be confine to their respective Region for a given time, as well report to the Region Probation Officer on a monthly basis and such visit recorded.

(5) The legislation must be so draped that in the case of an individual allows, his or her self to be infected for, personal vendetta or financial gains – such person must also fall on the purview of the law.

(6) Such legislation must not only be confine to the official gazette, but much publicity must be carried out on T.V and Schools.

(7) If an offender is found guilty, with the exception of his house, his electrical equipment, fridge, motor cycle of car can be seized and sold for compensation.

(8) The complaint must be given free legal aid.

(9) Both the offender and affected must not be given travelers permit or passport.

(10) The immediate families of the giver and receiver of AIDS must be offered a copy of the Restriction order.

Submitted By:
I. Basir

NATIONAL AIDS COMMITTEE
c/o NAPS
Hadfield St. & College Road, P O Box 101325,
Georgetown, Guyana Tel: 225-7512

June 22, 2011

The Clerk of the Committee
Special Select Committee on
Criminal Responsibility of HIV Infected Individuals
(Resolution No. 129 of 2010)
Committee Division
Parliament Office
Public Buildings
Georgetown

Dear Clerk of Committee,

With Respect to Resolution No. 129 of 2010:

Please see enclosed the written Submission from the National AIDS Committee.

Also enclosed are copies of relevant documents that the Special Committee may find helpful: ***UNDP and UNAIDS Policy Brief-Criminalization of HIV Transmission; Declaration of Commitment on HIV/AIDS, 2001; UNGASS +5 Political Declaration HIV/AIDS; Annex: Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.***

By means of this letter, we communicate the willingness of a maximum of three persons affiliated to the National AIDS Committee to appear before the Special Select Committee to give oral evidence.

With best wishes,

Sincerely yours,

Bandi ford

Hyacinth Sandiford
Chair
Contact #: 602-5615

Merle Mendonca

Merle Mendonca
Secretary
Contact#: c/o 226-1789

The National AIDS Committee (NAC) is a voluntary body which promotes HIV/AIDS policy and advocacy issues, advises the Minister of Health and assesses the work of the National AIDS Programme Secretariat (NAPS) in relation to the National AIDS Programme. The NAC also encourages the formation of Regional AIDS Committees (RACs) and networking amongst NGOs involved in the fight against the HIV/AIDS pandemic.

NATIONAL AIDS COMMITTEE
c/o NAPS
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SUBMISSION TO THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS (Resolution No. 129 of 2010)

The GAP/ROAR Motion referred to the Special Select Committee on Criminal Responsibility of HIV Infected Individuals (Resolution No. 129 of 2010) is ill-informed, dangerous and ultimately counter-productive. Rather than accord the respectability of Select Committee hearings, this Motion should have been roundly rejected especially in light of the fact that, with both major parliamentary parties opposed to it, the possibility of success is zero. Moreover, Parliament, under the present Government, has already adopted an enlightened national AIDS policy which renders the need for the proposed legislation redundant. The pretence that the Motion merits serious consideration panders to opinion in the Region that continue to prevent the English-speaking Caribbean from demonstrating leadership in the struggle against stigma and discrimination towards people living with HIV and AIDS.

At a time when lack of legal reform aimed at dismantling archaic laws is the most serious obstacle to progress in confronting HIV in Guyana and the wider Caribbean, the seriousness accorded to this Resolution is an affront to all who are committed to fighting, funding and grappling with the reality of HIV and AIDS. While action on such issues as protection of women and girls against sexual violence, buggery laws and legal recognition of sexual identity remain stubbornly resisted, Governments cannot expect proposals criminalizing transmission to be viewed as anything other than an extension of these repressive policies.

Of particular importance in the context of Guyana is the fact that efforts to criminalize transmission are often defended in terms of protecting women and girls against infection from unfaithful or violent partners, precisely because the vast majority of infected women in the Caribbean have in fact acquired the virus from such sources Women constitute 53% of all PLWHA in the Region. However, as pointed out in the UNDP and UNAIDS Policy Brief looking for protection to criminalizing transmission may backfire against women. Many women cannot disclose their status without the likelihood of violence from their partner, nor can they negotiate safe sex. Moreover, women more than men tend to seek prompt medical assistance on any health matter and, for this reason, are likely to be blamed for "bringing HIV into the relationship". For all of these reasons legislation to criminalize transmission may work against women, despite them being victims in the situation. Moreover, in the Guyana case, the modern Sexual Offences Legislation of 2010 provides more effective protection from sexual violence than can be contemplated by legislation criminalizing transmission.

We wish to re-emphasize the importance of the UNDP and UNAIDS Policy Brief on Criminalization of HIV Transmission. Ref:
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

Specifically, the brief concludes with the following recommendations for governments:

Recommendations: For Governments

- Abide by international human rights conventions on equal and inalienable rights, including those related to health, education and social protection of all people, including people living with HIV.
- Repeal HIV-specific criminal laws, laws directly mandating disclosure of HIV status, and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups.
- Apply general criminal law only to the intentional transmission of HIV, and audit the application of general criminal law to ensure it is not used inappropriately in the context of HIV.
- Redirect legislative reform, and law enforcement, towards addressing sexual and other forms of violence against women,26 and discrimination and other human rights violations against people living with HIV and people most at risk of exposure to HIV.
- Significantly expand access to proven HIV prevention (including positive prevention) programmes, and support voluntary counselling and testing for couples, voluntary disclosure, and ethical partner notification.

It should also be noted that UN member States at the recently concluded High Level meeting on HIV/ AIDS in New York affirmed their commitment in the *Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS* to:

"(77) *intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV..... "* and furthermore to:

"(78) *review as appropriate laws and policies that adversely affect the successful and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV..."*

Turning from these in-principle issues to the specifics of the Resolution, the Guyana National AIDS Committee and organizations associated with this Submission wish to make the following points:

Firstly, the authors appear to be oblivious of the long and difficult worldwide debate over the issue of intentional transmission of HIV which has concluded that legal remedies are complex to fashion, difficult and costly to apply and ultimately counter-productive. The Hon. Michael Kirby, an internationally-recognized Australian jurist, remarked at an international conference some years ago that *"In addition to HIV, a new virus has been detected that is sweeping the world. It is HIL – Highly Ineffective Laws."*

Secondly, the proposed Motion would arrive at being 'counter-productive' even more rapidly, given the demand that patient-physician confidentiality be waived if so invoked by the courts. Apart from a variety of contract and possible tort actions, HIV persons would be reluctant to reveal their status in these circumstances.

Thirdly, the core of the Government's preventative strategy, namely voluntary counselling and testing would be devastated. Confidential and accurate information on the numbers of HIV positive persons is an indispensable tool for effective public health strategies to combat HIV.

Fourthly, the Motion called for the transmission of HIV to any other person to be an indictable offence once a person knows that s/he is infected. The Motion does not require intent. If a condom breaks, for example, and transmission occurs, the transmitter would be liable. This may not be an oversight since the Preamble of the Motion speak to "persons, some knowingly, still infect others". In this respect, the Motion takes Guyana out of the community of nations debating this issue in a respectful and humanitarian way to place it in the company of retrograde societies.

Informed international opinion is in broad agreement that people who set out intentionally to harm other people commit a criminal act. However, a substantial body of legal and professional opinion around the world concur that specific laws relating to HIV transmission are inadvisable. Instead, existing criminal law should be used. No one seriously suggests a separate law be approved to address every possible way in which one person may harm another. This problem is routinely taken care of by incorporating phrases such as *'causing bodily harm'* or *'actual bodily harm'*, or in the case of sexual harm, within the ambit of the issue of *'consent'*. This approach both recognizes that the threat to public health of individuals intentionally setting out to harm others should be addressed, but equally important, that it should be done in a manner which protects the great majority of responsible people living with HIV from further being stigmatized by the implication that they, by virtue of living with HIV, constitute a threat to the rest of the society.

In the context of Guyana, protection against intentional harm is already anticipated in several pieces of criminal legislation which contain provisions of a general nature which can be readily interpreted to include cases of intentional transmission of HIV. At the same time the route of utilizing existing legislation narrows the parameters against possible abuse by the police requiring compulsory disclosure in circumstances in which intentional transmission is not an issue.

With a view to achieving the best balance between protecting non-infected partners and avoiding demonizing HIV infected persons, detailed recommendations are contained in the *Revised National Policy Document on HIV/AIDS in Guyana 2006* which Members of the Select Committee may wish to consult. This *Policy Document* contains detailed progressive recommendations for dealing with transmission. After an extensive consultation over amending legislation, the Policy settled for a series of provisions around the concept of 'partner notification'. In the first instance all infected persons are encouraged to notify partners and medical personnel are authorized but not obligated to assist this process where necessary (2.4.6a):

"Any individual with HIV/AIDS has the responsibility, and should be encouraged to notify partners promptly and directly, of their possible exposure to HIV. Ideally this exchange of information should be done without the involvement of health personnel. Individuals who request assistance from health personnel in the notification of partners should be provided with such assistance."

Information on the implications of having been exposed to infection is addressed in the context of counselling and guidance (2.4.6b):

"Information must be made available to partners on the implications of having been exposed to the infection, on confidential HIV testing facilities and pre-and post-test counselling (cf. also 2.2.5. and 2.2.6. above)."

The difficult situation of how to deal with a person whose behaviour is a threat to the community is addressed in (2.4.7):

"Where the behavior of an individual is deemed to be a threat to his/her immediate community, special care must be taken to inform the individual of his /her responsibilities and, while safeguarding the privacy of the individual, to educate the members of his/her community of their vulnerability.".

Finally, the detailed steps set out in section 2.2.6.1.address the situation in which medical or others with appropriate authority may over-ride the persistent refusal of an infected-person to notify a partner. The partner notification procedure to be set out in legislation will authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria, which will be included in the legislation:

2.2.6.1.The HIV-positive person in question has been thoroughly counselled as to the need for partner notification.

2.2.6.2.Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes.

2.2.6.3.The HIV-positive person has refused to notify, or consent to the notification of his/her partners(s).

2.2.6.4.A real risk of HIV transmission to the partner(s) exists.

2.2.6.5.The HIV-positive person is given reasonable advance notice of the intention to notify.

2.2.6.6.The identity of the HIV-positive person is concealed from the partner(s), if this is practically possible

2.2.6.7.Follow-up is provided as necessary to ensure support to those involved.

While the quoted sections refer to any sexual inter-action, the term 'partner' may be misinterpreted to refer to such activity in the context only of an on-going relationship. A first step in a serious debate of transmission issues in Guyana should, therefore, focus on broadening this policy concept to explicitly include casual, non-systematic sexual activity as well as sexual activity with settled partners. In casual sexual relationships, the onus of adopting preventive measures lies equally on both partners. The central prevention message is that everyone has a responsibility to take precautionary measures when engaging in sexual activity with persons with whom they are not in a stable relationship.

In a settled relationship when a partner has a reasonable expectation that an infection-free status is being maintained, the onus to inform is greater on a partner who becomes infected under whatever circumstance. The willful refusal to inform when the possibility of transmission exists, or intentionally harm through deception, in either a casual or a settled partnership may provide grounds for criminal proceedings as described above.

While recognizing that "infection rates are still disappointingly high", the National AIDS Committee and organizations associated with this Submission are completely opposed to the premise of this Motion that HIV positive persons are responsible for this state of affairs and must be penalized. For this and all of the above reasons we consider the Motion before the Parliamentary Special Select Committee to be inhumane, ill-informed and dangerous and for each and all of these reasons should be withdrawn immediately.

Submitted by:
National AIDS Committee (Guyana)
June 22, 2011

The National AIDS Committee (NAC) is a voluntary body which promotes HIV/AIDS policy and advocacy issues, advises the Minister of Health and assesses the work of the National AIDS Programme Secretariat (NAPS) in relation to the National AIDS Programme. The NAC also encourages the formation of Regional AIDS Committees (RACs) and networking amongst NGOs involved in the fight against the HIV/AIDS pandemic.

"GLOBAL CRISIS - GLOBAL ACTION"

DECLARATION OF COMMITMENT ON HIV/AIDS

YOUTH POSITION PAPER ON UNGASS ON HIV/AIDS

A CIVIL SOCIETY PERSPECTIVE ON THE UNGASS DECLRATION OF COMMITMENT

(Reproduced and Distributed by the National AIDS Committee (NAC) in collaboration with the National AIDS Programme Secretariat (NAPS), Hadfield St. & College Road, Georgetown, Guyana.)

United Nations General Assembly
Twenty-sixth Special Session
Doc: A/s-26/L.2
[adopted Wednesday 27th June 2001, New York]

Declaration of Commitment on HIV/AIDS

"Global Crisis - Global Action"

1. We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;

2. Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society - national, community, family and individual;

3. Noting with profound concern, that by the end of the year 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;

4. Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;

5. Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit;

6. Recalling and reaffirming our previous commitments on HIV/AIDS made through:

- *The United Nations Millennium Declaration of 8 September 2000;*

- *The Political Declaration and Further Actions and Initiatives to Implement the Commitments made at the World Summit for Social Development of 1 July 2000;*

- *The Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of 10 June 2000;*

- Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development of 2 July 1999;

- The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;

- The Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001;

- The Declaration of the Ibero-America Summit of Heads of State of November 2000 in Panama;

- The Caribbean Partnership Against HIV/AIDS, 14 February, 2001;

- The European Union Programme for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001;

- The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000;

- The Central Asian Declaration on HIV/AIDS of 18 May 2001;

7. Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;

8. Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;

9. Welcoming the commitments of African Heads of State or Government, at the Abuja Special Summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;

10. Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV/AIDS, the Latin America region with 1.5 million people living with HIV/AIDS, and the Central and Eastern European region with very rapidly rising infection rates; and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;

11. Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;

12. Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;

13. Noting further that stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;

14. Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;

15. Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognizing the need to achieve the prevention goals set out in this Declaration in order to stop the spread of the epidemic and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;

19. Recognizing that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;

20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic, and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;

23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;

24. Recognizing also that the cost availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;

25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continue to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people and recalling efforts to make drugs available at low prices for those in need;

26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations; and noting that the impact of international trade agreements on access to or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated;

27. Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North/South, South/South cooperation and triangular cooperation;

28. Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;

29. Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;

30. Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;

31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;

32. Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organizations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research-based pharmaceutical companies, trade unions, media, parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders are important;

33. Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;

34. Further acknowledging the efforts of international humanitarian organizations combating the epidemic, including among others the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;

35. Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the UNAIDS Programme Coordinating Board; noting its endorsement in December 2000 of the Global Strategy Framework for HIV/AIDS, which could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;

36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

LEADERSHIP

Strong leadership at all levels of society is essential for an effective response to the epidemic.

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector.

Leadership involves personal commitment and concrete actions.

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that:
- address the epidemic in forthright terms; confront stigma, silence and denial;
- address gender and age-based dimensions of the epidemic;
- eliminate discrimination and marginalization;
- involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people;
- are resourced to the extent possible from national budgets without excluding other sources, inter alia international cooperation;
- fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health;
- integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and
- strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional organizations and partners to: be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum Consensus and Plan of Action: Leadership to Overcome HIV/ AIDS; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Diseases; the CARICOM Pan-Caribbean Partnership Against HIV/AIDS; the ESCAP Regional Call for Action to Fight HIV/ AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; the European Union Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction;

41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national organizations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions within their respective mandates and resources to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant United Nations system organizations, including their full participation in the development and implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in this Declaration;

45. Support greater cooperation between relevant United Nations system organizations and international organizations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors and by 2003, establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

PREVENTION

Prevention must be the mainstay of our response

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;

48. By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection;

49. By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS;

50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;

51. By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;

52. By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by

communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers;

54. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babiesto effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

CARE, SUPPORT & TREATMENT

Care, support and treatment are fundamental elements of an effective response

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organizations as well as with civil society and the business sector, to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity. Also, in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/ AIDS; improve the capacity and working conditions of health care personnel, and the

effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psycho-social care;

57. By 2003, ensure that national strategies are developed in order to provide psycho-social care for individuals, families, and communities affected by HIV/AIDS;

HIV/AIDS AND HUMAN RIGHTS

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS.

Respect for the rights of people living with HIV/AIDS drives an effective response.

58. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that globally women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

REDUCING VULNERABILITY

The vulnerable must be given priority in the response.

Empowering women is essential for reducing vulnerability.

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those actors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and bys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by:

- ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls;
- expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and
- involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements forced or
otherwise;

CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for

counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa;

ALLEVIATING SOCIAL AND ECONOMIC IMPACT

To address HIV/AIDS is to invest in sustainable development

68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs; adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

RESEARCH AND DEVELOPMENT

With no cure for HIV/AIDS yet found, further research and development is crucial

70. Increase investment and accelerate research on the development of HIV vaccines, while building national research capacity especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased nationaland international investment in HIV/AIDS-related research and development including biomedical, operations, social, cultural and behavioural research and in traditional medicine to:

improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests, methods to prevent mother-to-child transmission; and improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; create a conducive environment for research and ensure that it is based on highest ethical standards;

71. Support and encourage the development of national and international research infrastructure, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of rapid expansion of the epidemic;

72. Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions, and drug resistance, develop methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

73. Strengthen international and regional cooperation in particular North/South, South/South and triangular cooperation, related to transfer of relevant technologies, suitable to the environment in prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage that the end results of these cooperative research findings and technologies be owned by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

74. By 2003, ensure that all research protocols for the investigation of HIV-related treatment including anti-retroviral therapies and vaccines based on international guidelines and best practices are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

HIV/AIDS IN CONFLICT AND DISASTER AFFECTED REGIONS

Conflicts and disasters contribute to the spread of HIV/AIDS.

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

RESOURCES

The HIV/AIDS challenge cannot be met without new, additional and sustained resources.

79. Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

80. By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between US$ 7 billion and US$ 10 billion in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that needed resources are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;

81. Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;

82. Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required and ensure that adequate allocations are made by all ministries and other relevant stakeholders;

83. Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking of 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries a agreed, as soon as possible, taking into account the urgency and gravity of the HIV/ AIDS epidemic;

84. Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;

85. Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate and encourage the most effective and transparent use of all resources allocated;

86. Call on the international community and invite civil society and the private sector to take appropriate measures to help alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;

87. Without further delay implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those most affected by HIV/AIDS, in return for their making demonstrable commitments to poverty eradication and urge the use of debt service savings to finance poverty eradication programmes, particularly for HIV/AIDS prevention, treatment, care and support and other infections;

88. Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including, as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

89. Encourage increased investment in HIV/AIDS-related research, nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

90. Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments inter alia in their efforts to combat HIV/AIDSwith due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

91. By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute tothe global HIV/ AIDS and health fund;

92. Direct increased funding to national, regional and subregional commissions and organizations to enable them to assist Governments at the national, subregional and regional level in their efforts to respond to the crisis;

93. Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of this Declaration;

FOLLOW - UP

Maintaining the momentum and monitoring progress are essential.

At the national level

94. Conduct national periodic reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

At the regional level

97. Include HIV/AIDS and related public health concerns as appropriate on the agenda of regional meetings at the ministerial and Head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organizations of progress in implementing regional strategies and addressing regional priorities and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in this Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual General Assembly session to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in this Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in this Declaration and in this regard encourage participation in and wide dissemination of the outcomes of: the forthcoming Dakar Conference on Access to Care for HIV Infection; the Sixth International Congress on AIDS in Asia and the Pacific; the XII International Conference on AIDS and Sexually Transmitted Infections in Africa; the XIV International Conference on AIDS, Barcelona; the Xth International Conference on People Living with HIV/AIDS, Port of Spain; the II Forum and III Conference of the Latin American and the Caribbean Horizontal Technical Cooperation on HIV/AIDS and Sexually Transmitted Infections, La Habana; the Vth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Chang Mai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organizations and other concerned partners, systems for voluntary monitoring and reporting of global drug prices;

We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments, and concerted efforts with full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement this Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.

(Reproduced and distributed by the Guyana National AIDS Committee (NAC), in collaboration with the National AIDS Programme Secretariat (NAPS), Hadfield St. & College Road, Georgetown, Guyana)

Youth Position Paper
on the United Nations General Assembly Special Session on HIV/AIDS*

PREAMBLE

We, the young women and men present at the United Nations General Assembly Special Session on HIV/AIDS, reaffirm our collective commitment to fighting the AIDS epidemic while pledging solidarity with the struggles of all people affected by HIV/AIDS.

We recognize the efforts of young people worldwide, who have been at the forefront of fighting the epidemic as peer educators, caregivers and activists.

In particular, we refer to the Abuja Declaration; the African Development Forum Consensus Document, including the ADF Youth Statement; the Beijing Platform of Action; the International Conference on Population and Development; and the World Program of Action for Youth to the Year 2000 and Beyond, and pledge solidarity with young people in all regions of the world engaged in the fight to prevent transmission, save lives and end discrimination and injustice.

We call upon youth structures, governments and international partners to join us in the following:

1. Recognizing that young women and men must occupy positions of leadership in the global fight against AIDS.
2. Adopting a rights-based approach to HIV prevention, that affirms young people's rights to sexual and reproductive health information and care and services, as an indispensable way to stop the spread of AIDS.
3. Acknowledging that the rights of children and young people orphaned by AIDS to education, shelter and a life free from discrimination must be respected.
4. Affirming that care, support and treatment are a fundamental right for all people living with HIV/AIDS.
5. Ensuring that the following groups of vulnerable young people are directly targeted for prevention, care and support, and treatment services: young women, people confined to prisons and institutions, young people in refugee settings, homeless youth, unemployed youth, out of school youth, young people from ethnic minorities and/or stigmatised social groups, young people living with AIDS, rural youth, young injecting drug users, young commercial sex workers, young men who have sex with men and young people living in extreme poverty.
6. Establishing a Youth Advisory Board is put in place by the General Assembly, to monitor funds and programs of the Global AIDS Health Fund, and integrate youth into all other decision-making structures established by the Fund at national, regional, and global levels.

In order to ensure the implementation of the aforementioned goals we call upon youth to make the following commitments, and further call upon civil society and governments to take the necessary actions outlined below for ending the AIDS pandemic.

LEADERSHIP

Young people are and will remain at the front lines of combating the global AIDS pandemic, however, we can and must do more. We must be bold and assume leadership in breaking the conspiracy of silence and shame that drives AIDS underground and stigmatizes PLWHAs.

Youth commitments

- We agree to assume leadership responsibilities in our communities, in full partnership with families, schools, faith-based groups, advocates, and grassroots organizations.
- We further agree to play a dual role of both direct service provision and engaging in broader processes to advocate, lead, inform, and mobilize communities to demand action on AIDS where enough is not being done.
- We commit ourselves to ensuring that young people living with HIV/AIDS assume key leadership positions in youth organizations and are an integral component of our collective efforts to end the epidemic.
- At the national level we pledge to hold governments accountable for their commitments at global and regional level – words are no longer enough.
- We will work with youth organizations globally to monitor governments' progress in ensuring that the rights of young PLWHAs are respected, by using networks and calling to attention the violation of young people's human rights wherever they come under attack.

CALL TO CIVIL SOCIETY AND GOVENMENT

- All relevant governments, international institutions, and non-governmental organizations at all levels must accept youth leadership, and provide resources to allow and empower youth to meaningfully participate in decisions that affect us.
- We call on civil society to assist us in a monitoring role, by providing technical support to our efforts and ensuring that young people's human rights are integrated into their rights agendas globally.

PREVENTION

Young people (15 – 24) represent half of new HIV infections. This is an unacceptable situation that can be reversed if young people continue to fight the epidemic with greater political and economic commitment from their governments. Young people have a right to protect themselves against HIV, and our prevention efforts must use this as a basis for all activities geared toward stopping the spread of AIDS.

Youth commitments

- We will address the power relations between young women and men as central to prevention, ensuring that all prevention programs are gender sensitive and provide young women with the skills to negotiate safer sex while teaching young men to respect the human rights of girls and young women.
- We will obtain and provide full and complete sexual and reproductive education, information and services to allow youth to make informed decisions about sex.
- Our prevention efforts will confront the range of situations in which young people may find themselves, in order to address all vulnerable youth, including but not limited to: young women, people confined to prisons and institutions, young people in refugee settings, homeless youth, unemployed youth, out of school youth, young people from ethnic minorities and/or stigmatized social groups, young people living with AIDS, rural youth, young injecting drug users, young commercial sex workers, young men who have sex with men and young people living in extreme poverty;
- We will demand access to male and female condoms for all young people who are sexually active, and will support and encourage young people who choose to abstain from sex;
- We will take HIV/AIDS tests and encourage our peers to find out their sero-status so that we can live healthy and productive lives.

CALL TO CIVIL SOCIETY AND GOVERNMENT

- We call on civil society and governments to develop and distribute sound female-controlled methods of prevention such as microbicides and female condoms;
- We will work with governments and international agencies to specifically target young people, especially those most vulnerable to HIV/AIDS who include the groups named above;
- We will work in partnership with our communities, governments and relevant international agencies to develop programs that create economic opportunities for young people, particularly young women, so that they are able to make more informed choices.

ORPHANS

Those orphaned by AIDS include both children and young people. Eldest siblings are often left as heads of household, breadwinners and caretaker~ for younger siblings. Young people orphaned by AIDS are not just tragic victims who deserve pity. They are human beings with rights, needs and an enormous capacity to survive adverse circumstances. We are outraged that societies continue to watch as more and more orphans turn to the streets and a life of sex work to survive.

Youth commitments

- We dedicate ourselves to designing youth managed programs that offer orphans safe spaces in which to play and grow. We will work to eliminate the stigma associated with being orphaned by or living in a family affected by HIV/AIDS.

CALL TO CIVIL SOCIETY AND GOVERNMENT

- We call upon our governments to ensure that orphans are provided with the same basic human rights that should be afforded to all children and young people;
- Children and young people in families affected by HIV/AIDS must receive support for shelter, nutrition, health, and full education.
- We further recommend that orphans should not be denied inheritance and urge that support be provided to mothers and/or older women who are caring for families so as not to erode the rights of women caretakers where they are responsible for the care of the family.
- We strongly call upon governments to put in place mechanisms to ensure that homeless children are included in all orphan initiatives

TREATMENT, SUPPORT AND CARE

HIV/AIDS treatment is a fundamental human right, and is indispensable for effective prevention. Therefore care, treatment and support to young PLWHAs must be a critical element of comprehensive HIV/AIDS response.

Youth commitments

- We dedicate ourselves to work at community levels to develop programs in which young people assist their peers and women, who bear the brunt of caring for the sick and providing psycho-social support, in ways that promote community acceptance of HIV/AIDS, positive living, and the sharing of responsibility for the care and treatment of people living with HIV/AIDS.

- We pledge solidarity to a global network of young people living with HIV/AIDS to provide guidance to youth organizations regarding program and policy frameworks for combating discrimination and stigma and ensuring the respect of the human rights of PLWHAs.

CALL TO CIVIL SOCIETY & GOVERNMENT

- We demand that governments adopt and implement trade agreements that will guarantee access to AIDS medicines.
- We call on the private sector and governments to significantly scale up financing for infrastructure and treatment.

SOCIOECONOMIC IMPACT

In some regions, AIDS has deeply affected social and economic infrastructure. In parts of Sub-Saharan Africa, teachers and health-workers are contracting HIV at a rapid rate. Economies are unable to compete with a smaller workforce and increasing health care needs.

AIDS represents a serious threat to socioeconomic development. As a result, in resource poor settings, AIDS may also represent a threat to peace and stability. The socioeconomic impact of AIDS will only become more devastating unless definitive action is taken.

Youth commitments:

- We recognize that AIDS is a development crisis, and therefore necessitates a response that addresses the underlying poverty and inequality that fuels the epidemic.

CALL TO CIVIL SOCIETY AND GOVERNMENT

- We call on governments and civil society to prioritize poverty eradication programs that place young people at the center.
- We call for complete debt cancellation for all countries with high HIV prevalence rates, in order to free resources which must be effectively spent on social services such as health and education.

***This document was drafted by 64 youth participants coming from 25 countries representing the Youth Caucus of the UNGASS on HIV/AIDS.**

A Civil Society Perspective on the UNGASS Declaration of Commitment

[New York, Wednesday 27th June, 2001]

The following statement presents the outcome of meetings involving civil society organisations held at the UNGASS on HIV/AIDS in June 2001. This document builds upon "Comment on the draft declaration of commitment for UNGASS on HIV/AIDS - civil society organisations meeting in Geneva, 25-27 April 2001", comments submitted to the Break the Silence forum and meetings among civil society members during the UNGASS itself.

Preamble

Members of civil society welcome governments' response to the global HIV/AIDS crisis through the formulation of a ***Declaration of Commitment***. In this document, we wish to offer a civil society perspective on the Declaration.

The Declaration provides a useful tool for focusing on the HIV/AIDS pandemic and addressing this urgent crisis through joint governmental and civil society leadership as well as all governments' political commitment to implement the Declaration. We particularly support the references to the role of poverty, underdevelopment and illiteracy as principal contributing factors in the spread of HIV/AIDS. We welcome and support the emphasis given to the empowerment of women and girls and the essential contribution of people living with HIV/AIDS and civil society. We also welcome and support the acknowledgement of the unique vulnerability of young people and indigenous populations.

However, it is essential that we continue to speak about vulnerable groups in relation to the epidemic; this is not simply a question of semantics but of ensuring the avoidance of inappropriate policies and programmes. We insist on specific references to vulnerable groups regarding decision-making and implementation of prevention, care and treatment strategies, especially those groups not mentioned in the Declaration. These are men who have sex with men, sex workers and their partners/clients, injecting drug users and their sexual partners, prison populations, mentally and physically disabled people, ethnic minorities and racial groupings, and transgendered persons.

Though the Declaration notes that prevention, care, support and treatment are mutually reinforcing elements of an effective response to the epidemic, it is necessary to link these components within a comprehensive approach that recognises the impact of HIV/AIDS on multiple sectors. Additionally, these measures should actively involve people living with HIV/AIDS and organizations working in the economic, social, legal, political and cultural sectors. Such an approach is essential to address one of the underlying contributory factors to the widespread advancement of the epidemic – poverty.

The Declaration refers to making prevention programmes "available", or "efforts" to provide high standards of treatment – wording which implies a passive approach. This does not acknowledge the dominant role communities and self-empowerment efforts have played and continue to play in the response to HIV/AIDS. The role of communities, however, must be complemented by government programmes; governments must be held accountable for actual implementation of such programmes, in great part by actively empowering vulnerable groups and civil society in the design, implementation and monitoring of programmes within a human-rights framework.

Such empowerment, including the mobilization of financial and human resources, is a necessary condition for the success of programmes; only when people are aware that they have rights to prevention and care programmes and services can they adequately act to defend and implement those rights.

The following points, some of which have only been briefly mentioned in the Declaration, need much more attention.

Openness

Twenty years of experience with this pandemic has clearly shown that openness about HIV/AIDS, in all its aspects, is crucial to curb further spread of HIV and guarantee access to care, support and treatment. Real leadership is needed to address denial, stigma, intolerance and all forms of discrimination based on race, socio-economic status, ethnicity, HIV status, class and religion, which to this date remain major obstacles to an effective response.

Prevention

Prevention efforts for the most vulnerable groups should include:

- full access to comprehensive sexuality and sexual & reproductive health education and services, regardless of race, gender, age, HIV status, socio-economic status and sexual orientation;
- risk- and harm-reduction strategies, including the availability and accessibility of STI diagnosis/treatment, condoms, microbicides and lubricants, as well as needle and syringe exchange and drug substitution and maintenance programmes, for all people;
- consideration of breast milk substitutes for babies of mothers living with HIV/AIDS only when they are acceptable, feasible, affordable, sustainable and safe; otherwise their use could lead to greater infant morbidity and mortality in resource-poor countries;
- political leadership, commitment and action to address policies, legislative, cultural and economic factors that increase vulnerability to HIV/AIDS, including reviews of the extent to which current prohibition laws on illegal drugs and sex work contribute to the spread of HIV infection.

Human Rights

We reiterate that the response to HIV/AIDS should be framed within a strong and meaningful human rights-based approach avoiding the use of discriminatory language, with an emphasis on all those rights that are related to HIV/AIDS – in particular international agreements and conventions adopted by the UN, such as the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Special attention must be paid to ensuring all human rights, including freedom from poverty, racism, gender bias and (threats of) violence against those affected by the epidemic and working in the field, as well as promoting the rights of people living with HIV/AIDS to education, work, shelter and medication.

We emphasize the importance of meaningful participation by, and support of, people living with HIV/AIDS at all levels of decision-making, planning, implementation and evaluation.

We note the crucial importance of developing a culture-specific approach. We do not support a rationale in which culture is used to weaken the Declaration and limit the universal necessity to curb the HIV/AIDS epidemic.

Gender

The gender-based and gender-biased social norms and beliefs prevalent in most societies form a major contributory factor to the spread of HIV and people's inability to confront the consequences of the epidemic in an adequate and effective manner. All prevention and care programmes must be gender-sensitive, challenging and addressing gender-based stereotypes in socialization processes that prevent men from sharing decision-making and responsibility with their partners. These programmes must also ensure that all adult and adolescent men and women – irrespective of their sexual orientation – can enjoy their human rights to appropriate prevention and care services.

Within this context, special attention is needed for empowering women and girls, particularly those that are affected by poverty, so that they can have control over, and make decisions about their sexuality and reproduction in a voluntary, responsible and informed manner, free from any coercion whatsoever.

Within the health sector, it is vital that HIV/AIDS programmes be carried out as part of a broader sexual and reproductive health policy and programming framework to ensure that the multiple needs of those affected by HIV/AIDS, both HIV-negative and HIV-positive, are addressed in an integrated manner that is meaningful to their daily lives. It is often the

same factors and situations that place people at risk of suffering gender-based violence, HIV/STI infection, lack of access to harm-reduction measures, pre- and post-natal care, unwanted pregnancy and unsafe abortions.

Race and Ethnicity

Discriminatory practices based on race and ethnicity limit basic human rights, especially for women, to education, employment, housing and access to services. This makes members of specific racial and ethnic groups and indigenous populations particularly vulnerable to HIV infection. Recognition of the intersection of race, gender and HIV/AIDS is crucial for taking urgent action.

Youth

Young people have and will continue to serve on the frontlines in the fight against AIDS. Given that youth make up a significant part of the world's population, and that half of all new HIV infections globally occur among them, governments and civil society must recognise the value of investing in young people.

Young people must be included in key decision-making positions at every level, from community-based grassroots organisations to those with a global scope. It is vital that young people actively participate in the design and implementation of, and have guaranteed access to youth-friendly comprehensive information, education, treatment, services and care related to sexual and reproductive health, including HIV/AIDS. It is important to note that young people are also members of other social groups that are most vulnerable to HIV/AIDS.

Young people, especially marginalized and out-of-school youth, have the least access to full enjoyment of their rights. In order to effectively combat the AIDS pandemic, the political, civil, economic, social, cultural and development rights of young people must be guaranteed and protected regardless of their HIV status. We stress that community participation is needed to protect and promote the rights of adolescents to address their sexuality positively. These community-based efforts should include strategies to promote changes in the social norms that act as barriers to adopting safer sex.

We support the acknowledgement in the Declaration that children orphaned and affected by HIV/AIDS require special assistance. Orphans are frequently subjected to situations that significantly increase their vulnerability to many abuses. Therefore, all vulnerable children should have guaranteed protection from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

Care, Support and Treatment

An effective response to HIV must include prevention, care and support (including treatment) and impact mitigation, especially the continuing support for orphans and vulnerable children.

In many countries, the burden of care has gone beyond the capacities of families, communities and institutions. Therefore, we insist that more attention be given to supporting care-givers, with special attention for women and older persons, who bear a disproportionate part of this burden.

Care packages should be comprehensive and relevant to the local context. Client-centred counselling and education on all the elements of promoting a healthy life, as well as nutritional support, constitute an essential component of treatment and support for people living with HIV/AIDS. Within this context, it is essential to provide ongoing education and training for health-care providers on internationally recommended treatment protocols and regimens, and on appropriate client-centred counselling.

Human rights are not negotiable: the global threat posed by HIV/AIDS does not allow people's health and lives to be traded against companies' intellectual property rights. Antiretroviral drugs and medications for the treatment of opportunistic infections must be made available and accessible to all people living with HIV/AIDS. The international community, governments, civil society and the business sector should take extraordinary initiatives to fully exploit existing trade agreements or adapt them where conditions require to do so, in order to guarantee access to treatment and care. The pricing of treatments should be differentiated and adapted, so that all countries have equitable opportunities to provide such treatment. These efforts must be integrated into national treatment and care programmes by 2003, not 2005 as stated in the Declaration.

Provision of treatment should be continuous and sustainable in order to avoid drug-resistance. This implies that governments should make investments in the health-care infrastructure and human resources to ensure such continuity and sustainability.

Civil Society Access to Resources

Governments of both industrialized and resource-poor countries should be held accountable for providing adequate funding for HIV/AIDS-related policies and programmes. We not only urge, but demand that all governments of industrialised countries uphold their commitment to 0.7% of their GNP for overall official development assistance. These funds should be allocated to countries according to challenges and needs. New, additional resources should also be drawn from an accelerated strategy of debt cancellation, consistent with existing Poverty Reduction Strategy Papers (PRSP) especially for the poorest countries that have been most affected by HIV/AIDS.

We reiterate that all governments should not only commit themselves to a substantial increase in their national budgets made available for HIV/AIDS, but that they immediately implement a precise, time-framed and publicly transparent plan for these funds, in particular describing how they will be made accessible to NGOs, including community-based and grassroots organisations and organisations of people living with HIV/AIDS.

It is critical to ensure that new global funding mechanisms, like the Global Health Fund, recognise, complement and strengthen existing efforts with additional resources and reinforcing strategies. Community-based action is critical to the response to HIV/AIDS, particularly in resource-poor countries: civil society must have access to these additional funds. Their involvement in the management of the Fund is essential for transparency of funding decisions, and to guarantee access. Governments, particularly in poor countries, should collect and disseminate data and information on the impact of the epidemic on various sectors of the community and on policies, programmes and funding allocated to reduce the impact.

Follow-up to UNGASS

In conclusion, we acknowledge that the Declaration expresses many commitments on the part of member states of the UN General Assembly. However, unfulfilled commitments are not enough: all governments must be held accountable. Follow-up should not only include periodic national reviews and an annual General Assembly, one-day review. We propose the establishment of an international Declaration Monitoring body, similar to the Treaty Monitoring Committees for international conventions, to which governments must submit biannual or triennial reports on their compliance with the provisions of the Declaration. This monitoring body should also review shadow reports generated by civil society and present recommendations to Governments regarding their compliance with the commitments made in the Declaration. Furthermore, the monitoring body must include the active involvement of civil society and people living with HIV/AIDS as a key criterion in assessing compliance.

(ALREADY AGREED ON BY 190 ORGANISATIONS, THE GUYANA NATIONAL AIDS COMMITTEE IS ENCOURAGING LOCAL ORGANISATIONS TO ENDORSE THIS DOCUMENT.)

Accion Ciudadana contra le Sida, Venezuela
Action pour le Developpement de l'Afrique a la base, Cameroun
Advocates for Youth, USA
AIDS Committee of Toronto, Canada
AIDS Foundation East-West, Russia
AIDS Medicine & Miracles, USA
AIDS NGOs Network in East Africa, Tanzania
AIDS Project Los Angeles, USA
AIDS Society of Asia and the Pacific
Aids Suisse Contre le Sida, Switzerland
All-Ukranian Network of PLWHA
Apostat pour la Liberation des personnes Vivant avec le VIH/SIDA, Zaire
Asia Pacific Network of People Living with HIV/AIDS
Asia Training center on Ageing, Thailand
Asian Harm Reduction Network
Asociacion para la salud integral y ciudadania de America Latina, Colombia
Aspociacion de Ayuda al Sero Positivo, Uruguay
Associacio Ciutadana Anti-sida de Catalunya, Spain
Association Defense des Droits de la Femma et de l'Enfant, Mauritanie
Association Nationale de Soutien aux Seropositifs et Sideens, Burundi
Botswana Network of AIDS Service Organisations
Botswana Network on Ethics, Law and HIV/AIDS
Canadian HIV-AIDS Legal Network
Caritas, Egypt
Catholic AIDS Action, Namibia
Catholic Organisation for Relief and Development, The Netherlands
Central and Eastern European Harm Reduction Network
Centre for the Right to Health, Nigeria
Centro de Derechos Humanos, Mexico
Comite de Observacion Tecnica y Vigilancia Ciudadana del VIH/SIDA, Mexico
Companeros en Ayuda Voluntaria Educativa A.C., Mexico
Deutche AIDS-Hilfe e.V.
Development Alternatives with Women for a New Era, Brasil
Environment et developpement du tiers-monde, Senegal
Equal Opportunities Commission, Hong Kong
EUROCASO
Eurpean von Scalasser
Family Life Movement of Zambia
Frente nacional de personas afectados por el VIH/SIDA, Mexico
Fundacion Marco Antonio, Guatemala
Fundacion Preventiva del Sida, Guatemala
Fundamind, Argentina
Gente Positivo Asociacion, Guatemala
Groupe sida Geneva, Switzerland
Grupo de Apoio e Desafio a Sida, Portugal
Grupo Pella VIDDA, Brasil
Guyana Human Rights Association
Guyana National AIDS Committee

Health & Development Networks, Ireland/South Africa
Hong Kong AIDS Foundation
Instituto de Educacion Integral Para la Salud y el Desarrollo, Guatemala
Instituto de Education y salud, Peru
InterAfrica group
Interchurch Medical Association, USA
International AIDS Empowerment, USA
International Federation on Ageing, USA
International Harm Reduction Association
International HIV/AIDS Alliance, UK
Interreligious and International Federation for World Peace, USA
IPAS, USA
Japanese Association of University Women
Journalists Against AIDS, Nigeria
Kenya AIDS NGO Consortium
Kimirina, Ecuador
Lesotho Network of AIDS Service Organisations
Letra Salud – Sexualida – SIDA, Mexico
Liga Colombiana de lucha contra sidaPlan International, UK
Lumiere Action, Cote d'Ivoire
Maryknoll Sisters, USA
Medicos del Mundo, Spain
MSF, Ukraine
Network of Sex Work Projects
New Jersey Medical School, USA
No Limit for Women Project, Cameroun
Norwegian Association Against AIDS
Oasis, Guatemala
Open Society Institute, Hungary
Recolvih, Colombia
Rotary International, India
Royal Tropical Institute, The Netherlands
Share-Net, The Netherlands
Sofia Municipality Center for Addictions, Bulgaria
Southern African AIDS Information Dissemination Service, Zimbabwe
Stichting AIDS Fonds, The Netherlands
Stop AIDS Now, The Netherlands
Terrence Higgins Trust, UK
The Agua Buena Human Rights Association, Costa Rica
The Nation Magazine
The River Fund, USA
UK NGO Consortium
Unifem, Japan
Via Libre, Peru
Vivo Positivo, Chile
WAMATA, Tanzania
Women's Health in Women's Hands, Canada

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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Draft resolution submitted by the President of the General Assembly

Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS

The General Assembly,

Adopts the Political Declaration on HIV/AIDS annexed to the present resolution.

Annex
Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS

1. We, Heads of State and Government and representatives of States and Governments assembled at the United Nations from 8 to 10 June 2011 to review progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS[1] and the 2006 Political Declaration on HIV/AIDS,[2] with a view to guiding and intensifying the global response to HIV and AIDS by promoting continued political commitment and engagement of leaders in a comprehensive response at the community, local, national, regional and international levels to halt and reverse the HIV epidemic and mitigate its impact;

2. Reaffirm the sovereign rights of Member States, as enshrined in the Charter of the United Nations, and the need for all countries to implement the commitments and pledges in the present Declaration consistent with national laws, national development priorities and international human rights;

3. Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and the urgent need to scale up significantly our

[1] Resolution S-26/2, annex.
[2] Resolution 60/262, annex.

efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support;

4. Recognize that although HIV and AIDS are affecting every region of the world, each country's epidemic is distinctive in terms of drivers, vulnerabilities, aggravating factors and the populations that are affected, and therefore the responses from both the international community and the countries themselves must be uniquely tailored to each particular situation taking into account the epidemiological and social context of each country concerned;

5. Acknowledge the significance of this high-level meeting, which marks three decades since the first report of AIDS, ten years since the adoption of the Declaration of Commitment on HIV/AIDS and its time-bound measurable goals and targets, and five years since the adoption of the Political Declaration on HIV/AIDS and its commitment to urgently scale up responses towards achieving the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;

6. Reaffirm our commitment to the achievement of all the Millennium Development Goals, in particular Goal 6, and, recognizing the importance of rapidly scaling up efforts to integrate HIV and AIDS prevention, treatment, care and support with efforts to achieve those Goals, in this regard welcome the outcome of the 2010 High-level Plenary Meeting of the General Assembly on the Millennium Development Goals entitled "Keeping the promise: united to achieve the Millennium Development Goals";[3]

7. Recognize that HIV and AIDS constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response that takes into account that the spread of HIV is often a consequence and cause of poverty;

8. Note with deep concern that despite substantial progress over the three decades since AIDS was first reported, the HIV epidemic remains an unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world, that more than 30 million people have died from AIDS, with another estimated 33 million people living with HIV, that more than 16 million children have been orphaned because of AIDS, that over 7,000 new HIV infections occur every day, mostly among people in low- and middle-income countries, and that less than half of the people living with HIV are believed to be aware of their infection;

9. Reiterate with profound concern that Africa, in particular sub-Saharan Africa, remains the worst affected region and that urgent and exceptional action is required at all levels to curb the devastating effects of this epidemic, and recognize the renewed commitment by African Governments and regional institutions to scale up their own HIV and AIDS responses;

10. Express deep concern that HIV and AIDS affect every region of the world and that the Caribbean continues to have the highest prevalence outside sub-Saharan Africa, while the number of new HIV infections is increasing in Eastern Europe, Central Asia, North Africa, the Middle East and parts of Asia and the Pacific;

[3] Resolution 65/1.

11. Welcome the leadership and commitment shown in every aspect of the HIV and AIDS response by Governments, people living with HIV, political and community leaders, parliaments, regional and subregional organizations, communities, families, faith-based organizations, scientists, health professionals, donors, the philanthropic community, workforces, the business sector, civil society and the media;

12. Welcome the exceptional efforts at the national, regional and international levels to implement the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and the important progress being achieved, including a more than 25 per cent reduction in the rate of new HIV infections in over 30 countries, the significant reduction in mother-to-child transmission of HIV, and the unprecedented expansion of access to HIV antiretroviral treatment to over 6 million people, resulting in the reduction of AIDS-related deaths by more than 20 per cent in the past five years;

13. Recognize that the worldwide commitment to the global HIV epidemic has been unprecedented since the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, represented by an over eight-fold increase in funding from $1.8 billion in 2001 to $16 billion in 2010, the largest amount dedicated to combating a single disease in history;

14. Express deep concern that funding devoted to HIV and AIDS responses is still not commensurate with the magnitude of the epidemic either nationally or internationally, and that the global financial and economic crisis continues to have a negative impact on the HIV and AIDS response at all levels, including the fact that for the first time international assistance has not increased from the levels in 2008 and 2009, and in this regard welcome the increased resources that are being made available as a result of the establishment by many developed countries of timetables to achieve the target of 0.7 per cent of gross national product for official development assistance by ~~2015~~, stressing also the importance of complementary innovative sources of financing, in addition to traditional funding, including official development assistance to support national strategies, financing plans and multilateral efforts aimed at combating HIV and AIDS;

15. Stress the importance of international cooperation, including the role of North-South, South-South and triangular cooperation, in the global response to HIV and AIDS, bearing in mind that South-South cooperation is not a substitute for, but rather a complement to, North-South cooperation, and recognize the shared but differentiated responsibilities and respective capacities of Governments and donor countries, as well as civil society, including the private sector, while noting that national ownership and leadership are absolutely indispensable in this regard;

16. Commend the Secretariat and the co-sponsors of the Joint United Nations Programme on HIV/AIDS for their leadership role on HIV/AIDS policy and coordination and for the support they provide to countries through the Joint Programme;

17. Commend the Global Fund to Fight AIDS, Tuberculosis and Malaria for the vital role it is playing in mobilizing and providing funding for national and regional HIV and AIDS responses and in improving the predictability of financing over the long-term, and welcome the commitment of over $30 billion in funding from donors to date, including the significant pledges made by donors at the 2010 Global Fund

replenishment meeting; note with concern that while these pledges represented an increase in financing, they fall short of the amounts targeted by the Global Fund to further accelerate progress towards universal access, and recognize that to reach that goal it is imperative that the work of the Global Fund be supported and also that it be adequately funded;

18. Commend also the work of the International Drug Purchase Facility, based on innovative financing and focusing on accessibility, quality and price-reduction of antiretroviral drugs;

19. Welcome the United Nations Global Strategy for Women's and Children's Health, undertaken by a broad coalition of partners in support of national plans and strategies, to significantly reduce the number of maternal, newborn and under-five child deaths, as a matter of immediate concern, including by scaling up a priority package of high-impact interventions and integrating efforts in sectors such as health, education, gender equality, water and sanitation, poverty reduction and nutrition;

20. Recognize that agrarian economies are heavily affected by HIV and AIDS, which debilitate their communities and families with negative consequences for poverty eradication, that people die prematurely from AIDS because, inter alia, poor nutrition exacerbates the impact of HIV on the immune system and compromises its ability to respond to opportunistic infections and diseases, and that HIV treatment, including antiretroviral treatment, should be complemented with adequate food and nutrition;

21. Remain deeply concerned that globally women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the care-giving burden, and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation against them;

22. Welcome the establishment of UN-Women as a new stakeholder that can play an important role in global efforts to combat HIV by promoting gender equality and the empowerment of women, which are fundamental for reducing the vulnerability of women to HIV, and the appointment of the first Executive Director of UN-Women;

23. Welcome the adoption of the Convention on the Rights of Persons with Disabilities,[4] and recognize the need to take into account the rights of persons with disabilities as set forth in that Convention, in particular with regard to health, education, accessibility and information, in the formulation of our global response to HIV and AIDS;

24. Note with appreciation the efforts of the Inter-Parliamentary Union in supporting national parliaments to ensure an enabling legal environment supportive of effective national responses to HIV and AIDS;

25. Express grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young

[4] Resolution 61/106, annex I.

people becoming infected with HIV each day, and note that most young people still have limited access to good quality education, decent employment and recreational facilities, as well as limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves that only 34 per cent of young people possess accurate knowledge of HIV, and that laws and policies in some instances exclude young people from accessing sexual health-care and HIV-related services, such as voluntary and confidential HIV-testing, counselling and age-appropriate sex and HIV prevention education, while also recognizing the importance of reducing risk taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms;

26. Note with alarm the rise in the incidence of HIV among people who inject drugs and that, despite continuing increased efforts by all relevant stakeholders, the drug problem continues to constitute a serious threat to, among other things, public health and safety and the well-being of humanity, in particular children and young people and their families, and recognize that much more needs to be done to effectively combat the world drug problem;

27. Recall our commitment that prevention must be the cornerstone of the global HIV and AIDS response, but note that many national HIV prevention programmes and spending priorities do not adequately reflect this commitment, that spending on HIV prevention is insufficient to mount a vigorous, effective and comprehensive global HIV prevention response, that national prevention programmes are often not sufficiently coordinated and evidence-based, that prevention strategies do not adequately reflect infection patterns or sufficiently focus on populations at higher risk of HIV, and that only 33 per cent of countries have prevalence targets for young people and only 34 per cent have specific goals in place for condom programming;

28. Note with concern that national prevention strategies and programmes are often too generic in nature and do not adequately respond to infection patterns and the disease burden; for example, where heterosexual sex is the dominant mode of transmission, married or cohabitating individuals, including those in sero-discordant relationships, account for the majority of new infections but they are not sufficiently targeted with testing and prevention interventions;

29. Note that many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context;

30. Note with grave concern that despite the near elimination of mother-to-child transmission of HIV in high-income countries and the availability of low-cost interventions to prevent transmission, approximately 370,000 infants were estimated to have been infected with HIV in 2009;

31. Note with concern that prevention, treatment, care and support programmes have been inadequately targeted or made accessible to persons with disabilities;

32. Recognize that access to safe, effective, affordable, good-quality medicines and commodities in the context of epidemics such as HIV is fundamental to the full realization of the right of everyone to enjoy the highest attainable standard of physical and mental health;

33. Express grave concern that the majority of low- and middle-income countries did not meet their universal access to HIV treatment targets, despite the major achievement of expansion in providing access to antiretroviral treatment to over 6 million people living with HIV in low- and middle-income countries, that there are at least 10 million people living with HIV who are medically eligible to start antiretroviral treatment now, that discontinued treatment is a threat to treatment efficacy, and that the sustainability of providing life-long HIV treatment is threatened by factors such as poverty, lack of access to treatment and insufficient and unpredictable funding and by the number of new HIV infections outpacing the number of people starting HIV treatment by a factor of two to one;

34. Recognize the pivotal role of research in underpinning progress in HIV prevention, treatment, care and support and welcome the extraordinary advances in scientific knowledge about HIV and its prevention and treatment, but note with concern that most new treatments are not available or accessible in low- and middle-income countries and even in developed countries there are often significant delays in accessing new HIV treatments for people not responding to currently available treatment; and affirm the importance of social and operational research in improving our understanding of factors that influence the epidemic and actions that address it;

35. Recognize the critical importance of affordable medicines, including generics in scaling up access to affordable HIV treatment; and further recognize that protection and enforcement measures for intellectual property rights should be compliant with Trade-Related Aspects of Intellectual Property Rights Agreement and should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all;

36. Note with concern that regulations, policies and practices, including those that limit legitimate trade of generic medicines, may seriously limit access to affordable HIV treatment and other pharmaceutical products in low- and middle-income countries, and recognize that improvements can be made, inter alia through national legislation, regulatory policy and supply chain management, and note that reductions in barriers to affordable products could be explored in order to expand access to affordable and good quality HIV prevention products, diagnostics, medicine and treatment commodities for HIV, including for opportunistic infections and co-infections;

37. Recognize that there are additional means to reverse the global epidemic and avert millions of HIV infections and AIDS-related deaths, and in this context also recognize that new and potential scientific evidence is available that could contribute to the effectiveness and scaling up of prevention, treatment, care and support programmes;

38. Reaffirm the commitment to fulfil obligations to promote universal respect for and the observance and protection of all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, the Universal Declaration of Human Rights[5] and other instruments relating to human rights and international law; and emphasize the importance of cultural, ethical and religious values, the vital role of the family and the community and in particular people living with and affected by HIV, including their families, and the need to take into account the

[5] Resolution 217 A (III).

particularities of each country in sustaining national HIV and AIDS responses, reaching all people living with HIV, delivering HIV prevention, treatment, care and support and strengthening health systems, in particular primary health care;

39. Reaffirm that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic, including in the areas of prevention, treatment, care and support, recognize that addressing stigma and discrimination against people living with, presumed to be living with or affected by HIV, including their families, is also a critical element in combating the global HIV epidemic, and recognize also the need, as appropriate, to strengthen national policies and legislation to address such stigma and discrimination;

40. Recognize that close cooperation with people living with HIV and populations at higher risk of HIV infection will facilitate the achievement of a more effective HIV and AIDS response, and emphasize that people living with and affected by HIV, including their families, should enjoy equal participation in social, economic and cultural activities, without prejudice and discrimination, and that they should have equal access to health care and community support as all members of the community;

41. Recognize that access to sexual and reproductive health has been and continues to be essential for HIV and AIDS responses, and that Governments have the responsibility to provide for public health, with special attention to families, women and children;

42. Recognize the importance of strengthening health systems, in particular primary health care and the need to integrate the HIV response into it, and note that weak health systems, which already face many challenges, including a lack of trained and retention of skilled health workers, are among the biggest barriers to access HIV/AIDS-related services;

43. Reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors in reducing the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments especially for young girls, expanding good-quality youth-friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes, to the extent possible;

44. Recognize the role that community organizations play, including those run by people living with HIV, in sustaining national and local HIV and AIDS responses, reaching all people living with HIV, delivering prevention, treatment, care and support services and strengthening health systems, in particular the primary health-care approach;

45. Acknowledge that the current trajectory of costs of HIV programmes is not sustainable and that programmes must become more cost-effective and evidence-based and deliver better value for money, and that poorly coordinated and transaction-heavy responses and lack of proper governance and financial accountability impede progress;

46. Note with concern that evidence-based responses, which must be informed by data disaggregated by incidence and prevalence, including by age, sex and mode of transmission, continue to require stronger measuring tools, data management systems and improved monitoring and evaluation capacity at the national and regional levels;

47. Note the relevant strategies of the Joint United Nations Programme on HIV/AIDS and the World Health Organization on HIV and AIDS;

48. Recognize that the deadlines for achieving key targets and goals set out in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS have now expired, while noting with deep concern that many countries have been unable to fulfil their pledges to achieve them, and stress the urgent need to recommit to those targets and goals and commit to new, ambitious and achievable targets and goals building on the impressive advances of the past 10 years and addressing barriers to progress and new challenges through a revitalized and enduring HIV and AIDS response;

49. Therefore, we solemnly declare our commitment to end the epidemic with renewed political will and strong, accountable leadership and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions as set out below, taking into account the diverse situations and circumstances in different countries and regions throughout the world;

Leadership: uniting to end the HIV epidemic

50. Commit to seize this turning point in the HIV epidemic and through decisive, inclusive and accountable leadership to revitalize and intensify the comprehensive global HIV and AIDS response by recommitting to the commitments made in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and by fully implementing the commitments, goals and targets contained in the present Declaration;

51. Commit to redouble efforts to achieve, by 2015, universal access to HIV prevention, treatment, care and support as a critical step towards ending the global HIV epidemic, with a view to achieving Millennium Development Goal 6, in particular to halt and begin to reverse by 2015 the spread of HIV;

52. Reaffirm our determination to achieve all the Millennium Development Goals, in particular Goal 6, and recognize the importance of rapidly scaling up efforts to integrate HIV prevention, treatment, care and support with efforts to achieve these goals;

53. Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

54. Commit by 2012 to update and implement, through inclusive, country-led and transparent processes and multisectoral national HIV and AIDS strategies and plans, including financing plans, which include time bound goals to be reached in a targeted, equitable and sustained manner, to accelerate efforts to achieve universal access to HIV prevention, treatment, care and support by 2015, and address unacceptably low prevention and treatment coverage;

55. Commit to increase national ownership of HIV and AIDS responses, while calling on the United Nations system, donor countries, the Global Fund to Fight AIDS, TB and Malaria, the business sector and international and regional organizations, to support Member States in ensuring that nationally driven, credible, costed, evidence-based, inclusive and comprehensive national HIV and AIDS strategic plans are, by 2013, funded and implemented with transparency, accountability and effectiveness in line with national priorities;

56. Commit to encouraging and supporting the active involvement and leadership of young people, including those living with HIV, in the fight against the epidemic at the local, national and global levels, and agree to work with these new leaders to help develop specific measures to engage young people about HIV, including in communities, families, schools, tertiary institutions, recreation centres and workplaces;

57. Commit to continue engaging people living with and affected by HIV in decision-making, and planning, implementing and evaluating the response, and to partner with local leaders and civil society, including community-based organizations, to develop and scale up community-led HIV services and to address stigma and discrimination;

Prevention: expand coverage, diversify approaches and intensify efforts to end new HIV infections

58. Reaffirm that prevention of HIV must be the cornerstone of national, regional and international responses to the HIV epidemic;

59. Commit to redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including through, but not limited to:

(a) Conducting public awareness campaigns and targeted HIV education to raise public awareness about HIV;

(b) Harnessing the energy of young people in helping to lead global HIV awareness;

(c) Reducing risk-taking behaviour and encouraging responsible sexual behaviour including abstinence, fidelity and consistent and correct use of condoms;

(d) Expanding access to essential commodities, particularly male and female condoms and sterile injecting equipment;

(e) Ensuring that all people, particularly young people, have the means to exploit the potential of new modes of connection and communication;

(f) Significantly expanding and promoting voluntary and confidential HIV testing and counselling and provider-initiated HIV testing and counselling;

(g) Intensifying national testing promotion campaigns for HIV and other sexually transmitted infections;

(h) Giving consideration, as appropriate, to implementing and expanding risk and harm reduction programmes, taking into account the *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* in accordance with national legislation;

(i) Promoting medical male circumcision where HIV prevalence is high and male circumcision rates are low;

(j) Sensitizing and encouraging the active engagement of men and boys in promoting gender equality;

(k) Facilitating access to sexual and reproductive health-care services;

(l) Ensuring that women of child-bearing age have access to HIV prevention-related services and that pregnant women have access to antenatal care, information, counselling and other HIV services, and increasing the availability of and access to effective treatment for women living with HIV and infants;

(m) Strengthening evidence-based health sector prevention interventions, including in rural and hard to reach places;

(n) Deploying new biomedical interventions as soon as they are validated, including female-initiated prevention methods such as microbicides, HIV treatment prophylaxis, earlier treatment as prevention, and an HIV vaccine;

60. Commit to ensure that financial resources for prevention are targeted to evidence-based prevention measures that reflect the specific nature of each country's epidemic by focusing on geographic locations, social networks and populations vulnerable to HIV infection, according to the extent to which they account for new infections in each setting, in order to ensure that resources for HIV prevention are spent as cost-effectively as possible, and to ensuring that particular attention is paid to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities, depending on local circumstances;

61. Commit to ensure that national prevention strategies comprehensively target populations at higher risk and that systems of data collection and analysis about these populations are strengthened; and to take measures to ensure that HIV services, including voluntary and confidential HIV testing and counselling, are accessible to these populations so that they are encouraged to access HIV prevention, treatment, care and support;

62. Commit to working towards reducing sexual transmission of HIV by 50 per cent by 2015;

63. Commit to working towards reducing transmission of HIV among people who inject drugs by 50 per cent by 2015;

64. Commit to working towards the elimination of mother-to-child transmission of HIV by 2015 and substantially reducing AIDS-related maternal deaths;

Treatment, care and support: eliminating AIDS-related illness and death

65. Pledge to intensify efforts that will help to increase the life expectancy and quality of life of all people living with HIV;

66. Commit to accelerate efforts to achieve the goal of universal access to antiretroviral treatment for those eligible based on World Health Organization HIV treatment guidelines that indicate timely initiation of quality assured treatment for its maximum benefit, with the target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015;

67. Commit to support the reduction of unit costs and improve HIV treatment delivery, including through, inter alia, provision of good quality, affordable, effective, less toxic and simplified treatment regimens that avert drug resistance, simple, affordable diagnostics at point-of-care, cost reductions for all major elements of treatment delivery, mobilization and capacity-building of communities to support treatment scale-up and patient retention, programmes that support improved treatment adherence, directing particular efforts towards hard-to-reach populations far from physical health-care facilities and programmes and those in informal settlement settings and other locations where health-care facilities are inadequate, and recognizing the supplementary prevention benefits from treatment alongside other prevention efforts;

68. Commit to develop and implement strategies to improve infant HIV diagnosis, including through access to diagnostics at point-of-care, significantly increase and improve access to treatment for children and adolescents living with HIV, including access to prophylaxis and treatments for opportunistic infections, as well as increased support to children and adolescents through increased financial, social and moral support for their parents, families and legal guardians, and promote a smooth transition from paediatric to young adult treatment and related support and services;

69. Commit to promote services that integrate prevention, treatment and care of co-occurring conditions, including tuberculosis and hepatitis, improve access to quality, affordable primary health care, comprehensive care and support services, including those which address physical, spiritual, psychosocial, socio-economic, and legal aspects of living with HIV, and palliative care services;

70. Commit to take immediate action on the national and global levels to integrate food and nutritional support into programmes directed to people affected by HIV, in order to ensure access to sufficient, safe and nutritious food to enable people to meet their dietary needs and food preferences, for an active and healthy life as part of a comprehensive response to HIV and AIDS;

71. Commit to remove before 2015, where feasible, obstacles that limit the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and to reduce costs associated with life-long chronic care, including by amending national laws and regulations, as deemed appropriate by respective Governments, so as to optimize:

(a) The use, to the full, of existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights Agreement specifically geared to promoting access to and trade of medicines, and, while recognizing the importance of the intellectual property rights regime in contributing towards a more effective AIDS response, ensure that intellectual property rights provisions in trade agreements do not undermine these existing flexibilities, as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health, and call for early acceptance of the

amendment to article 31 of the TRIPS Agreement adopted by the General Council of the World Trade Organization in its decision of 6 December 2005;

(b) Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help reduce costs associated with life-long chronic care, and by encouraging all States to apply measures and procedures for enforcing intellectual property rights in such a manner as to avoid creating barriers to the legitimate trade of medicines, and to provide for safeguards against the abuse of such measures and procedures;

(c) Encouraging the voluntary use, where appropriate, of new mechanisms such as partnerships, tiered pricing, open-source sharing of patents and patent pools benefiting all developing countries, including through entities such as the Medicines Patent Pool, to help reduce treatment costs and encourage development of new HIV treatment formulations, including HIV medicines and point-of-care diagnostics, in particular for children;

72. Urge relevant international organizations, upon request and in accordance with their respective mandates, such as, where appropriate, the World Intellectual Property Organization, the United Nations Industrial Development Organization, the United Nations Development Programme, the United Nations Conference on Trade and Development, the World Trade Organization and the World Health Organization, to provide national Governments of developing countries with technical and capacity-building assistance for the efforts of those Governments to increase access to HIV medicines and treatment, in accordance with the national strategies of each Government, consistent with, and including through the use of, existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights Agreement, as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health;

73. Commit by 2015 to address factors that limit treatment uptake and contribute to treatment stock-outs and delays in drug production and delivery, inadequate storage of medicines, patient drop-out, including inadequate and inaccessible transportation to clinical sites, lack of accessibility of information, resources and sites, especially to persons with disabilities, sub-optimal management of treatment-related side effects, poor adherence to treatment, out-of-pocket expenses for non-drug components of treatment, loss of income associated with clinic attendance, and inadequate human resources for health care;

74. Call on pharmaceutical companies to take measures to ensure timely production and delivery of affordable, good quality and effective antiretroviral medicines so as to contribute to maintaining an efficient national system of distribution of these medicines;

75. Expand efforts to combat tuberculosis, which is a leading cause of death among people living with HIV, by improving tuberculosis screening, tuberculosis prevention, access to diagnosis and treatment of tuberculosis and drug-resistant tuberculosis and access to antiretroviral therapy, through more integrated delivery of HIV and tuberculosis services in line with the Global Plan to Stop TB, 2011-2015, and commit by 2015 to work towards reducing tuberculosis deaths in people living with HIV by 50 per cent;

76. Commit to reduce the high rates of HIV and hepatitis B and C co-infection by developing as soon as practicable an estimate of the global treatment need,

increasing efforts towards the development of a vaccination for hepatitis C and rapidly expanding access to appropriate vaccination for hepatitis B and diagnostics and treatment of HIV and hepatitis co-infections;

Advancing human rights to reduce stigma, discrimination and violence related to HIV

77. Commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms with particular attention to all people vulnerable to and affected by HIV;

78. Commit to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV, and consider their review in accordance with relevant national review frameworks and time frames;

79. Encourage Member States to consider identifying and reviewing any remaining HIV-related restrictions on entry, stay and residence so as to eliminate them;

80. Commit to national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including through sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support;

81. Commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, through strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

82. Commit to strengthen national social and child protection systems and care and support programmes for children, in particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development to full potential of orphans and other children affected by and living with HIV, especially through equal access to education, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, including civil registration systems, and provision of comprehensive information and support to children and their families and caregivers, especially age-appropriate HIV information to assist children living with HIV as they transition through adolescence, consistent with their evolving capacities;

83. Commit to promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms for young people, particularly those living with HIV and those at higher risk of HIV infection, so as to eliminate the stigma and discrimination they face;

84. Commit to address, according to national legislation, the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support;

85. Commit to mitigate the impact of the epidemic on workers, their families, their dependants, workplaces and economies, including by taking into account all relevant conventions of the International Labour Organization, as well as the guidance provided by the relevant International Labour Organization recommendations, including Recommendation No. 200, and call on employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support;

Resources for the AIDS response

86. Commit to working towards closing the global HIV and AIDS resource gap by 2015, currently estimated by the Joint United Nations Programme on HIV/AIDS to be $6 billion annually, through greater strategic investment, continued domestic and international funding to enable countries to access predictable and sustainable financial resources and sources of innovative financing, and by ensuring that funding flows through country finance systems, where appropriate and available, and is aligned with accountable and sustainable national HIV and AIDS and development strategies that maximize synergies and deliver sustainable programmes that are evidence-based and implemented with transparency, accountability and effectiveness;

87. Commit to breaking the upward trajectory of costs through the efficient utilization of resources, addressing barriers to the legal trade of generics and other low-cost medicines, improving the efficiency of prevention by targeting interventions to deliver more efficient, innovative and sustainable programmes for the HIV and AIDS response, in accordance with national development plans and priorities, and ensuring that synergies are exploited between the HIV and AIDS response and efforts to achieve the internationally agreed development goals, including the Millennium Development Goals;

88. Commit by 2015, through a series of incremental steps and through our shared responsibility, to reach a significant level of annual global expenditure on HIV and AIDS, while recognizing that the overall target estimated by the Joint United Nations Programme on HIV/AIDS is between $22 billion and $24 billion in low- and middle-income countries, by increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources of funding, including official development assistance;

89. Strongly urge those developed countries which have pledged to achieve the target of 0.7 per cent of gross national product for official development assistance by 2015, and urge those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard;

90. Strongly urge African countries that adopted the Abuja Declaration and Framework for Action for the Fight against HIV/AIDS, Tuberculosis and other Diseases to take concrete measures to meet the target of allocating at least 15 per cent of their annual budget to the improvement of the health sector, in accordance with the Abuja Declaration and Framework for Action;

91. Commit to enhance the quality of aid by strengthening national ownership, alignment, harmonization, predictability, mutual accountability and transparency, and results-orientation;

92. Commit to supporting and strengthening existing financial mechanisms, including the Global Fund and relevant United Nations organizations, through the provision of funds in a sustained and predictable manner, in particular to those countries with low and middle incomes with a high disease burden or a large number of people living with and affected by HIV;

93. Recommit to fully implementing the enhanced Heavily Indebted Poor Countries Initiative and agree to cancel all eligible bilateral official debts of qualified countries within the Initiative, who reach the completion point under the initiative, in particular the countries most affected by HIV and AIDS, and urge the use of debt service savings, inter alia, to finance poverty eradication programmes, particularly for prevention, treatment, care and support for HIV and AIDS and other infections;

94. Commit to scaling up new, voluntary and additional innovative financing mechanisms to help address the shortfall of resources available for the global HIV and AIDS response and to improve the financing of the HIV and AIDS response over the long term, and to accelerating efforts to identify innovative financing mechanisms that will generate additional financial resources for HIV and AIDS to complement national budgetary allocations and official development assistance;

95. Appreciate that the Global Fund to Fight AIDS, Tuberculosis and Malaria is a pivotal mechanism for achieving universal access to prevention, treatment, care and support by 2015, recognize the programme for reform of the Global Fund, and encourage Member States, the business community, including foundations, and philanthropists to provide the highest level of support for the Global Fund, taking into account the funding targets to be identified at the 2012 midterm review of the Global Fund replenishment process;

Strengthening health systems and integrating HIV and AIDS into broader health and development

96. Commit to redouble efforts to strengthen health systems, including primary health care, particularly in developing countries, through measures such as allocating national and international resources, appropriate decentralization of HIV and AIDS programmes to improve access for communities, including rural and hard-to-reach populations, integration of HIV and AIDS programmes into primary health care, sexual and reproductive health-care services and specialized infectious disease services, improving planning for institutional, infrastructure and human resource needs, improving supply chain management within health systems, and increasing human resource capacity for the response, including by scaling up the training and retention of human resources for health policy and planning, health-care personnel, consistent with the World Health Organization voluntary Global Code of Practice on

the International Recruitment of Health Personnel, community health workers and peer educators, and with support from and in partnership with international and regional organizations, the business sector and civil society, as appropriate;

97. Support and encourage, through domestic and international funding and the provision of technical assistance, the substantial development of human capital, development of national and international research infrastructures, laboratory capacity, improved surveillance systems, and data collection, processing and dissemination, and training basic and clinical researchers, social scientists and technicians, with a focus on those countries most affected by HIV and/or experiencing or at risk of a rapid expansion of the epidemic;

98. Commit by 2015 to working with partners to direct resources to and strengthen the advocacy, policy and programmatic links between HIV and tuberculosis responses, primary health-care services, sexual and reproductive health, maternal and child health, hepatitis B and C, drug dependence, non-communicable diseases and overall health systems, leverage health-care services to prevent mother-to-child transmission of HIV, strengthen the interface between HIV services, related sexual and reproductive health care and services and other health services, including maternal and child health, eliminate parallel systems for HIV-related services and information where feasible, and strengthen linkages among national and global efforts concerned with human and national development, including poverty eradication, preventative health care, enhanced nutrition, access to safe and clean drinking water, sanitation, education and the improvement of livelihoods;

99. Commit to supporting all national, regional and global efforts to achieve the Millennium Development Goals, including those undertaken through North-South, South-South and triangular cooperation, to improve comprehensive and integrated HIV prevention, treatment, care and support programmes, as well as tuberculosis, sexual and reproductive health, malaria and maternal and child health care;

Research and development: the key to preventing, treating and curing HIV

100. Commit to investing in accelerated basic research on the development of sustainable and affordable HIV and tuberculosis diagnostics and treatments for HIV and its associated co-infections, microbicides and other new prevention technologies, including female-controlled prevention methods, rapid diagnostic and monitoring technologies, as well as biomedical operations, social, cultural and behavioural and traditional medicine research and continue to build national research capacity, especially in developing countries, through increased funding and public-private partnerships, and create a conducive environment for research and ensure that it is based on the highest ethical and scientific standards and strengthening national regulatory authorities;

101. Commit to accelerate research and development for a safe, affordable, effective and accessible vaccine and for a cure for HIV, while ensuring that sustainable systems for vaccine procurement and equitable distribution are also developed;

Coordination, monitoring and accountability: maximizing the response

102. Commit to having effective evidence-based operational monitoring and evaluation and mutual accountability mechanisms between all stakeholders to support multisectoral national strategic plans for HIV and AIDS to fulfil the

commitments in the present Declaration, with the active involvement of people living with, affected by and vulnerable to HIV, and other relevant civil society and private sector stakeholders;

103. Commit to revise by the end of 2012 the recommended framework of core indicators that reflect the commitments made in the present Declaration and to develop additional measures, where necessary, to strengthen national, regional and global coordination and monitoring mechanisms of HIV and AIDS responses through inclusive and transparent processes with the full involvement of Member States and other relevant stakeholders, with the support of the Joint United Nations Programme on HIV/AIDS;

Follow up: sustaining progress

104. Encourage and support the exchange among countries and regions of information, research, evidence and experiences for implementing the measures and commitments related to the global HIV and AIDS response and in particular those contained in the present Declaration, facilitate intensified North-South, South-South and triangular cooperation, as well as regional, subregional and interregional cooperation and coordination, and, in this regard, continue to encourage the Economic and Social Council to request the regional commissions, within their respective mandates and resources, to support periodic, inclusive reviews of national efforts and progress made in their respective regions to combat HIV;

105. Request the Secretary-General to provide an annual report to the General Assembly on progress achieved in realizing the commitments made in the present Declaration, and, with support from the Joint United Nations Programme on HIV/AIDS, report progress to the Assembly in accordance with global reporting on the Millennium Development Goals at the 2013 and subsequent Millennium Development Goal reviews.

UNGASS+5 POLITICAL DECLARATION HIV/AIDS

2006 High-Level Meeting on AIDS
General Assembly, United Nations, New York
31 May-2 June 2006
(2 June 2006)

1. We, heads of State and Government and representatives of States and Governments participating in the comprehensive review of the progress achieved in realizing the targets set out in the Declaration of Commitment on HIV/AIDS on 31 May and 1 June 2006 and the High-Level Meeting on 2 June 2006;

2. *Note with alarm* that we are facing an unprecedented human catastrophe and that a quarter of a century into the pandemic, AIDS has inflicted immense suffering on countries and communities throughout the world, and that more than 65 million people have been infected with HIV, more than 25 million people have died, 15 million children have been orphaned by AIDS, with millions more made vulnerable, and 40 million people are currently living with HIV, more than 95 per cent of whom are in developing countries;

3. *Recognize that HIV/AIDS constitutes a global emergency* and poses one of the most formidable challenges to development, progress, and stability of our respective societies and the world at large and requires an exceptional and comprehensive global response;

4. Acknowledge that national and international efforts have resulted in important progress since 2001 in the areas of funding, expanding access to HIV prevention, treatment, care and support and in mitigating the impact of AIDS, and in reducing HIV prevalence in a small but growing number of countries, and also acknowledge that

many targets contained in the Declaration of Commitment on HIV/AIDS have not yet been met;

5. *Commend the UNAIDS Secretariat and the Cosponsors for their leadership role* on HIV/AIDS policy and coordination, and for the support they provide to countries through the Joint United Nations Programme on HIV/AIDS;

6. *Recognize the contribution of, and the role played by various donors* in combating HIV/AIDS as well as the fact that one-third of resources spent on HIV/AIDS responses in 2005 came from the domestic sources of low-and middle-income countries and therefore emphasize the importance of enhanced international cooperation and partnership in our responses to HIV/AIDS worldwide;

7. *Remain deeply concerned,* however, by the overall expansion and ***feminisation of the pandemic*** *and that* ***women now represent half of all people living with HIV*** including nearly 60 percent in Africa, and in this regard, recognize that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/AIDS;

8. *Express grave concern* that ***half of all new HIV infections are among children and young people*** under the age of 25 and that there is a lack of information, skills and knowledge regarding HIV/AIDS among young people;

9. *Also remain gravely concerned* that today *2.3* ***million children are living with HIV/AIDS,*** and recognize that the lack of paediatric drugs in many countries significantly hinders efforts to protect the health of children;

10. *Reiterate with profound concern* that ***the pandemic affects every region*** *and that* ***Africa, in particular Sub-Saharan Africa, remains***

the worst affected region and that urgent and exceptional action is required at all levels to curb the devastating effects of this pandemic, and recognize the renewed commitment by African governments and regional institutions to scale up their own HIV/AIDS responses;

11. ***Reaffirm that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic***, including in the areas of prevention, treatment, care and support, and recognize that addressing stigma and discrimination is also a critical element in combating the global HIV/AIDS pandemic;

12. *Reaffirm that* ***access to medication*** in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

13. *Recognize* that in many parts of the world, ***the spread of HIV/AIDS is a cause and consequence of poverty*** and effectively combating HIV/AIDS is essential to achieving internationally agreed development goals and objectives, including the Millennium Development Goals;

14. *Recognize that we now have the means to reverse the global pandemic and to avert millions of needless deaths, and also recognize that to be effective, we must deliver an intensified, much more urgent and comprehensive response in partnership with the United Nations system, intergovernmental organizations, people living with HIV and vulnerable groups, medical, scientific and educational institutions, non-governmental organizations, the business sector including generic and research – based pharmaceutical companies, trade unions, the media,*

parliamentarians, foundations, community organizations, faith-based organizations and traditional leaders;

15. *Recognize also that to mount a comprehensive response, we must overcome any legal, regulatory, trade and other barriers that block access to prevention, treatment, care and support; commit adequate resources; promote and protect all human rights and fundamental freedoms for all; promote gender equality and empowerment of women; promote and protect the rights of the girl child in order to reduce their vulnerability to HIV/AIDS; strengthen health systems and support health workers; support greater involvement of people living with HIV; scale up use of known effective and comprehensive prevention interventions; do everything necessary to ensure access to life-saving drugs and prevention tools; and develop just as urgently better tools – drugs, diagnostics and prevention technologies, including vaccines and microbicides – for the future;*

16. ***Convinced that without renewed political will, strong leadership and sustained commitment and concerted efforts from all stakeholders at all levels, including people living with HIV, civil society and vulnerable groups, and without increased resources, the world will not succeed in bringing about the end of the pandemic.***

17. *Solemnly declare our commitment* to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Therefore, we:

18. **Reaffirm our commitment to implement fully the Declaration of Commitment on HIV/AIDS "Global Crisis -**

Global Action" adopted at the twenty-sixth special session of the General Assembly in 2001 and to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, and in particular the goal to halt and begin to reverse the spread of HIV/AIDS, Malaria and other major diseases, the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development;

19. Recognize the importance and encourage **the implementation** of the recommendations **of the inclusive, country-driven processes and regional consultations facilitated by the Joint United Nations Programme on HIV/AIDS and its Cosponsors for scaling up HIV prevention, treatment, care and support and strongly recommend that this approach be continued**;

20. Commit to pursue all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards **the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010;**

21. Emphasize the need to **strengthen policy and programme linkages and coordination between HIV/AIDS, sexual and reproductive health,** national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of HIV/AIDS on national development plans and strategies;

22. Reaffirm that **prevention of HIV infection must be the mainstay of the national, regional and international responses** to the pandemic and therefore commit to intensify efforts to ensure that a wide range of prevention programs which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections;

23. Reaffirm that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the pandemic;

24. Commit to overcome legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

25. Pledge to promote at the international, regional, national and local levels **access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote social and legal environment that is supportive of and safe for voluntary disclosure of HIV status;**

26. Commit to address the **rising rates of HIV infection among young people** to ensure an HIV-free future generation through the

implementation of comprehensive, evidence- based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence-and skills-based, youth specific HIV education, mass media interventions, and the provision of youth friendly health services;

27. Commit to ensure further that **pregnant women have access to antenatal care, information, counselling and other HIV services** and to increase the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as through effective interventions for women living with HIV, including voluntary and confidential counselling and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

28. Resolve to **integrate food and nutritional support,** with the goal that all people at all times, will have access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences, for an active and healthy life, as part of a comprehensive response to HIV/AIDS;

29. Commit to **intensify efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;**

30. Pledge to **eliminate gender inequalities, gender-based abuse and violence, and to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection,** principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and full access to comprehensive information and education, and ensure that women can exercise their right to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence and in this context, reiterate the importance of the role of men and boys in achieving gender equality;

31. Commit to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

32. Commit to address **as a priority the vulnerabilities faced by children affected by and living with HIV,** to provide support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers, to promote child-oriented HIV/AIDS policies and programmes, and increased protection for children orphaned and affected by HIV/AIDS, to ensure access to treatment and intensify efforts to develop new treatments for children, and to build, where needed, and to support the social security systems that protect them;

33. Emphasize the need for **accelerated scale-up of collaborative activities on tuberculosis and HIV** in line with the Global Plan to stop TB 2006-2015 and investment in new drugs, diagnostics and vaccines appropriate for people with TB-HIV co-infection;

34. Commit to expand to the greatest extent possible, supported by international cooperation and partnership, **our capacity to deliver comprehensive HIV/AIDS programmes in ways that strengthen existing national health and social systems,** including by integrating HIV/AIDS intervention into programmes for primary health care, mother and child health, sexual and reproductive health, tuberculosis, hepatitis C, sexually transmitted infections, nutrition, children affected, orphaned or made vulnerable by HIV/AIDS, as well as formal and informal education;

35. Undertake to **reinforce, adopt and implement, where needed, national plans and strategies, supported by international cooperation and partnership, to increase capacity of human resources for health to meet the urgent need for training and retention of a broad range of health workers including community-based health workers, improve training and management and working conditions including treatment for health workers, and to effectively govern the recruitment, retention and deployment of new and existing health workers to mount a more effective HIV/AIDS response;**

36. Commit ourselves, invite international financial institutions and the Global Fund to fight AIDS, Tuberculosis and Malaria according to its policy framework and **encourage other donors to provide additional resources to low- and middle- income countries** for the strengthening of HIV/AIDS programmes and health systems, and for addressing human resources gaps, including the development of alternative and simplified service delivery models and the expansion

of community-level provision of HIV/AIDS prevention, treatment, care and support, as well as other health and social services;

37. Reiterate the need for governments, the United Nations agencies, regional and international organizations as well as non-governmental organizations involved with the provision and delivery of assistance to countries and regions affected by conflicts, **humanitarian emergencies or natural disasters to incorporate HIV/AIDS prevention, care and treatment elements into their plans and programmes;**

38. Pledge to provide the highest level commitment to ensure that **costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency, accountability and effectiveness, in line with national priorities;**

39. Commit to **reduce the global HIV/AIDS resource gap** through greater domestic and international funding to enable countries to have access to predictable and sustainable financial resources and to ensure that international funding is aligned with national HIV/AIDS plans and strategies, and in this regard welcome the increased resources that are being made available through bilateral and multilateral initiatives, as well as those that will become available as a result of the establishment of timetables by many developed countries to **achieve the targets of 0.7 per cent of gross national product for official development assistance by 2015 and to reach at least 0.5 per cent of gross national product for official development assistance by 2010 as well as, pursuant to the Brussels Programme of Action for the Least Developed Countries for the Decade 2001-2010, 0.15 per cent to 0.20 per cent for the least developed countries no later than 2010, and urge those developed countries that have not yet done so to make**

concrete efforts in this regard in accordance with their commitments;

40. Recognize that the Joint United Nations Programme on HIV/AIDS estimated that 20 to 23 billion dollars is needed per annum by 2010 to support rapidly scaled-up AIDS responses in low and middle income countries, and therefore commit to take measures to ensure that new and additional resources are made available from donor countries and also from national budgets and other national sources;

41. Commit to support and strengthen existing financial mechanisms, including the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, as well as relevant United Nations organizations, through provision of funds in a sustained manner, while continuing to develop innovative sources of financing, as well as pursuing other efforts, aimed at generating additional funds;

42. Commit to find appropriate solutions to overcome barriers in pricing, tariffs and trade agreements, and to make improvement in legislation, regulatory policy, procurement and supply chain management, in order to accelerate and intensify access to affordable and quality HIV/AIDS prevention products, diagnostics, medicines and treatment commodities;

43. Reaffirm that the **World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights does not and should not prevent members from taking measures now and in the future to protect public health.** Accordingly, while reiterating our commitment to the TRIPS Agreement, reaffirm that the Agreement can and should be interpreted and implemented in a manner supportive of the right to protect public health and, in particular, to promote access to medicines for all including production of generic antiretroviral drugs and other essential drugs

for AIDS- related infections. In this connection, we reaffirm the right to use, to the full, the provisions in the TRIPS Agreement, the Doha Declaration on TRIPS Agreement and Public Health and the World Trade Organization's General Council Decision of 2003 and the amendments to Article 31, which provide flexibilities for this purpose;

44. Resolve to assist developing countries to enable them to employ flexibilities outlined in the World Trade Organization's Agreement on TRIPS and to strengthen their capacities for this purpose;

45. Commit to intensify investment in and efforts towards the **research and development of new, safe and affordable HIV/AIDS-related medicines, products and technologies, such as vaccines, female-controlled methods and microbicides, paediatric antiretroviral formulations,** including through such mechanisms as Advance Market Commitments, as well as encourage increased investment in HIV/AIDS-related research and development in traditional medicine;

46. Encourage pharmaceutical companies, donors, multilateral organizations, and other partners to **develop public-private partnerships in support of research and development and technology transfer**, and in the comprehensive HIV/AIDS response;

47. Also encourage bilateral, regional and international efforts in **promoting bulk procurement, price negotiations, and licensing to lower prices for HIV prevention** products, diagnostics, medicines and treatment commodities, while recognizing that intellectual property protection is important for the development of new medicines and also recognize the concerns about its effects on prices

48. Recognize the initiative by a group of countries such as the International Drug Purchase facility, based on innovative financing mechanisms which are aimed at providing further drug access at affordable prices to developing countries on a sustainable and predictable basis;

49. **Commit to set in 2006, through inclusive, transparent processes, ambitious national targets, including interim targets for 2008 in accordance with core indicators recommended by the Joint United Nations Programme on HIV/AIDS, that reflect the commitment of this Declaration and the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010, as well as to set and maintain sound and rigorous monitoring and evaluation frameworks within their HIV/AIDS strategies;**

50. Call on the Joint United Nations Programme on HIV/AIDS, including its cosponsors to assist national efforts to coordinate the HIV/AIDS response, as elaborated in the "Three Ones" principles, and in line with recommendations of the 'Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors', to assist national and regional efforts to monitor and report on efforts to achieve the targets above, and to strengthen global coordination on HIV/AIDS, including through the thematic sessions of the Programme Coordinating Board;

51. Also call on Governments, national parliaments, donors, regional and sub-regional organizations, organizations of the United Nations system, the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, civil society, people living with HIV, vulnerable groups, private sector, communities most affected by HIV/AIDS and other stakeholders to work closely together to achieve the targets above, and to ensure accountability and

transparency at all levels through participatory reviews of HIV/AIDS responses;

52. Request the **Secretary-General** of the United Nations, with the support of the Joint United Nations Programme on HIV/AIDS, to include in his **annual report to the General Assembly on the status of implementation of the Declaration of Commitment** on HIV/AIDS in accordance with resolution S-26/2 of 27 June 2001 the progress achieved in realizing the commitments set out in the present Declaration;

53. **Decide to undertake comprehensive reviews in 2008 and 2011** within the annual review of the General Assembly on the progress achieved in realizing the Declaration of Commitment on HIV/AIDS "Global Crisis – Global Action" adopted at the twenty-sixth special session and this present Declaration.

[emphases added]

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POLICY BRIEF

Criminalization of HIV Transmission

Introduction

In some countries, criminal law is being applied to those who transmit or expose others to HIV infection.[1] There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights. Because of these concerns, UNAIDS urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.

In other instances, the application of criminal law should be rejected by legislators, prosecutors and judges. In particular, criminal law should not be applied to cases where there is no significant risk of transmission or where the person:

- did not know that s/he was HIV positive;
- did not understand how HIV is transmitted;
- disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or
- previously agreed on a level of mutually acceptable risk with the other person.

States should also:

- avoid introducing HIV-specific laws and instead apply general criminal law to cases of intentional transmission;
- issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining "intentional" transmission, by stipulating that an accused person's responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution);[2] and
- ensure any application of general criminal laws to HIV transmission is consistent with their international human rights obligations.[3]

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[1] For information on different countries and their legislation see Canadian HIV/AIDS Legal Network (2007) *A Human Rights Analysis of the N'djamena model legislation on AIDS and HIV specific legislation in Benin, Guinea, Guinea Bissau, Mali, Niger, Sierra Leone and Togo*, GNP+ and Terrence Higgins Trust (2005) *Criminalisation of HIV transmission in Europe: A rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights*. http://www.gnpplus.net/criminalisation/rapidscan.pdf and WHO (2006) *Report of the WHO European Region Technical Consultation, in collaboration with the European AIDS Treatment Group (EATG) and AIDS Action Europe (AAE), on the criminalization of HIV and other sexually transmitted infections*. WHO, Copenhagen

[2] See OHCHR and UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights* UNAIDS Geneva Guideline 4 "Criminal and/or public health legislation should not include specific offences against the deliberate or intentional transmission of HIV, but rather should apply general criminal offences to these exceptional cases. Such applications should ensure the elements of forseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties".

[3] Particularly the individual's rights to privacy, the highest attainable standard of health, freedom from discrimination, equality before the law and liberty and security of the person (see Articles 3, 7 and 12 of the *Universal Declaration of Human Rights* and *Article 12 of the International Covenant on Economic, Social and Cultural Rights*.

Where a violent offence (e.g. rape, other sexual assault or defilement) has also resulted in the transmission of HIV or created a significant risk of transmission, the HIV-positive status of the offender may legitimately be considered an aggravating factor in sentencing only if the person knew he or she was HIV positive at the time of committing the offence.

Alternatives to criminal law

Instead of applying criminal law to HIV transmission, governments should expand programmes which have been proven to reduce HIV transmission[4] while protecting the human rights both of people living with HIV and those who are HIV negative. Such measures include providing HIV information, support and commodities to people so they can avoid exposure to HIV through practising safer behaviours; increasing access to voluntary (as opposed to mandatory) confidential HIV testing and counselling;[5] and addressing HIV-related stigma and discrimination. Prevention programmes should include *positive prevention* efforts which empower people living with HIV to avoid transmitting HIV to others, to voluntarily disclose their positive status in safety,[6] avoid new sexually transmitted infections, and delay HIV disease progression.

Governments should also strengthen and enforce laws against rape (inside and outside marriage), and other forms of violence against women and children; improve the efficacy of criminal justice systems in investigating and prosecuting sexual offences against women and children, and support women's equality and economic independence, including through concrete legislation, programmes and services. These are the most effective means by which to protect women and girls from HIV infection and should be given the highest priority.

Such public health and legislative measures are necessary for States to realize their commitments to achieve universal access to HIV prevention, treatment, care, and support by 2010,[7] and to halt and begin to reverse the spread of HIV by 2015.[8]

Discussion

The two main reasons advanced for criminalizing HIV transmission are to:

- *punish* harmful conduct by imposing criminal penalties, and
- *prevent HIV transmission* by deterring or changing risk behaviours.

Except in the rare cases of intentional HIV transmission, applying criminal law to HIV transmission does not serve these goals.

Punishing harmful conduct

If someone, knowing that he or she is HIV positive, acts with the intent to transmit HIV, and does transmit HIV, that person's state of mind, behaviour, and the resulting harm justifies punishment. Such malicious acts in the context of HIV are rare, and the available evidence shows that most people living with HIV who know their status take steps to prevent transmitting HIV to others.[9]

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[4] For example, see Johnson WD, Holtgrave DR, McClellan WM, Flanders WD, Hill AN, Goodman M (2005) "HIV intervention research for men who have sex with men: a 7-year update" *AIDS Education Prevention* 17(6):568-89. See also Auerbach J and Coates T (2000) "HIV Prevention Research: Accomplishments and Challenges for the Third Decade of AIDS" *American Journal of Public Health* 90:1029-1032, Green EC, Halperin DT, Nantulya V and Hogle JA (2006) "Uganda's HIV Prevention Success: The Role of Sexual Behaviour Change in the National Response" *AIDS and Behavior* 10(4):335-346, Phoolcharoen W (1998) "HIV/AIDS Prevention in Thailand: Successes and Challenges" *Science* 280:1873-74

[5] See *International Guidelines on HIV/AIDS and Human Rights* Guideline 3 (b) "Apart from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should only be performed with the specific consent of that individual" and Guideline 5 22(j) "Public health, criminal and antidiscrimination legislation should prohibit mandatory HIV testing of targeted groups, including vulnerable groups."

[6] See *2006 Political Declaration on HIV/AIDS* General Assembly Resolution 60/262 Article 20 paragraph 25, where governments "Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status."

[7] See Political Declaration on HIV/AIDS (2006) paragraphs 11, 15,20,24 and 49

[8] Millennium Development Goal 6 UN General Assembly Resolution 55/2, Article 19

[9] For example, see Bunnell R et al (2006) "Changes in sexual risk behaviour and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda" *AIDS* 20:85-92, and Marks G et al (2005) "Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs" *Journal of Acquired Immune Deficiency Syndromes* 39:446-53.

In situations apart from intentional transmission, criminal prosecution is not warranted. For example, the criminal law is not appropriately applied where a person has disclosed his or her HIV-positive status to a partner (who is able to consent freely to sex); where that partner is already aware through some other means that the person is HIV-positive; or where the HIV-positive person takes steps to reduce the risk of HIV transmission (e.g. by using condoms or otherwise practising safer sex by avoiding higher risk activities). Such actions indicate that the person did not intend to transmit HIV, and that their conduct should not be considered reckless. To prosecute people in such situations would directly contradict efforts to prevent HIV transmission by encouraging safer sexual practices, voluntary HIV testing, and voluntary disclosure.

Much onward transmission takes place soon after a person has acquired HIV, when his/her infectiousness is high and before the person knows or suspects s/he is HIV positive or that s/he may be passing the virus onto others.[10,11] After this period, many people still do not learn their HIV status, either because they do not have access to confidential voluntary HIV testing and counselling or because they are afraid to be tested due to negative consequences, such as discrimination or violence, which might arise from a positive diagnosis.[12] In such cases, people are unknowingly transmitting HIV and should not face criminal prosecution.

Concerns about miscarriage of justice

Extending criminal liability beyond cases of deliberate or intentional HIV transmission – to reckless conduct – should be avoided. Such broad application of the criminal law could expose large numbers of people to possible prosecution without their being able to foresee their liability for such prosecution. Prosecutions and convictions are likely to be disproportionately applied to members of marginalized groups, such as sex workers, men who have sex with men and people who use drugs. These groups are often "blamed" for transmitting HIV, despite insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safer behaviours with their partners due to their marginalized status.[13] In jurisdictions where HIV transmission has been criminally prosecuted, the very few cases that are prosecuted out of the many infections that occur each year[14] often involve people from ethnic minorities, migrants or men who have sex with men.[15]

The inappropriate or overly-broad application of criminal law to HIV transmission creates also a real risk of increasing stigma and discrimination against people living with HIV, thus driving them further away from HIV prevention, treatment, care and support services.

[10] Brenner BG et al (2007) "High rates of forward transmission events after acute/early HIV-1 infection" *Journal of Infectious Diseases* 195: 951-59; Marks G, Crepaz N and Janssen R (2006) "Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA" *AIDS* 20:1447-1450.

[11] Even of tested soon after infection, people may receive a false negative diagnosis as HIV antibodies can take up to 3 months to become evident in tests. See Fauci AS and Clifford LH (2001) "Human immunodeficiency virus (HIV) disease: AIDS and related disorders", p. 1852–1913. *In* Braunwald E, Fausi AS, Kasper DL, Hauser SL, Longo DL, and Jameson JL (eds.), *Harrison's principles of internal medicine, 15th international ed.* New York: McGraw-Hill Companies, Inc.

[12] WHO/UNAIDS/UNICEF (2007) *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress Report.* Geneva: World Health Organization, UNAIDS and United Nations Children's Fund; April 2007.

[13] For example, see Human Rights Watch (2003) *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa* Human Rights Watch, New York and Human Rights Watch reports cited therein; Human Rights Watch (2006) *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS* Human Rights Watch, New York; Human Rights Watch (2004) *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights in Thailand* Human Rights Watch, New York; Human Rights Watch (2003) *Injecting Reason: Human Rights and HIV Prevention for Injection Drug Users; California: A Case Study* Human Rights Watch, New York

[14] In the UK, for example, there have been only 15 prosecutions since 2001 compared to over 42 000 new HIV diagnoses in the same period, see www.nat.org.uk .

[15] GNP+ Europe and Terrence Higgins Trust see (2005) *Criminalisation of HIV Transmission in Europe: A rapid scan of the laws and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights* www.gnpplus.net/criminalization/index.html

Establishing who transmitted HIV to who is often difficult (particularly where both parties have had more than one sexual partner) and may depend on testimony alone. People charged with HIV transmission may thus be found guilty in error.[16] Phylogenetic testing can only determine the degree of relatedness of two samples of HIV and cannot establish beyond a reasonable doubt the source, route or timing of infection; it is also not available in many jurisdictions and is very costly.

Prevention of HIV transmission

There are no data demonstrating that the threat of criminal sanctions significantly changes or deters the complex sexual and drug-using behaviours which may result in HIV transmission. Available data show no difference in behaviour between places where laws criminalizing HIV transmission exist and where they do not.[18] Furthermore, using criminal law beyond cases of intentional

Disclosure and partner notification

The law in some countries imposes a legal obligation to disclose one's HIV positive status to sexual partners or others, such as health-care workers. UNAIDS does not support a legal obligation to disclose one's HIV-positive status. Everyone has the right to privacy about their health and should not be required by law to reveal such information, especially where it might lead to serious stigma, discrimination and possibly violence, as in the case of HIV status.

However, all people have the ethical obligation not to harm others. Governments should provide HIV programmes for HIV-positive people that empower them to practice safer sex and/or voluntarily disclose their status in safety. This was agreed in the Political Declaration on HIV (2006) and includes government's commitments to ensure laws and programmes to protect people against discrimination and other human rights abuses based on HIV status.

To protect themselves from exposure to HIV in health-care settings, health-care workers should have access to and training on universal precautions against all blood-borne pathogens, including HIV.

The International Guidelines on HIV/AIDS and Human Rights advises that public health legislation should authorize, but not require, that health professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient.[17] Such a decision should only be made in accordance with the following criteria:

- The HIV-positive person in question has been thoroughly counselled.
- Counselling of the HIV positive person has failed to achieve appropriate behavioural changes.
- The HIV positive person has refused to notify or consent to the notification of his/her partner(s).
- A real risk of HIV transmission to the partner(s) exists.
- The HIV-positive person is given reasonable advance notice.
- The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice.
- Follow up is provided to ensure support to those involved, as necessary.

Particular consideration and support should be given to HIV-positive women who may not be able to disclose their status for fear of violence or other negative consequences.

[16] See Bernard, E et al (2007) *The use of phylogenetic analysis as evidence in criminal investigation of HIV transmission*, available at (www.aidsmap.com) February 2007.

[17] See Guideline 3 20 (g).

[18] Lazzarini Z, Bray S and Burris S (2002) "Evaluating the Impact of Criminal Laws on HIV Risk Behavior" Journal of Law, Medicine and Ethics 30:239-253, Burris S, Beletsky L, Burleson J, Case P and Lazzarini Z.(2007) "Do Criminal Laws Effect HIV Risk Behavior? An Empirical Trial" http://papers.ssrn.com/sol3/papers.cfm?abstract_id=913323.

transmission could actually undermine effective HIV prevention efforts in the following ways.

- It could discourage HIV testing, since ignorance of one's status might be perceived as the best defence in a criminal law suit. This would obstruct efforts to increase the number of people accessing testing and being referred to HIV treatment, care and support. HIV testing and treatment are vital for HIV prevention because people who receive a positive diagnosis usually change their behaviour to avoid transmitting HIV and because taking antiretroviral therapy reduces infectiousness and the likelihood of onward HIV transmission.[19]
- It places legal responsibility for HIV prevention exclusively on those already living with HIV and dilutes the public health message of shared responsibility for sexual health between sexual partners. People may (wrongly) assume their partners are HIV negative *because* they have not disclosed, and thus not use protective measures.
- It could create distrust in relationships with health- service professionals and researchers and impede the provision of quality care and research, as people may fear information regarding their HIV status will be used against them in a criminal case.

The rights of women and girls

Behind some efforts to criminalize HIV transmission is the understandable desire to prevent transmission of HIV to vulnerable women and girls and to punish the men who have infected them. In many societies, women and girls are particularly vulnerable to HIV due to cultural norms which sanction multiple partnerships for men, sexual coercion and others forms of gender-based violence, and discrimination in education and employment which makes it difficult for women to leave relationships which place them at risk of exposure to HIV. Reports indicate many women have acquired HIV in marriage and other intimate relationships, including where rape or sexual coercion have occurred.[20]

Yet, ironically, applying criminal law broadly to HIV transmission may result in women being disproportionately prosecuted. Women often learn they are HIV positive before their male partners because they are more likely to access health services[21] and thus, are blamed for "bringing HIV into the relationship". For many women, it is also either difficult or impossible to negotiate safer sex or to disclose their status to a partner for fear of violence, abandonment or other negative consequences.[22] Women may face prosecution as a result of their failure to disclose for valid reasons.

In such situations the better way to protect women from exposure to HIV is to enact and enforce laws protecting them from sexual violence, discrimination based on gender and HIV status, and inequality in employment, education, and domestic relations, including property, inheritance and custody rights.

[19] Vernazza P, Hirschel B, Bernasconi E and Flepp M (2008) "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), Castilla J, Del Romero J, Hernando V, Marincovich B, Garcia S and Rodriguez C (2005) "Effectiveness of Highly Active Antiretroviral Therapy in Reducing Heterosexual Transmission of HIV" *Journal of Acquired Immune Deficiency Syndrome* 40(1) 96-101

[20] Report on the ARASA/OSISA *Civil Society Consultative Meeting on the Criminalisation of the Wilful Transmission of HIV* Johannesburg, South Africa, 11-12 June 2007

[21] UNAIDS (2007) *Report of the International Consultation on the Criminalization of HIV Transmission* forthcoming

[22] Asia Pacific Network of People Living with HIV/AIDS (2004) *AIDS Discrimination in Asia* APN+, Bangkok, Gielen·AC, McDonnell KA, Burke JG, O'Campo P (2000) "Women's lives after an HIV positive diagnosis: disclosure and violence" *Maternal and Child Health Journal* 4(2): 111-120

Mother-to-child transmission

There is a 30% risk of HIV transmission from a HIV-positive mother to her child during pregnancy, delivery or via breastfeeding. This risk is significantly reduced when the mother and child are given antiretroviral treatment, but in 2007 only an estimated 34% of pregnant HIV-positive women in need were receiving such treatment.[23]

Some countries have enacted or are considering legislation which criminalizes mother to child transmission.[24] This is inappropriate because:

- everyone has the right to have children,[25] including women living with HIV;
- when pregnant women are counselled about the benefits of antiretroviral therapy, almost all agree to being tested and receiving treatment;
- in the rare cases where pregnant women may be reluctant to undergo HIV testing or treatment, it is usually because they fear that their HIV-positive status will become known and they will face violence, discrimination or abandonment;
- forcing women to undergo antiretroviral treatment in order to avoid criminal prosecution for mother-to-child transmission violates the ethical and legal requirements that medical procedures be performed only with informed consent; and
- often, HIV-positive mothers have no safer options than to breastfeed, because they lack breast milk substitutes or clean water to prepare formula substitutes.

Public health measures, including counselling and social support, are more appropriate to deal with the rare cases of pregnant women or mothers with HIV who refuse treatment. Governments should ensure both parents have information and access to measures to reduce mother-to-child transmission, including access to HIV testing and treatment. Women also need effective measures to protect them and their infants from violence and discrimination related to their HIV status.

Recommendations

For Governments

- Abide by international human rights conventions on equal and inalienable rights, including those related to health, education and social protection of all people, including people living with HIV.
- Repeal HIV-specific criminal laws, laws directly mandating disclosure of HIV status, and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups.
- Apply general criminal law only to the intentional transmission of HIV, and audit the application of general criminal law to ensure it is not used inappropriately in the context of HIV.
- Redirect legislative reform, and law enforcement, towards addressing sexual and other forms of violence against women,[26] and discrimination and other human rights violations against people living with HIV and people most at risk of exposure to HIV.
- Significantly expand access to proven HIV prevention (including positive prevention) programmes, and support voluntary counselling and testing for couples, voluntary disclosure, and ethical partner notification.

[23] Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals: Report of the Secretary-General (2008). UN Document A/RES/60/262.

[24] For example, see Canadian HIV/AIDS Legal Network (2007) *A Human Rights Analysis of the N'djamena model legislation on AIDS and HIV specific legislation in Benin, Guinea, Guinea Bissau, Mali, Niger, Sierra Leone and Togo.*

[25] Article 16 of the Universal Declaration of Human Rights

[26] For more detailed recommendations, see the *International Guidelines on HIV/AIDS and Human Rights* and IPU, UNAIDS and UNDP (2007) *Taking Action Against HIV: A Handbook for Parliamentarians* IPU, UNAIDS and UNDP, Geneva

- Ensure that civil society, including women's and human rights groups, representatives of people living with HIV and other key populations, is fully engaged in developing and/or reviewing HIV laws and their enforcement.
- Promote gender equality in education and employment, provide age-appropriate sexual and life-skills education (including negotiation skills) to children and adolescents, and enact and enforce laws to promote women's rights to property, inheritance, custody and divorce so women can avoid and leave relationships that place them at risk of exposure to HIV.

For civil society

- Monitor proposed and existing laws and advocate against those which inappropriately criminalize HIV transmission and impede provision of effective HIV prevention, treatment, care and support services.
- Advocate for laws against sexual and other violence; support services for those who experience such violence, as well as HIV-related discrimination.
- Organize legal support and HIV-prevention services for people living with HIV and other vulnerable groups; and
- Engage with the media to ensure that coverage of such issues is proportionate and well-informed, explaining the difficulties of disclosing HIV status and reiterating the shared responsibility for sexual health.

For international partners

- Support research on the impact of HIV-related laws on public health and human rights.
- Support governments to expand proven HIV prevention (including positive prevention) programmes, reduce stigma and discrimination against people living with HIV and other marginalized groups, and instigate appropriate law reform and to end gender inequality and violence.

Excerpts from the conclusions of the 1st GLOBAL PARLIAMENTARY MEETING ON HIV/AIDS Manila, Phillipines, December 2007[27]

14. Some countries have enacted HIV-specific criminal legislation making it a crime to transmit or expose another person to HIV, and there are public calls for such legislation in other countries where it does not yet exist.
15. We have asked whether criminal laws and prosecutions represent sound policy responses to conduct that carries the risk of HIV transmission. On the one hand, it is obviously reprehensible for a person knowingly to infect another with HIV or any other life-endangering health condition. On the other hand, using criminal sanctions for conduct other than clearly intentional transmission may well infringe upon human rights and undermine important public policy objectives.
16. We accept that the use of criminal law may be warranted in some circumstances, such as in cases of intentional transmission of HIV or as an aggravating factor in cases of rape and defilement. Individual parliaments will determine the specific circumstances, depending on their local context.
17. Before rushing to legislate, however, we should give careful consideration to the fact that passing HIV-specific criminal legislation can: further stigmatize persons living with HIV; provide a disincentive to HIV testing; create a false sense of security among people who are HIV-negative; and, rather than assisting women by protecting them against HIV infection, impose on them an additional burden and risk of violence or discrimination.
18. In addition, there is no evidence that criminal laws specific to HIV transmission will make any significant impact on the spread of HIV or on halting the epidemic. Therefore, priority must be given to increasing access to comprehensive and evidence-informed prevention methods in the fight against HIV/AIDS.

[27] Approximately 160 parliamentarians from all parts of the world attended this meeting and adopted these final conclusions on the last day.

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UNAIDS' Submission to the Special Select Committee on Criminal Responsibility of HIV infected Individuals of the Parliament of Guyana (Resolution No 129 of 2010)

> There are a number of policy considerations that should be taken into account in determining criminal law policy in relation to HIV transmission or exposure. These considerations might mitigate against the use of criminal sanctions and highlight the need for caution.
>
> International Parliamentary Union (IPU), UNAIDS and UNDP, *Taking action against HIV and AIDS: A handbook for parliamentarians,* p 209

1. The Joint United Nations Programme on HIV/AIDS (hereinafter referred to as "UNAIDS") welcomes the opportunity to make a written submission to the Special Select Committee on Criminal Responsibility of HIV Infected Individuals of the National Assembly of Guyana. The present submission is based on public health and human rights considerations that are pertinent in the context of HIV. These public health and human rights considerations are articulated, among others, in the following guidance documents: the *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS,*[1] the *International Guidelines on HIV/AIDS and Human Rights,*[2] *Taking action against HIV and AIDS: A handbook for parliamentarians,*[3] and the *Policy Brief on the Criminalisation of HIV Transmission.*[4]

2. Before turning to the main content of the submission, UNAIDS would like to express its appreciation to the National Assembly of Guyana for establishing an open process for *"members of the public, professional individuals, and organisations"*[5] to express their views on whether or not Guyana should institute legislation to *"hold persons criminally responsible for wilfully infecting other with HIV"*.[6] UNAIDS is of the view that the development and/or reform of HIV-related legislation should be an open and participatory process that engages all key stakeholders involved in national HIV responses.

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[1] United Nations General Assembly, Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, June 2011

[2] UNAIDS and Office of the United Nations High Commissioner for Human Rights (OHCHR), *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version*, 2006.

[3] Inter-Parliamentary Union (IPU), UNAIDS and UNDP, *Taking Action Against HIV and AIDS: A handbook for parliamentarians*, 2007.

[4] UNAIDS and UNDP (2008) *Policy brief on the criminalisation of HIV transmission*. Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

[5] National Assembly of Guyana," Invitation to the public for written submission", 8 June 2011.

[6] As above.

HIV-related law reform process should provide a valuable opportunity for public discussion and awareness-raising on HIV, the response to the epidemic and the role of the law in that response. UNAIDS hopes that the call for public submissions issued by the National Assembly of Guyana will lead to numerous responses and that the views expressed by various stakeholders will be duly considered. UNAIDS further hopes that specific measures will be undertaken by the National Assembly of Guyana, as appropriate, to ensure that the voices of people living with HIV and those likely to be affected by legislative reform in this area are heard, as part of this consultation and submission process.

UNAIDS recommends against the overly broad criminalisation of HIV transmission

3. UNAIDS is concerned that the overly broad criminalisation of HIV transmission not only does not advance public health; it may also threaten effective HIV responses. Nor is it clear that it is good criminal justice policy to criminalise HIV transmission or exposure, that is, apply the harshest legal sanctions to the transmission of, or exposure to, HIV beyond the rare cases of intentional transmission. UNAIDS is against the criminalisation of mere exposure to HIV where transmission does not occur. UNAIDS and UNDP issued a *Policy Brief on the Criminalisation of HIV transmission* in 2008 which recommends against the adoption of specific legislation to criminalise HIV transmission or exposure.[7]

4. UNAIDS is concerned that experience has shown that the implementation of laws criminalizing HIV transmission create serious miscarriages of justice and other problems relating, among others, to:
   - selective enforcement;
   - difficulty with proof;
   - infringement of confidentiality and privacy; and
   - uninformed assessment of risk and harm.

   If there is to be application of the criminal law to HIV transmission or exposure, UNAIDS urges governments to limit the recourse to the criminal law to cases of intentional transmission meaning **where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.** In these cases, it is recommended that: *"application [of the criminal law] should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties."*[8]

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[7] See UNAIDS and UNDP (2008) *Policy brief on the criminalisation of HIV transmission.* Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

[8] UNAIDS and Office of the United Nations High Commissioner for Human Rights (OHCHR), *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version*, 2006, Guideline 4, para. 21(a).

Further elaborating on these elements, the *Policy Brief on the Criminalisation of HIV transmission* states that:

> In particular, criminal law should not be applied to cases where there is no significant risk of transmission or where the person:
> - did not know that s/he was HIV positive;
> - did not understand how HIV is transmitted;
> - disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
> - did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
> - took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or
> - previously agreed on a level of mutually acceptable risk with the other person.[9]

5. UNAIDS' position on the criminalisation of HIV transmission and exposure is based on the need to establish a threshold for criminal responsibility that would serve justice in truly blameworthy cases – where the intention to harm can be establish beyond any reasonable doubt – without jeopardising public health interests. As governments the world over, seek to achieve universal access to HIV-related prevention, treatment, care and support services, criminal law should not become a deterrent to uptake of such services.

There is no evidence that criminalisation of HIV transmission has public health benefit; criminalisation may actually harm the HIV response

6. The *Policy brief on the Criminalisation of HIV transmission* clearly states that *"there are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission"*.[10] Studies suggest that the criminalisation of HIV transmission is unlikely to lead to behaviour change, and that on the contrary, punitive laws, stigma and discrimination against people living with HIV could play a role in deterring people living with HIV and those most at risk from seeking and accessing HIV-related treatment, care and support.[11]

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[9] UNAIDS and UNDP (2008) *Policy brief on the criminalisation of HIV transmission*, p 1. Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[10] UNAIDS and UNDP (2008) *Policy brief on the criminalisation of HIV transmission*. Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[11] See, for instance, Z Lazzarini *et al* 'Evaluating the impact of criminal laws on HIV risk behaviour' (2002) 30 *J. L. Med & Ethics;* S Burris *et al*, "Do criminal laws influence HIV risk behavior? An empirical trial" Arizona State Law Journal, 2007; Temple University Legal Studies Research Paper No. 2007-03; and also S Burris and E Cameron "The case against the criminalisation of HIV transmission" in *Journal of the American Medical Association* 300(5):578-581.

7. The recourse to the criminal law to punish HIV transmission or exposure is likely to negatively impact HIV prevention and treatment efforts by spreading wrong messages about HIV and people living with HIV; by targeting – as in certain countries – acts that carry no or very little risk of infection such as spitting, biting or sex with condom; and for fueling misinformation and hysteria about HIV.

8. UNAIDS notes with great appreciation the progress realised in the HIV response in Guyana. The overall HIV prevalence in the country has declined from 3.1% in 2003 to 1.1% in 2009.[12] There is an increasing number of people who are receiving HIV counseling and testing services in the country. According to the 2010 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report submitted by Guyana, a total of 85,554 persons were counselled and tested for HIV in 2009, compared to 16,065 persons in 2005.[13] The number of people receiving antiretroviral (ART) therapy in the country also increased steadily to 83.7% in 2009 with a survival rate of 72.18% among those on treatment.[14] This is significant progress which shows that the efforts by all stakeholders involved in the national response to HIV in Guyana are yielding results. UNAIDS is therefore concerned that the adoption of specific legislation to criminalise HIV transmission could jeopardise these achievements by deterring people, especially those most risk, from getting tested and seeking HIV prevention, treatment, care and support services due to fear of prosecution.

9. Health and human rights experts and advocates have also expressed concerns about the fact that the criminalisation of HIV transmission or exposure may also increase violence against women and place them at higher risk of criminal prosecution.[15] Because women are, in many settings, the first to know of their HIV status due to the routine offer of HIV testing in antenatal care settings, they are indeed more likely to be blamed for "bringing HIV into the relationship" and face prosecution for HIV transmission or exposure.[16] Some laws criminalising HIV transmission could potentially be used to prosecute a woman who transmits HIV to her baby during pregnancy, delivery or through breast feeding.[17]

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[12] See Government of Guyana *United Nations General Assembly Special Session on HIV/AIDS Progress Report 2008-2009,* 2010, p 32, p 31. Available at http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/guyana_2010_country_progress_report_en.pdf.

[13] See Government of Guyana *United Nations General Assembly Special Session on HIV/AIDS Progress Report 2008-2009,* 2010, p 32. Available at http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/guyana_2010_country_progress_report_en.pdf.

[14] See Government of Guyana *United Nations General Assembly Special Session on HIV/AIDS Progress Report 2008-2009,* 2010, p 32, pp 39-40.

[15] J. Kehler *et al* "10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women". Available at http://www.aln.org.za/downloads/10%20Reasons%20Why%20Criminalisation%20Harms%20Women.pdf.

[16] See above.

[17] In one African State, the law expressly criminalises women for mother-to-child-transmission of HIV. See Article 21(2) of the Prevention and Control of HIV and AIDS Act N0 8 of 2007 of Sierra Leone. For a further analysis, see P. Eba, "One

Countries across the world are questioning the validity of their laws that criminalise HIV transmission and exposure

10. Over the past two years, an increasing number of countries are questioning or re-considering their laws and practices relating to the criminalisation of HIV transmission and exposure. These positive developments have taken several forms, including the suspension of HIV specific laws criminalising HIV transmission, the amendment of laws criminalising HIV transmission, the issuing of guidelines to restrict prosecutorial discretion regarding criminalisation of transmission, and the setting up of experts and parliamentary committees or working groups to consider the issue of criminalisation of HIV transmission or exposure. Below are some relevant country examples:

    - On 17 February 2011, Denmark's Minister of Justice announced the suspension of Article 252 of the Danish Criminal Code. This text is reportedly the only HIV-specific criminal law provision in Western Europe and has been used to prosecute several individuals. A working group has been established by the Danish government to consider whether the law should be revised or abolished based on the best available scientific evidence relating to HIV and its transmission.
    - In 2010, a similar official committee was created in Norway to inform the ongoing revision of Section 155 of the Penal Code, which criminalises the wilful or negligent infection or exposure to communicable disease that is hazardous to public health—a law that has only been used to prosecute people transmitting HIV.
    - In the United States, the National AIDS Strategy adopted in July 2010 raised concerns about HIV-specific laws that criminalize HIV transmission or exposure. The Strategy clearly calls on *"State legislatures [to] consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV"*.[18]
    - Law makers in Switzerland are currently re-considering a draft provision relating to the criminalisation of HIV transmission. The debate on the draft provision is likely to be influenced by the January 2008 article published by leading Swiss medical experts, stating that HIV-positive individuals on effective antiretroviral therapy and without sexually transmitted infections (STIs) are sexually non-infectious.[19]

Size Punishes All: A critical appraisal of the criminalisation of HIV transmission", *AIDS Legal Quarterly* Sept-Nov 2008. Available at http://www.aln.org.za/downloads/ALQ%20Criminalisation.pdf; and also J Csete *et al* "Vertical HIV transmission should be excluded from criminal prosecution" *Reproductive Health Matters*, Vol. 17, No. 34, pp. 154-162, November 2009.

[18] Government of the United States of America, *National HIV/AIDS Strategy for the United States,* July 2010, pp 36-37. Available at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

[19] 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

This scientific statement was already invoked as evidence in a court case relating to the criminalisation of HIV transmission in Switzerland.[20] Further to the 2008 Swiss article, a research trial conducted on several continents recently showed that antiretroviral therapy is 96% effective in reducing HIV transmission in couples where one partner has HIV.[21]

- In the United Kingdom, the Crown Prosecution Services (CPS) issued legal guidance on "Intentional or reckless sexual transmission of infection" which sets out how prosecutors should handle allegations of HIV transmission.[22]
- At least three African countries—Guinea, Togo and Senegal—have revised their existing HIV-related legislation or adopted new legislation that restrict the use of the criminal law to exceptional cases of intentional transmission of HIV.
- In November 2008, the Southern African Development Community (SADC) Parliamentary Forum, an organisation that brings together parliamentarians from all SADC Members States adopted a Model Law on HIV that did not recommend the criminalisation of HIV transmission.[23] This Model Law was the product of several years of consultation between parliamentarians in the region, and it is aimed at guiding parliamentarians in the region to adopt HIV-related legal frameworks that support the response to HIV at national level.

11. These positive developments tend to indicate that parliamentarians, prosecutors, judges, health experts, people living with HIV and others key stakeholders across the world are increasingly aware of, and concerned about, the negative public health and human rights impact of the overly broad criminalisation of HIV transmission and exposure. These concerns are leading to efforts to ensure that any recourse to the criminal law is informed by the best scientific evidence and does not compromise public health objectives.

12. In an attempt to further investigate the scientific, medical, legal and human rights issues raised by the criminalisation of HIV transmission and advise countries on this issue, UNAIDS has initiated a science and policy consensus-building project on the criminalisation of HIV transmission and exposure to be completed by the end of 2011.

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[20] See E. Bernard "Switzerland: Geneva Court of Justice accepts 'Swiss statement', quashes HIV exposure conviction" 25 Febraury 2010. Available at http://criminalhivtransmission.blogspot.com/2009/02/switzerland-swiss-courts-accept-swiss.html.

[21] See, among others, UNAIDS, "Groundbreaking trial results confirm HIV treatment prevents transmission of HIV", 12 May 2011. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/pressrelease/2011/05/20110512_PR_TrialResults_en.pdf.

[22] See CPS "Legal guidance on intentional or reckless sexual transmission of infection". Available at http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/#Intro.

[23] See Southern Africa Development Community Parliamentary Forum, *Model Law on HIV Southern Africa* adopted on 24 November 2008 in Arusha, Tanzania.

This project aims to ensure that the application, if any, of criminal law to HIV transmission or exposure is appropriately circumscribed by the latest and most relevant scientific evidence and legal principles so as to result in the best possible outcomes in terms of justice and protection of public health. The findings and recommendations from this project will be presented to the will also be submitted to the UNDP-led Global Commission on HIV and the Law, which was launched by UNDP and UNAIDS in June 2010. These findings and recommendations will also be publicly available to all interested stakeholders.

Respectfully Yours,

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Georgetown, 22 June 2011

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UNDP Submission to the Special Select Committee on Criminal Responsibility of HIV infected Individuals of the Parliament of Guyana (Resolution No., 129 of 2010)

prepared by:
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June 27, 2011

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1. Introduction

The United Nations Development Programme welcomes the opportunity to make a written submission to the Special Select Committee on Criminal Responsibility of HIV Infected Individuals of the national Assembly of Guyana. This submission supplements the UNAIDS Submission to the Special Select Committee and contains more detail on the issues of intention to transmit, considerations as to whether and when criminal law can justifiably be applied, difficulties of proof and the risk of punishing blameless behaviour. It then goes on to examine the case that applying Criminal Responsibility to HIV exposure or transmission does not reduce the spread of HIV and undermines prevention efforts, promoted fear and stigma, and further oppresses women's rights, before making recommendations to the Committee. This submission also adds to the country-specific examples give in the UNAIDS submission.

UNDP, like UNAIDS, strongly argues that the criminal law should only ever be used as a last resort in situations of HIV transmission, to deal with rare and egregious cases of intentional HIV transmission. UNDP recommends that Guyana does ***not*** introduce legislation to criminalize HIV exposure or transmission by people living with HIV. Guyana's recent progress in the HIV response has been positive, with the overall HIV prevalence in the country declining from 3.1% in 2003 o 1.1% in 2009. UNDP is concerned that the adoption of specific legislation to criminalise HIV transmission could jeopardize these achievements and believes that Guyana should instead focus on taking positive steps to increase HIV prevention and treatment efforts.[1]

A decision to apply criminal law to HIV exposure and transmission is often driven by concerns about the spread of HIV and what is perceived to be a failure of existing HIV prevention efforts. While these are important issues to address, using criminal sanctions for conduct other than clearly intentional transmission unjustifiably infringes upon human rights and sidesteps the real challenges of HIV prevention. Criminalization may undermine important public policy objectives such as encouraging access to HIV testing since ignorance of one's status might be perceived as a defence in a law suit, diluting the public health message that preventing HIV is a shared responsibility between sexual partners, creating distrust in relationships with health-service providers and so impeding the quality of care afforded, and further endangering and oppressing women's rights, as discussed below. Public health can be more effectively achieved without resorting to the criminal law, for example by linking people living with HIV to community health workers and peer educators, strengthening anti-stigma campaigns, providing legal support services for people who have faced discrimination, providing counseling services for newly diagnosed people and providing sexuality, relationships and values education as a part of the school curriculum.

An analysis of the issues raised by criminalization of HIV exposure reveals that criminalization is unlikely to prevent new infections or reduce vulnerability to HIV. Available data shows no difference in behaviour between places where laws criminalizing HIV transmission exists and where they do not[2].

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[1] UNAIDS and UNDP (2008) *"Policy brief on the criminalization of HIV transmission"* Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[2] Lazzarini Z, Bray S and Burris S, (2002) *"Evaluating the Impact of criminal laws on HIV risk behaviours"* Journal of Law, Medicine and Ethics. Burris S et al (2007) *"Do Criminal Laws Effect HIV Risk Behaviours? An Empirical Trial"*.

Indeed, it may have an unforeseen negative impact on public health. There is concern that creating HIV-specific criminal legislation will further stigmatize persons living with HIV[3], provide disincentives to testing and impose an additional burden and risk of violence and discrimination on vulnerable groups. There is no evidence that HIV-specific criminal laws will make any significant impact on the complex sexual and drug use behaviours which may result in HIV transmission and as such, brings into question the efficacy of criminalization as a publicly justifiable response.

2. Criminalizing HIV is only justified where individuals maliciously transmit with intent to harm; laws are often drafted too broadly and often punish behavior that is not blameworthy

Intent to transmit

Resolution 129 seeks legislation to criminalize any person who transmits HIV to another where they have "prior knowledge" of their HIV-positive status.

In cases where individuals *maliciously* and *intentionally* transmit or expose others, intending to cause harm through HIV transmission, criminal law is warranted. However, intentional transmission is very difficult to prove in the context of consensual sex; even where intention is conclusively shown, the prosecution must also prove that that it was the accused and not a third party who transmitted HIV to the complainant in order to obtain an intentional transmission.

Existing criminal laws are normally sufficient to punish individuals in exceptional cases of intentional transmission where there is knowing or willful behavior with the purpose of transmitting the virus. These might include existing laws against assault, homicide and causing bodily harm, or laws allowing intervention where a person is spreading communicable diseases[4]. Specific HIV offenses are not generally warranted.[5,6]

To extend the application of criminal law from cases of malicious intent to cases of "recklessness" or "negligent" transmission would not be effective public policy as the facts are often so difficult to prove. A charge of recklessness or negligence usually requires proving the defendant's state of mind including gaining testimony from witnesses such as healthcare professionals, diaries, emails or other communications that provide insight into a defendant's thoughts. UNAIDS and UNDP recommends

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[3] Stigma research (2005) "Grievous harm: The use of offences against the person's act 1861 for sexual transmission of HIV" http://www.sigmaresearch.org.uk/go.php?/reports/report2005b/

[4] In Sweden the public health statute grants authority to public health authorities to intervene in the event a person is spreading, or is suspected of spreading, a communicable disease.

[5] Norway has a penal provision that in theory applies to all infectious diseases but which in fact has only ever been applied to cases involving HIV, creating a de facto HIV exceptionalism, contrary to UNAIDS policy and best practice.

[6] In Denmark, the relevant criminal law was suspended in February 2011 after intense lobbying as a result of increased understanding about the significantly reduced risk of onward transmission when a person living with HIV Is being treated successfully with ART and because for most people on treatment life expectancy and quality of life is not significantly diminished. In Finland, the Finnish Expert Group on HIV has recently initiated efforts to achieve legislative change and to prevent policies that reinforce HIV-related stigma and discrimination.

against prosecuting cases of alleged HIV exposure or transmission where recklessness or negligence is alleged[7].

Significant developments have been reported recently in Africa; in the past few years Guinea, Togo and Senegal have all revised their existing HIV-related legislation or adopted new legislation that restricts the use of criminal law to exceptional cases of *intentional* transmission of HIV. Denmark has recently suspended a law criminalizing HIV which included mere exposure while it considers revising its law to limit criminalization only if there is actual transmission, or abolishing the HIV-specific law entirely[8].

Considerations as to whether criminal law could be justifiably applied

Considerations as to whether criminal law could be justifiably applied would have to consider the following, all of which may be difficult to prove conclusively:

- whether or not a person was HIV-positive at the time of the alleged offence;
- whether or not a person knew he or she was HIV positive. This may require obtaining access to the accused healthcare records or calling healthcare professionals as witnesses. UNAIDS specifically recommends against prosecution in circumstances of willful blindness which would allow prosecution of individuals who "ought to have known" their status [9],[10],[11]
- whether a person understood how HIV is transmitted at the time of transmission,

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[7] UNAIDS and UNDP (2008) *"Policy brief on the criminalization of HIV transmission"* (recommendations) Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf and see also *"Taking Action Against HIV – Handbook for Parliamentarians"* (2007) UNAIDS and UNDP Publication.

[8] Denmark had one of the harshest laws criminalizing HIV. Penal Code 252 (2) made it criminal for anyone with HIV who willfully or negligently infects or exposes another to the risk of infection, meaning that a person may be guilty even though there is no actual transmission. UNAIDS has called on governments to limit criminalization to cases where a person knows his HIV-positive status and acts with intent to transmit HIV *and actually transmits HIV.* In contrast, the Danish provision is precisely the kind of legislation that UNAIDS warns against. On 17 February 2011 Denmark announced the suspension of this criminal code provision on the grounds that people living with HIV on treatment today live much longer lives and the risk of transmission is much reduced. A working group has been established to consider whether the law should be revised or abolished based on the available scientific evidence relating to HIV and its transmission. The fact that new treatment developments have led to this change in the law is relevant when considering questions on the risks of transmission. (See Edwin Cameron, South African Constitutional Court Judge, AIDS foundation Politiken 8 June 2011)

[9] In Sweden, the policy requires that there shall be no prosecution unless the scientific evidence supporting the allegation is sufficiently robust and the defendant knew he or she was HIV positive. An expansive definition of "knowledge" is used so that "willful blindness" to the fact of infection may be insufficient. Evidence that the defendant used appropriate precautions would normally preclude a charge.

[10] In the Swiss Statement produced on behalf of the Swiss National AIDS Commission following a quashed conviction for transmission, the Geneva Court of Justice took into account both the honest belief that a defendant had as to his or her risk of onward transmission, and looked at the relevance of viral load, noting that in cases where the viral load is negligible a person should not be treated as infectious. The Court considered whether or not they may not be considered reckless if they engage in sex with a possibility of transmission. There have been significant developments towards the relevance of viral load in Europe. In the Netherlands a court ordered the retrial of a man in 2005 who was subsequently acquitted because the probability of infection was not sufficiently high.

[11] In Zimbabwe, the first African country to adopt an HIV-specific offence in 1996, the current law criminalises those who suspect they are HIV positive but are undiagnosed and who not only act deliberately but do anything that they know involves a real risk or possibility of infecting another. Zimbabwe Criminal Law (Codification and Reform) Act 2004.

- whether a person had a duty to disclose their status to the person at risk and whether they believed the person at risk already knew their status,
- whether a person intended to transmit or expose another and whether they took risk-reducing measures such as using a condom or other precautions i.e. whether they were criminally reckless or negligent[12], [13]
- whether an HIV-positive person reasonably believed their partner consented to the risk of HIV exposure,
- whether the threat of violence meant a person did not disclose their status[14],
- whether it was the defendant or a third party who actually transmitted HIV to the plaintiff. This will usually involve questions of causality and the need for scientific evidence and testimony to reconstruct fact, timing and direction (i.e. who infected whom[15]) with the evidence needing to be established to the requisite criminal standard (usually "beyond reasonable doubt"), and
- whether criminal liability exists only where conduct results in HIV transmission or whether it also applies where conduct risks transmission even where there is no actual transmission[16].[17]

Difficulties of proof

It is not often possible to clearly and legally establish elements of foreseeability, intent, causality and consent in order to support a guilty verdict. It is very hard to state with certainty in the vast majority of cases that X is the cause of Y's infection. This is because although Y may discover his HIV-positive status after establishing that X is HIV-positive, this does not prove that Y was not already HIV-positive and that someone else may be the cause.

Prosecutors in some countries have sought to use phylogenetic analysis evidence as a means of proving who infected whom because this method can establish whether the sub-type of HIV in the defendant's body is the same as in the complainants. However, this analysis cannot prove the cause of a virus beyond reasonable doubt or prove the timing, route or source of transmission; there are cases where

[12] In England and Wales, there is an active lobby against criminalization and the Crown Prosecution Service issued a policy in 2003 on the prosecution of intentionally and recklessly transmitted infections, which makes clear that evidence that the defendant used some precautions against transmission would normally preclude a charge of reckless transmission. The policy also requires, amongst other things, that the defendant knew that he or she was HIV positive; as in Sweden, willful blindness is an insufficient argument.

[13] In Togo, people who do not use male or female condoms in "all risky sexual relations" are considered to be breaking the law

[14] In Liberia, despite there being an HIV-specific law grounded in willfulness, there is no liability for conduct where there exists no significant risk of HIV infection, where safer sex is practiced, where there has been disclosure prior to sex or the partner is aware by some other means, or where non-disclosure is the result of a reasonable fear of violence.

[15] Studies have shown that people can often be mistaken when they identify a sexual partner as the source of their infection. A study of couples in Cuba found that around two-thirds were mistaken when they named one of their recent sexual partners as the source of their infection during routine contact tracing. A study of men in California found that a third were mistaken when they were asked to name the sexual partner they believed to be the source of their infection.

[16] See footnote 8 and Danish Penal Code 252 (2)

[17] An official committee was established in Norway in 2010 to inform ongoing revision of its Penal Code which criminalises the willful or negligent infection or exposure to communicable disease that is hazardous to public health, a law that has only been used to prosecute people with HIV.

the defendants have challenged this evidence and been acquitted. Phylogenetic analysis is also very expensive to apply and unaffordable in many low-resource countries.

Risk of punishing behavior that is not blameworthy

Some laws require people with HIV to inform "all sexual contacts" of their status, meaning they could in theory be jailed for not revealing their status before kissing or engaging in behaviour that carries no risk of transmission. In practice, people have been jailed for performing oral sex on a partner despite the fact that the risk of HIV transmission was minimal if not non-existent. Other laws punish people who take risk-reducing measures such as using condoms and people who have consensual sex after disclosing their HIV status.

Extending laws to actions that pose no significant risk of transmission trivializes the use of criminal sanctions and imposes disproportionate penalties, undermining HIV prevention efforts by perpetuating the misperception that the conduct carries a significant risk of infection because it has been targeted for criminal prosecution[18]. The law must therefore be clear about the degree of risk of HIV transmission that will be captured by any criminal law and strongly suggests that exposure to HIV without a resulting infection is not harmful enough to warrant criminal penalties.

Laws are often applied unfairly and ineffectively

Where HIV–specific criminal provisions exist, only very few cases are actually prosecuted, creating scope for selective and arbitrary prosecution, often invoked in sensational circumstances and directed at those who are socially or economically marginalized including immigrants, prisoners, refugees, and sex workers. In 2008 in Texas, Willie Campbell, an African-American homeless man with mental health issues and living with HIV who spat at a police officer during an arrest for being drunken and disorderly was sentenced to 35 years in prison because a jury found that his saliva was a deadly weapon[19], despite the fact that HIV cannot be transmitted by spitting. In 1998 an HIV-positive Minnesota prisoner was convicted of biting two prison guards and his mouth and teeth were found to be a "deadly and dangerous weapon". [20]

Even where specific HIV-transmission laws do not exist, the impact of prosecutions for reckless endangerment for passing on HIV can be stark. Mr. Williams, a 21-year old African American from New York was sentenced to 4 – 12 years in prison for having sex with a minor and reckless endangerment for passing on HIV to two women. Mr. Williams' case evoked an emotional media campaign and Williams was referred to in the press as "AIDS predator", "monster", "dirtbag", "maggot", "bogeyman incarnate" and a "one man AIDS epidemic". *"Verdict on a Virus"*, a paper on public health, human rights and criminal law, examines this case and states that *"There were exaggerations, misunderstandings, and distortions in the media coverage which possibly fuelled a persuasive atmosphere of threat, undermined*

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[18] 2007 Inter-Parliamentary Union, UNDP and UNAIDS *"Taking Action against HIV – A Handbook for Parliamentarians"*.

[19] http://www.nytimes.com/2008/05/16/us/16spit.html

[20] United States v Moore 846 F.2d 1163 (1988)

the integrity and fairness of application of criminal justice, and arguably reinforced racist stereotypes about the hyper-sexuality of African Americans" [21].

From a practical perspective, even where HIV-specific legislation exists, only very few cases will ever be prosecuted. Justice Edwin Cameron has argued that such unequal treatment of people living with HIV amounts to discrimination and that the person living with HIV is being *"punished less for what they did than for the virus they carried. A similarly situated person engaging in the same acts without HIV would almost certainly not be charged with any crime. HIV status made the difference"*[22]. When a case comes to trial using HIV-specific laws, the often marginalized status of the accused and the media interest generated mean that public policy messages (strengthening anti-stigma campaigns, encouraging access to testing, educating the public that preventing HIV is a shared responsibility etc) often get distorted due to the vilification of the accused in the press. Prosecutions reinforce the idea of HIV as shameful and the impact on those living with HIV and on wider public policy messages can be devastating.

N'Djamena Model Law

Many counties have adopted HIV-specific legislation base on the Model Law on STI/HIV/AIDS for West and Central Africa, conceived as human rights legislation to combat discrimination and address testing. The model law is a template HIV act that has some good features, such as provisions guaranteeing pre- and post-test counselling, health care services for people living with the virus, and protecting HIV-positive people from discrimination in the workplace, when receiving healthcare and when trying to access credit and insurance. However, the Model Law also has some serious flaws.

Many versions of this Model Law developed by countries have included punitive and coercive provisions on HIV-specific legislation that run counter to internationally recognized best practice and the *UNAIDS International Guidelines on HIV/AIDS and Human Rights*[23] which recommends against the creation of HIV-specific crimes. Niger's legislation expressly distinguishes between exposure and transmission punishing "anyone who knowingly exposes a person to a risk, of transmission" and in Mali inoculation of infected substances is prohibited regardless of whether or not infection occurs and a person can be prosecuted even though he has taken careful measures to reduce the risk of transmission by wearing a condom.

Despite the wide adoption of HIV-specific legislation, there have not been many prosecutions given the difficulties with proof, the fact that the legislation is little known, and whether or not it is part of the culture to file criminal complaints; given the high incidence of HIV transmission these laws are *"practically unenforceable"*[24].

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[21] Verdict on a Virus, IPPF, GNP+ and ICW, IPPF Advocacy and Coordination team http://www.ippf.org/en/Resources/Guides-toolkits/Verdict+on+a+virus.htm

[22] Cameron E, *The Criminalization of HIV transmission and exposure, 1st Annual symposium on HIV, Law and Human Rights*, Toronto, June 12-13, 2009.

[23] UNAIDS *UNAIDS International Guidelines on HIV/AIDS and Human Rights* 2006 www.unaids.org

[24] Kazatchkine, C, *"Criminalizing HIV transmission or exposure: the context of French-speaking West and Central Africa"*. HIV/AIDS Policy and Law Review 14(3), 2010

UNAIDS has published a document proposing amendments to certain problematic areas of the model Law, acknowledging that many legislators wish to punish HIV transmission or exposure but intending to limit the negative effect of those provisions. UNAIDS recommends stating that cases involving protected sex, cases involving prior disclosure of HIV-positive status to a partner, cases where the HIV-positive individual is unable to disclose his or her status out of fear of abuse or violence, and cases of mother-to-child transmission are to be excluded from the ambit of criminal law.[25]

UNAIDS has issued recommendations that include alternative ways of phrasing some provisions in the N'Djamena model law including defining "willful transmission" as "transmission of HIV that occurs through an act done with the deliberate purpose of transmitting HIV".

3. Applying Criminal Responsibility to HIV exposure or transmission does not reduce the spread of HIV and undermines prevention and treatment efforts

Criminalization does not rehabilitate

Applying criminal law to HIV risk behavior has not been shown to incapacitate, rehabilitate or deter in significant numbers.[26] HIV-specific criminal law cannot have a large scale effect on the vast numbers of people who would have to be prevented from unsafe sex, sharing syringes or engaging in risk behaviors. The fact that there is so little criminalisation in practice in Africa and Asia may be either as a consequence of limited resources or due to an unwillingness of people to make formal complaints. As HIV becomes normalized in higher prevalence countries, the less likely it is to be seen as something that warrants state punishment.

There is little evidence that criminal penalties for transmission rehabilitate offenders from future transmission of HIV given that most cases of HIV are related to sexual activity and/or drug use. Individual behaviour is more likely to change as a result of interventions such as counseling, support and education.

Criminalization promotes disincentive to disclose HIV-positive status to sexual partners, to HIV testing and to seeking post exposure assistance

There is no evidence to show that the threat of criminal prosecution encourages people living with HV to disclose their HIV status to their sexual partners, particularly where lack of prior knowledge of one's status could be the best defense in a criminal lawsuit. Research in the USA and the UK has observed that some HIV-positive men reported not disclosing their HIV-positive status to their partners prior to sex due to the fear of the criminal justice system and potential legal repercussions.

HIV testing counselors are often obliged to caution people that getting an HIV test will expose them to criminal liability if they continue having unprotected sex. People living with HIV need to be able to feel

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[25] *"UNAIDS Recommendations for alternative language to some problematic articles in the N'Djamena model legislation on HIV"*
http://data.unaids.org/pub/Manual/2008/20080912_alternativelanguage_ndajema_legislation_en.pdf

[26] There have been very few reports of prosecutions and still fewer convictions in regions where HIV-transmission is criminalized. It has been noted by GNP+ in its *Global Criminalization Scan Report* (2010) that there have been no convictions in countries where the general population prevalence s higher than 16%.

free to have discussions in advance of sexual activity and feel free to access services, including child and maternal health services, without fear of potential prosecution.

Where a person with HIV exposes someone to the risk of HIV infection, it may be in the person's best interest to seek post-exposure prophylaxis (PEP)[27] in order to minimize the risk of becoming infected if transmission has occurred. If exposure is criminalized, the person with HIV may fear alerting his or her partner to the benefits of PEP because of the possibility of prosecution. Criminalization of exposure and/or transmission has the potential to undermine the public health interest in minimizing the number of people living with HIV.

In addition, during the first months following infection when the risk of HIV transmission is highest, most people do not yet know that they are HIV positive, limiting the preventive value any criminal legislation may have.

Requirement for medical agencies to release information to a court promotes disincentive to HIV testing

In a number of cases the confidentiality of medical records kept by health professionals has been breached in an attempt to establish someone's HIV status during a criminal prosecution. If medical information is not protected by confidentiality rules and is liable to search and seizure by police or a court order, this could undermine confidence in these services and reduce the willingness of HIV-positive people to discuss risk behaviours with counselors and seek treatment[28].

For women, in particular, confidentiality of medical information is essential to protect their human rights because women may find themselves abandoned, subject to domestic violence, and ostracized form their families and communities if it is discovered that they are HIV-positive.

Criminalization creates a false sense of security

Criminalization could create a false sense of security among people who are or believe they are HIV-negative because some may expect that criminalization of HIV-positive people reduces the risks involved in unprotected sex. This undermines the public health message that everyone should take measures to avoid activities that risk transmission.

4. **Applying Criminal Responsibility to HIV exposure or transmission promotes fear and stigma**

HIV remains highly stigmatized. Treating HIV differently from other communicable diseases and sexually transmitted infections means that the general public may conclude there is something particularly ominous about HIV if it is singled out by specific HIV legislation. Applying criminal law to HIV exposure or

[27] This is a short course of HIV medication, usually a combination of two or three drugs, prescribed for 28 days. It is prescribed to prevent the small amount of HIV that may have entered the body from taking over enough cells to establish lasting infection.

[28] Guidelines for healthcare professionals regarding issues of confidentiality and disclosure of information in investigations into alleged criminal HIV exposure exist in several countries including Australia, Canada, the UK and the USA.

transmission reinforces the stereotype that people living with HIV are immoral and dangerous criminals rather than people endowed with dignity and human rights.

The introduction of HIV-specific criminal offences has often been accompanied by inflammatory or ill-informed media coverage or commentary from high-profile politicians and prosecutors, which can only discourage people from coming forward to seek counseling and testing and from talking openly about AIDS[29]. Any effect criminal law has on deterring risky activity is outweighed by the harm it does to public health by deterring people from seeking HIV testing.

In some jurisdictions including Canada and the USA, criminal charges have been laid against people for activities such as biting, scratching and spitting, despite evidence that the risk of HIV transmission from these activities is extraordinarily small (and in some cases non-existent) and prosecutions can overstate the risks and spread myths and misinformation about how HIV is transmitted, undermining efforts to educate the public about HIV and further engendering fear of people living with HIV.

5. Applying criminal responsibility to HIV exposure or transmission further oppresses women

It may seem that the application of criminal law to HIV exposure or transmission may protect women and girls from contracting HIV from unfaithful partners through sexual violence or coercion into sexual intercourse by partners who do not reveal their status. Criminalization is seen as a way to remedy violence and for countries to give the impression that they are taking action against HIV. However, applying criminal law to HIV transmission does not address the deeper social, economic and political inequalities that are at the root of women and girls' disproportionate vulnerability to HIV. Laws are likely to be used to prosecute women more often than men for the following reasons:

Women are more likely to know their status and to be prosecuted

Women are more likely to know their status due to engaging with the health systems more frequently including during pre-natal testing. In June 2005, a trial was initiated in Guyana at two ante-natal clinics whereby women were tested unless they chose to "opt out". According to official statistics 90 per cent of women at these two trial sites chose to be tested for HIV. This protocol disproportionately increases the numbers of women who test for HIV/AIDS in comparison to men, which means that the majority of people who know they are HIV positive or whose HIV status is known are women. This potentially risks HIV/AIDS being portrayed as a female disease, instead of one that affects and infects all regardless of gender. [30]

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[29] The Willie Johnson case referred to above is an example of where false facts about spreading HIV through spitting were spread following a jury conviction where an HIV-positive man was found guilty of spitting, which was equated to being a deadly weapon. http://www.nytimes.com/2008/05/16/us/16spit.html

[30] *"'I am not ashamed!': HIV/AIDS and human rights in the Dominican Republic and Guyana. Amnesty International".* http://www.amnesty-caribbean.org/en/gy/reports/ENGAMR010022006.html

Where laws criminalize HIV exposure, people who test positive have to disclose their status to their partners and this carries the risk of violence, disinheritance and eviction for many women, often giving them an impossible choice. Since knowledge of one's HIV-positive status is often a necessary element of prosecution, women are more likely to be prosecuted despite women being less likely to have access to legal services and being less likely to achieve favourable outcomes in patriarchal legal systems.

Women are more likely to be blamed for HIV transmission

Women are more likely to be blamed for HIV transmission and for 'bringing HIV into the home', resulting in eviction, ostracism, disinheritance and loss of child custody. Research indicates that young HIV-positive women are ten times more likely than HIV-negative women to experience violence and abuse and there are increasing reports of women being killed by their partners for 'bringing HIV into the family'. Laws criminalizing HIV transmission would only provide another tool for oppression especially where apportionment of blame in relation to divorce and inheritance is a part of legal systems.

Laws may criminalize pregnancy

Laws criminalizing HIV transmission or exposure are often broad enough to include transmission of HIV to a child during pregnancy or breastfeeding; for many women this effectively makes pregnancy a criminal offence. In places like Guinea, Guinea-Bissau, Mali and Niger, a woman can be criminally charged with not taking the steps necessary to prevent HIV transmission to her unborn baby, such as taking antiretroviral (ARV) drugs during pregnancy. In several African jurisdictions, the wording of the law stretched wide enough to cover a pregnant woman who knows or fears she may have HIV but if she does anything that involved the possibility of infecting another person (such as giving birth or breastfeeding) the law makes her guilty of a criminal offence, even if the baby does not contract HIV. There are more effective ways to prevent mother to child transmission including preventing unwanted pregnancies, providing medication to prevent transmission, improving education and information and reducing stigma and discrimination.[31]

Even non-HIV specific laws have been used to criminally prosecute a mother for failing to seek prevention of transmission services. In Canada in 2005, a woman was charged with criminal negligence and aggravated assault when she chose not to access essential services and was sentenced to 6 months conditional service followed by three years probation, and also burdened with a criminal record which can have serious implications for future employment, travel and access to social welfare. Criminal prosecution has implications for developing countries where the law could be applied to the transmission of HIV from mother-to-child but where access to preventative medications is more difficult. Women may be discouraged from accessing services if they think they may be HIV-positive. In 2007,

[31] A recent UNAIDs study showed that even where laws do not criminalize HIV transmission from mother-to-child, up to 55% of cases of mother-to-child transmission are in settings where preventative medications are readily available but that transmission may be caused by fear of stigma and discrimination. UNAIDS 2010 Ensuring Non discrimination on responses to HIV.

only an estimated 34% of pregnant HIV-positive women worldwide were receiving antiretroviral treatment to prevent transmission and this number is likely to drop further if women are fearful of criminal prosecution. [32]

Criminalization does nothing to protect women from violence

Criminalization will not prevent women and girls from coercion and violence that can result in transmission of HIV. Many countries already have pre-existing strong anti-rape and anti-violence laws but fail to enforce them; instead of HIV specific laws that will be used against them, women and girls have a human right to timely and effective prosecution of all forms of violence and to receive medical and other services to reduce their risk of contracting HIV.

Women's rights to make informed sexual choices will be further compromised

Many women are not in a position to negotiate the conditions of sex or to negotiate condom use. Criminalization of HIV transmission or exposure may further limit women's ability to choose whether and how to engage in sex and whether or not to have children due to the risk of being prosecuted for exposing and transmitting HIV to a partner or child. Negotiating condom use may be perceived as 'proof' of knowledge of an HIV-positive diagnosis. Further, criminalization undermines the promotion of sexual and reproductive health and rights of HIV-positive women.

6. Laws criminalizing HIV exposure ignore the real challenges of HIV prevention and legislators should instead look to reform laws that stand in the way of HIV prevention and treatment

Applying criminal law shifts the burden onto people living with HIV, contradicting the message of shared responsibility during consensual sex where both partners should take measures to reduce the risk of HIV transmission. Criminalization does not empower HIV-positive people to avoid onward transmission and empowering others to protect themselves. Positive steps against criminalization have recently been taken in South Africa[33], Brazil[34], Trinidad and Tobago[35], and Mauritius.[36] Rather than applying criminal law to HIV transmission, government should instead demonstrate political will and dedication of resources to ensure HIV prevention programs.

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[32] In Sierra Leone, which had a law criminalizing mother-to child transmission, community efforts repealed the law in 2010.

[33] In 2001, the South African Law Commission concluded that there was neither benefit to be gained from nor any justification for an HIV-specific offence.

[34] In 2009 the Brazilian Ministry of Health decided to recommend cessation of prosecutions to focus on psychosocial aspects of HIV and shared responsibility for sexual health.

[35] Trinidad and Tobago have also decided not to criminalize on the basis that to do so could result in a false sense of security and that criminalization could prevent engagement with the deeper underlying issues.

[36] In 2007, Mauritius, which had originally intended to pass a criminalization of transmission law, decided after interventions from civil society groups not to criminalize exposure or transmission due to the difficulties with proof, the vagueness of the definition of exposure and the risks of selective prosecutions. The main reason was concern about detrimental effects on public health and the conviction that it would not serve any preventative purposes. Mauritius therefore decided to put resources into increased funding for testing and counseling. (Rama Valayden, Attorney General and Minister of Justice and Human Rights, Republic of Mauritius.)

Review and reform existing laws

Governments should look to reform any laws that stand in the way of HIV prevention and treatment; many people at highest risk of HIV are driven from seeking assistance by the fear of arrest on drug, prostitution and sodomy charges. Punitive laws against drug use, sex work and homosexuality fuel stigma and hatred and push socially marginalized groups away from services that might mitigate the impact of HIV and AIDS. In Asia and the Pacific, punitative legal environments for men who have sex with men and transgender people have been associated with restricted condom distribution, condom confiscation by police, censoring HIV prevention education materials and harassment and detention of outreach workers. [37] Criminalization of sex work in Botswana, Namibia and South Africa has been found to leave sex workers vulnerable to sexual and physical abuse as well as extortion from law enforcement officers, rendering sex workers vulnerable to HIV. [38]

Instead of passing more criminal laws, legislators should look to pass laws to protect women's equal rights, remove legal barriers to condoms and sex education including post-exposure prophylaxis and needle programs, and support drug dependence treatment. A study in Zambia showed that human rights protections against torture and degrading treatment, and access to justice, are essential for reducing the spread of HIV in prisons and in the general community. [39] Countries that enforce protective laws against discrimination of key populations such as sex workers, drug users and men who have sex with men have achieved greater coverage of HIV prevention services as people are more likely to use the services if they are confident that their confidentiality will be respected and they will not suffer from discrimination, especially important is countries such as Guyana and the Dominican Republic where levels of discrimination are high. [40]

In the Dominican Republic Congress enacted an AIDS/HIV Bill in May 2011 which, after being adopted by the President, will repeal law 55-93, *La Ley Sobre el SIDA*. Law 55-93 was introduced in 1993 and criminalized the transmission and exposure of HIV. At the recent High Level Meeting of VIH/SIDA in June 2011 in New York, the Dominican Republic Representative made a statement to the President recognizing the importance of respecting human rights of persons living with HIV and AIDS and announcing the repeal of the law, stating that it was a "transcendental step so that persons living with HIV or AIDS are assured of the necessary personal guarantees in the framework of the National Response on HIV/AIDS."[41]

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[37] UNDP and APCOM (2010), *Legal Environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action.* Thailand, UNDP.
[38] UNDP and Ford Foundation *Fact sheet on Human Rights and the Three Diseases*.
[39] Todrys et al, *"Imprisoned and Imperiled: access to HIV and TB prevention and treatment and denial of human rights in Zambian prisons"* Journal of International AIDS society 2011.
[40] UNAIDS (2008), *2008 Global Report on the Global AIDS Epidemic*, Geneva.
[41] The Representative also made reference to the need to lead actions to reduce stigma and discrimination, particularly in the workplace, in order to support the full realization of human rights and fundamental liberties for all. http://www.un.org/en/ga/aidsmeeting2011/pdf/dominican%20rep.pdf

Legislators should also reform police practices that target vulnerable groups[42], ensure treatment for all people living with HIV, review laws that criminalize or marginalize vulnerable groups such as men who have sex with men, people who use drugs, marginalized women, and sex workers. These vulnerable groups often lack access to HIV prevention and treatment services, primarily as a result of their 'criminalized' status, and criminalization of HIV exposure and transmission is likely to further stigmatize these groups and create further barriers to healthcare by posing a threat of double prosecution.

Consider public health law as an alternative to criminalization

The use of public health powers can often achieve the objectives said to be served by criminalization while doing less damage to public health initiatives and important interests such as right to non-discrimination. There is an unmet need for needle exchanges, antiretroviral therapy and opioid substitution; using public health policies to make these provisions could reduce the prevalence of HIV . A study published in The Lancet in 2010 suggested that HIV prevalence could be reduced by 41% in Odessa (Ukraine), 43% in Karachi (Pakistan) and 30% in Nairobi (Kenya) through a 60% reduction of these unmet needs.[43]

Empowering individuals to take control of their own health needs and ensuring sustainability of programmes can lead to improved access to HIV prevention treatment through addressing the social determinants of health and supporting effective community interventions to improve access for vulnerable and marginalized groups.

The Global Commission on HIV and the Law

The Global Commission on HIV and The Law[44] which is being convened by UNDP on behalf of the UNAIDS family, is currently investigating the relationship between legal responses, human rights and HIV. The Commission is focused on criminalization of HIV transmission, behaviours and practices such as drug use, sex work, same-sex sexual relations, and issues of prisoners, migrants, children's rights, discrimination and violence against women and access to treatment. The Global Commission on HIV and the Law will develop actionable, evidence-informed and human rights-based recommendations for effective HIV responses that protect and promote the human rights of people living with and most vulnerable to HIV. The findings and recommendations of the Commission will be summarized in a report to be launched in December 2011, and will identify practical solutions for countries through which the law can become a positive force for scaling up effective HIV responses. For more information on the work of the Global Commission please visit the Commission's website at:
http://www.hivlawcommission.org/

[42] Police harassment in Russia has been shown to increase direct HIV risks through increased unsafe needle-syringe practices and increased unsafe sex.
[43] Strathdee et al, *"HIV and the Risk Environment for injecting drug users; the past, the present and the future"* The Lancet, Volume 376, issue 9737, July 2010
[44] http://www.hivlawcommission.org/

7. Recommendations

UNDP, like UNAIDS, recommends that criminal liability is not imposed in the following non-exhaustive circumstances[45]:

- an act that poses no significant risk of HIV infection,
- a person living with HIV who was unaware of his or her infection at the time of the alleged offence,
- a person living with HIV who lacked understanding of how HIV is transmitted at the time of the alleged offence,
- a person living with HIV who practices safer sex including using a condom,
- a person living with HIV who disclosed his HIV-positive status to the sexual partner or other person before any act posing significant risk of transmission,
- a situation in which the other person was in some way aware of the person's HIV-positive status,
- a person living with HIV who did not disclose his or her status because of a well-founded fear of serious harm by the other person, and
- the possibility of transmission of HIV from a woman to her child before or during birth and through breastfeeding an infant or child.

UNDP, like UNAIDS, recommends that Guyana address the deeper social, economic and political inequalities that are at the root of women and girls' disproportionate vulnerability to HIV, reform existing laws to reduce discrimination against HIV-positive people and support AIDS awareness and treatment, and consider using public health law as an alternative to criminalization.

[45] UNAIDS and UNDP (2008) *Policy brief on the criminalization of HIV transmission* Available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf and *10 Reasons to Oppose Criminalization of HIV Exposure or Transmission,* HIVhumanrightsnow.org

Good Day Sir Madam:

Please find below a Submission from Artistes In Direct Support.

What does criminalization of HIV non-disclosure do for the public health response to HIV/AIDS?

- Criminalization will weaken the public health response to HIV/AIDS.

- The criminal law approach will stand in stark contrast to evidence-based, flexible and effective public health strategies that involve education, testing, counseling, and a range of sanctions to respond to behaviors that places others at risk.

- Criminalization will make people fearful of HIV testing and less likely to approach the public health system for information on reducing risk and support for safer behaviours.

- Untested and therefore untreated people are usually more infectious and more likely to spread HIV to others.

What does criminalization of HIV non-disclosure do for the court system?

- Criminalization will promote clogged courts. Our court system is already overburdened. Dealing with HIV non-disclosure in the courts will have a high cost to both society and the people involved.

- Courts may not be in a position to make the right decision. Since these cases are about the intimate details of personal relationships, it is often difficult to prove or defend against such charges. And police, prosecutors and judges are not experts in epidemiology, public health or the science of HIV transmission. So decisions about laying and prosecuting criminal charges, and court decisions, may be influenced by prejudices and fears.

• People will use the criminal justice system for personal gain. They will want to lay charges (or threaten to do so) against a sexual partner to control that person, out of a desire for revenge, or when a relationship breaks down. If they are good liars, their sex partners may be wrongly convicted and end up in jail.

What does criminalization of HIV non-disclosure do to community organizations?

• Responding to criminalization places unnecessary new burdens on already over-burdened community organizations.

• AIDS service organizations should be able to devote their energy and resources to services that have been shown to reduce HIV transmission and improve the lives of people living with HIV—education, testing, support services and programs addressing stigma, discrimination and poverty.

• Fears of legal liability will also interfere with counseling and education work in community organizations.

Our Prevention of Mother to Child Transmission Programme(PMTCT) that Guyana has spent so much money making successful, will be of no further use, because children would now be able to take their Parents to court for willing infecting them. What will happen to families? Children will hate their parents.

We were very successful in getting persons to get Tested for HIV-Know your Status- People will no longer go to get tested, so that they would not be accused of "Knowingly" infecting anyone, because they would known that they had HIV.

What does criminalization of HIV non-disclosure do for people living with HIV?

• Criminalization will demonize people living with HIV and place them at greater risk of isolation, stigmatization and discrimination.

• Criminalization will be a backward step in the response to HIV that can make people less likely to disclose their status if they know it, or to find out their status by getting tested.

• Using the criminal law to address issues of HIV exposure will have disproportionate impacts on specific groups. Some people living with HIV, especially sex workers and women in abusive relationships, may face violence if they are obligated to disclose their HIV to sex partners even where there is negligible risk of HIV transmission.

What does the criminalization of HIV non-disclosure do for the general public?

• Criminalization will make the general public more vulnerable to HIV infection by giving people a false sense of security.

• Criminalization will send the message that because HIV positive people have the responsibility to disclose their HIV status; people are "safe." This may increase risk behaviours amongst HIV negative people who will count on every HIV positive person to disclose. Criminalization will take the emphasis away from the tradition of shared responsibility for safe sex and preventing the spread of HIV. It is everyone's responsibility, whether they know their HIV status or not, to ensure that HIV is not transmitted. Criminalization potentially divides communities that need to be working together to fight the spread of HIV.

What are the alternatives to the criminal law?

Give public health authorities a greater role.
Public health authorities should do their utmost to support people to integrate their HIV infection into their lives, while promoting their health and that of their sexual partners. Public health interventions should progress from the least invasive, least restrictive responses, to more restrictive or coercive responses, including legal sanctions under public health laws, if necessary.

Re-commit to HIV prevention. All levels of government should focus HIV prevention and awareness on people who do not have the knowledge or skills necessary to protect themselves

from HIV. Public health should undertake these two activities in concert with community-based organizations that serve the needs of people living with or at risk of HIV.

Recognize that HIV is here to stay. There is no cure. And the reasons people become infected with HIV are complex and involve sex, disease, poverty, and power within relationships and in society. So it is unrealistic to expect that we can prevent all new cases of HIV, or that something as blunt as the criminal law will make a real difference in decreasing the number of new HIV infections.

Fight ignorance and stigma. Ask yourself, "What keeps some people from disclosing their HIV status?" The answer for many of these people is the stigma and discrimination that people living with HIV face every day. If there were less ignorance, prejudice and stigma people would have less difficulty disclosing their HIV status.

This Law would be removing the responsibility of both parties, who engage in a sexual act that result in HIV infection.

I would be grateful if I could make an Oral Presentation.

Desiree Edghill
EXECUTIVE DIRECTOR

Artistes In Direct Support
156 Alexander Street Kitty Georgetown
TEL# 225-5112/227-7321

The Clerk of the Committee
Special Select Committee on Criminal Responsibility of HIV Infected Individuals
(Resolution No 129 of 2010)
Committees Division
Parliament Office
Public Buildings
Georgetown

Dear Sir/Madam

The Society against Sexual Orientation Discrimination (SASOD) hereby requests a meeting to give an oral presentation to the above named committee.

SASOD is concerned that the criminalising of HIV transmission would further stigmatise the groups who are already marginalised from seeking access for HIV testing, prevention and care and that the strides being made in Guyana to increase access to testing and other services would be reversed as a result of persons not wanting to know their status.

Yours sincerely
Vidyaratha Kissoon
Trustee/Secretary

SASOD - Society Against Sexual Orientation Discrimination
CIDA Programme Support Unit Building
56 Main and New Market Streets
North Cummingsburg, Georgetown
Phone: + (592) 226-5155 / 623-5155
Website: http://www.sasod.org.gy

SASOD – Guyana

Position Against the Criminalization of HIV Transmission- Resolution No. 129- July 2011

CRIMINALIZATION OF HIV TRANSMISSION IS COUNTER TO THE OFFICIAL UNAIDS POSITION AND INCONSISTENT WITH INTERNATIONAL GUIDANCE ON HUMAN RIGHTS:

- According to UNAIDS and other international agencies, there is no evidence to suggest that criminalizing HIV transmission is an effective means to prevent the further spread of the virus or achieve criminal justice.

- Several countries that have such laws e.g. Guinea, Togo, Denmark and Senegal, are reviewing and suspending them in the face of increasing awareness of their inefficacy as well as concerns of violating individual human rights.

- SASOD supports international consensus that criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases.

- A legal review by the Belizean NAC found that the criminalizing of deliberate transmission deterred persons from getting tested for fear of criminal sanctions. The review indicated that there have been no prosecutions under the section because of the evidential difficulty in proving these cases under law and as a result, the recommendation is to repeal the law.

CRIMINALIZATION FURTHER VICTIMIZES WOMEN:

- We share Mr. Franklin's desire to better protect women from dishonest and malicious sexual partners, but the fact is that criminalization does not protect women- it increases the likelihood of them being victimized. The reason for this is that women access healthcare services more often than men (for reproductive services especially), so in many places, women who know their HIV status more often than men. As such, they can be accused of transmitting the virus to their male partners, even if those partners are the ones who infected them in the first place. Therefore, these laws can be described as harmful instead of helpful to women.

- More helpful to women would be to address gender-related violence, inequality and sexual coercion, as well as stigma and discrimination.

- Some women might be prosecuted for mother-to-child transmission. This occurs where laws criminalizing HIV transmission or exposure are drafted broadly enough to include transmission to a child during pregnancy or breastfeeding.

CRIMINALIZATION INCREASES STIGMA AND DISCRIMINATION AGAINST HIV+ INDIVIDUALS AND DRIVES TRANSMISSION:

- HIV is no longer a death sentence; it is now a medically manageable disease. Legislation such as this continues to spread fear and misinformation about HIV, however. There are other infections that can be transmitted via unprotected sex- some of which are also lifelong conditions- such as Herpes- but the same level of attention is not paid to those.

- The focus on criminalization of HIV transmission increases stigma and discrimination against HIV positive people by making potential criminals of all of them and has a deterrent effect on testing. Testing is a critical tool in reducing HIV transmission and anything that interferes with its efficacy- such as legislation like this- is very dangerous and counterproductive in the fight against this disease.

CRIMINALIZATION UNDERMINES PUBLIC HEALTH:

- Criminalization of HIV transmission also makes it even more difficult to work with 'hard to reach' communities such as men who have sex with men, sex workers, drug users, etc who are already fearful of the authorities and being criminalized for their lifestyle or sexual behaviors.

- Confidentiality between people and their healthcare provider is extremely important- especially in cases of HIV+ individuals who require long-term treatment. As such, anything that forces doctors and health care providers to reveal patients' private health information, or even testify about it, has a negative impact on patient trust of the health care system and willingness to remain engaged in HIV care- which has a negative long term impact on society as a whole. Far more effective HIV prevention programmes exist such as testing, counseling and general awareness campaigns.

THERE ARE ALREADY LAWS IN PLACE TO DEAL WITH THIS:

- We already have legislation in place- Sexual Offenses Act- which would deal with cases of non-consensual sex. In cases of such offenses, the accused is compelled to obtain a HIV test, the results shared with the victim, and taken into account when determining the sentence.

- Strengthening this existing legislation, educate citizens, law enforcement, and judicial officers about their rights and responsibilities under this law and putting policies into place that make it really work effectively on the ground is a better use of time and resources, in our opinion, instead of putting yet another misguided, ill-informed, and un-enforceable law on the books.

IN CONCLUSION:

The job of preventing HIV falls to society as a whole, not just those who are HIV positive. Focusing solely on them does us all a disservice. We need to focus instead on proven prevention strategies such as testing and counseling, education, and reducing stigma and discrimination, and protecting peoples' human rights and dignity.

APPENDIX IV

+NATIONAL ASSEMBLY OF THE FIRST SESSION

OF THE NINTH PARLIAMENT OF GUYANA (2006-2011)

REPORT OF THE PROCEEDINGS OF THE MEETING OF SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF

HIV INFECTED INDIVIDUALS, RESOLUTION NO. 129 0F 2010

4th Meeting	4.14 p.m.	13th July, 2011

MEMBERS OF THE COMMITTEE (10)

CHAIRMAN (1)

(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture, Youth and Sport

The Hon. Manzoor Nadir, M.P.,
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P.

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection 21st October, 2010)

Dr. George A. Norton, M.P.

Mrs. Volda A. Lawrence, M.P.

Ms. Africo Selman, M.P.

From the Guyana Action Party/Rise Organise and Rebuild (1)
Nominated by the Committee of Selection 21st October, 2010

Mr. Everall N. Franklin, M.P. [Absent-Excused]

Mr. Chairman: ...of the Special Select Committee on Criminal Responsibility HIV Infected Individuals, as agreed, this session is dedicated to hearing presentations from a number of organisations. We have invited Artistes of In Direct Support, SASOD which is the Society Against Sexual Orientation Discrimination, The National AIDS Committee, The Joint United Nations Programme on HIV/AIDS, that is UNAIDS, and the United Nations Development Programme (UNDP). The Artistes In Direct Support is already here. I would want to ask that we deferred the consideration of the Minutes of the last meeting and go straight to the presentations. If Members have no objections to that, I would proceed to begin the presentations by our guests. So I am putting a proposal that we deferred the Minutes. Is there any objections? Okay, so we will consider the Minutes at our next meeting.

The consideration of Minutes was deferred.

TO RECEIVE ORAL PRESENTATIONS FROM THE FOLLOWING ORGANISATIONS:

(a) Artistes In Direct Support @ 4.15 p.m.;

(b) Society Against Sexual Orientation Discrimination (SASOD) @ 4.30 p.m.;

(c) National AIDS Committee (NAC) @ 4.45 p.m.;

(d) Joint United Nations Programme on HIV/AIDS (UNAIDS) @ 5.15 p.m.; and

(e) United Nations Development Programme (UNDP) @ 5.30 p.m.

Mr. Chairman: I will ask the Committee staff to invite Ms. Desiree Edghill from Artistes In Direct Support.

Executive Director, Artistes In Direct Support, entered meeting.

Mr. Chairman: Good afternoon Ms. Edghill. Ms. Edghill, are you alone?

Executive Director, Artistes In Direct Support [Ms. Desiree Edghill]: Yes Sir.

Mr. Chairman: I know that you are quite capable.

Ms. Edghill: Yes Sir.

Mr. Chairman: Members, this is Ms. Edghill. I think most of you know Ms. Edghill. She has been the head of Artistes In Direct Support for a long time. This is an organisation that has been in existence for almost as long as Guyana's response to HIV/AIDS. I know Ms. Edghill in this fight since before I became a Member of Parliament. Ms. Edghill, the Members of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals, Resolution No. 129 of 2010 are privileged to have you here this afternoon and I believe that you know all of the Members here. Just in case, let me introduce the Minister of Public Service, Minister Dr. Westford, who you know very well; Minister Nadir, he is the Minister of Labour and Minister Dr. Frank Anthony, he is the Minister of Culture, Youth and Sports – one of the few times I believe I have got it right.

Minister of Culture, Youth and Sport [Dr. Anthony]: It is "Sport."

Mr. Chairman: I still did not get it right. Dr. Vishwa Mahadeo who is the Chief Executive Office of the Regional Health Authority, Region 6, and Rev. Dr. Kwame Gilbert, Member of Parliament. We also have Dr. – there is a lot of doctor around – George Norton, Mrs. Volda Lawrence and Ms. Africo Selman.

We are happy that you are here this afternoon; we have a little time constraint so I think as the Committee informs you, we have twenty minutes for this engagement and so I would like you to make a short presentation and then the Members might want to ask you questions.

Ms. Edghill: So, Sir, my presentation and question will all be for twenty minutes.

Mr. Chairman: I am the Chairman and you know how generous I can be.

Ms. Edghill: Thank you, I think I can make it. Good afternoon everyone I will like to add a bit to what Minister said concerning how long we have been in this Human Immunodeficiency Virus (HIV) fight, since 1992. Next year we will be celebrating twenty years - Artistes In Direct Support. The late Mr. Andre Sobryan owned himself... was HIV-positive. I think he was one of the first persons who came out and spoke about being HIV-positive in Guyana. At the time when this Criminalisation of HIV came up, we were opening a HIV testing site at our office at 156 Alexander Street, Kitty, and so right away I tuned in, because I was opening the site specially for the vulnerable population which includes Men Who have Sex With Men (MSM) and commercial sex workers because they are the ones who are facing a lot of stigma and discrimination. First of all, because of who they were, called "the marked most at risk population", and, then, secondly, we were told that when HIV came to Guyana that it came from the MSM's community. So we want to provide a place for them to feel free to come and be tested and not be discriminated against or stigmatised. Right away when I heard about this the first thing I said was that we will have to close our site down because if knowing my status makes me a criminal then I do not want to know it.

So this is where I want to start today to talk about the health response to HIV and AIDS. We have had evidence over the years where stigma and discrimination has reduced. We, at Artistes In Direct Support, when we started, the first production that we had there were fifty people at the National Cultural Centre and today we have to hold it two nights and there are two thousand people who can hold there. We know people have moved to a different place where they were fearful of talking of HIV and now not only talking about it but also coming to be tested without fear of being discriminated against. Long ago when one was seen going to a HIV site he or she is labelled as HIV-positive and people did not want any of that. Now that does not exist. We have really come a long way with education, with counselling, with helping people to change their behaviour. We are thinking that criminalising of HIV will make people fearless of going to do the very testing they have become so very custom to doing.

When I talk about testing, I want to speak a bit about super infection. Apart of getting tested, it is also to – if one is HIV-positive – have a plan where he or she is going to go, knowing now that he or she is HIV-positive and one of the main aspects that was discussed is super infection. Previously, it was called re-infection, now we are saying "super" because the word "re" would have meant it would have gone and it is now coming back, but it is not "re". It is "super" which means that one will get a little more of what he or she already has, especially for women who, we, ourselves, are the receptacles and so if we have unprotected sex with someone, a male who is HIV-positive, then we will be receiving some of what he has and if it is a higher strain than what we have then we will become super infected. So having HIV still puts one at risk of being super infected, so it not only that it can be passed on to someone else

unless that person is having unprotected sex. But one can also become super infected by someone else especially if his or her status is unknown because that person, himself or herself, can be HIV-positive.

I want to talk a bit about the Court system when we heard about of it being criminal and it would have to pass through the Court. The one thing that concerns me a lot is of the health care providers including the Non-Governmental Organisations (NGOs) which will have to make the information available for evidence, I guess, if someone is convicted of knowingly infected someone else. The information will have to be given at the NGO's level, or wherever people so to get tested, so as to prove that he or she did not know that he or she was HIV-positive which removes the whole doctor-client or health care provider-client confidentiality, so that people would not want to come and get tested knowing that they would have to share their confidentiality with them and also to say most people who have become HIV infected become HIV infected when they themselves did not even know that they are infected or the person they are having sex with, because you know that someone is HIV-positive you would have unprotected sex with that person, but it is because of that trust and because people think that people are not infected that they have unprotected sex with them. With all the burden on our Court system, I do not know how we are going to deal with this whole issue of trying the cases. People could become upset and go out and do some more infections while the case is going on, because, as you know, this might be the end of the road for some people to do so they may go and make a bad job of it and get it done because of the justice system that we do have.

I also want to talk a bit of if prisoners hear that someone who is going around there knowingly infected someone comes in to a prison then that person is not going to knowingly infected anyone in there, and so even before that person gets in there the prisoners will be waiting for. I do not want to say what could happen as a result of that, in prison, where there is no space as well to house people for other serious crimes.

I am also concerned about wives and husbands: If one partner infects the other and it was found out that knowingly he or she infected the other partner, the wife can then take her husband to Court or get him locked up for knowingly infected her and *vice versa,* especially for those people who are unfaithful and as a result that can have an effect on the family. If a child grows up to learn either his mother or father locked up either partner because of willingly infected him or her then hatred is going to come in to play and so there is going to have broken homes as a result of that.

I also want to talk a bit of our Prevention of Mother-to-Child Transmission programme. We have a very successful Prevention of Mother-to-Child Transmission programme where only about two per cent of our mothers who are HIV-positive their babies become positive themselves. We will have to close down the Prevention of Mother-to-Child Transmission programme because those women who are part of the Mother-to-Child Transmission programme know that they are HIV-positive before they have gone in to that programme. As a matter of fact, they have to be HIV-positive in order to be a part of that programme. Are we saying that the child has the opportunity to take the mother to Court for knowingly infected him or her if that child should become HIV-positive? We in Guyana have spent a lot of money on that and a lot of groundwork was done in trying to get women to be a part - to consent, because it is voluntary – of that Prevention of Mother-to-Child Transmission programme. So then, are we going to throw that through the window because a mother is not going to want to know that her child can get her locked up for knowingly infected the child?

Even with sharing their information when they come, because in order to be helped if one is HIV-positive a lot of information has to be shared with whoever is counselling the individual, whatever programme that individual will a part of and people are going to be fearful of sharing that information, therefore it can affect how they will be able to be helped, because if the correct information is not given then they will not be able to be helped in a good way or the way in which they should be helped. But if people know that they information are going out there then they are going to be very guarded as to how much information are given. Already the people would have to believe in you, believe that you are confidential, to give you all the information in order for them to be helped so we are going to have an issue with that as well.

I think also that criminalising of HIV can also make people become malicious, because if you have an issue with someone and you become HIV-positive and you know that that person too is HIV-positive and you want to have a grouse with that person then you can say that your HIV infection was from that person because you know that person is HIV-positive and you had sex with that person. How can you prove that I did not have sex with that someone when I got my HIV infection? It will take the responsibility away from both partners. I think if two persons agree willingly to have a sexual relationship, unprotected, then the two persons have to take the responsibility of the consequences of that sexual relationship. By criminalising HIV, if someone knowingly infected someone, the burden is placed on someone who is HIV infected and it is taken away from another person who has to have some kind of responsibility, especially with all the HIV education that is out there. You cannot go and have unprotected sex and say, "I am okay because if the person knows that person is not going to have sex with me because that person is going to get locked up." It is not going to curb the spread of HIV. If it is anything, it is going to make it worse because people are not going to go and get tested, then they would not know their status. So when you become HIV-positive, and we say, could you prove that you know that you are HIV-positive? You will say I did not know. So instead of curbing the spread, in fact what it would do is to make it worst, because people would not be tested; they would not know their status, and there they cannot be locked up because they did not know. As you know, there are malicious people, people who want to get back at people, and if their information can become public or to a place that it can be accessed then more people will know because, as you know, we are curious people and the *spit press* is the worst press ever, and once the *spit press* gets it, it will get around, and when people hear that people are HIV-positive... The *spit press* is *talk name*, text, and call on the phone, as you know. If you want to spread anything just use the *spit press*, it gets around faster than the media. The *spit press* works overnight, at midnight, while the other rest of media is sleeping. So it will get around.

Dr. Norton: Is this local?

Ms. Edghill: Yes. It is local. So the words will get around.

Mr. Chairman: It is local and international these days - facebook.

Ms. Edghill: Facebook is more media because it has to be put out there, but the *spit press* is talking so that there will be no face to the person who is talking and it cannot be proven unless it is recorded and that kind of thing. Once the words get out there that someone is HIV- positive and you have a grouse with that person you can take that person to Court to say that "I had sex with you and you knowingly passed on the HIV infection to me" so even in that sense people can become malicious and people can tell lies so well that it can become believable. So that is for the law.

So there is no cure for HIV infection, at present. There is treatment for HIV infection available in Guyana, free of charge. More people are accessing treatment in Guyana. More people are disclosing to partners and family because there is the Home Based Care programme, but that programme is to help families to take care of their relatives who are HIV-positive and need that care so that it would not put a burden on our health care system. But the stigma and discrimination plays a big part in that role, so if HIV is to be criminalised, families would not want... because if people go to jail for a two months, or whatever, and they come out, they are not going back there because it is already out there in the public and so the families... There is still stigma and discrimination where people feel that if there is someone who is HIV-positive in the home, then people do call the home "the AIDS home". I know that. I have faced it for years when we started doing this work. I used to be called "the AIDS woman". It was negative at first and then eventually when they called me I felt good about it because I know that someone needed help and I was going to help that person. We do not want to go back to that place. We have moved to a place where families are now helping and if we do that they will not want to be a part of it because not only persons are going to be a criminal but people will know that those persons are HIV-positive and then place stigma on families members who are willing to help if it was kept between us. People do not want to disclose their status because they are fearful of stigma and discrimination. People can only disclosed their status if they know their status. If by knowing my status makes me a criminal then I am not going to want to know it and therefore I am not going to disclose it because I do not know it, and no one can blame me for it, but what I can do is to pass on the virus to unsuspected persons because I, myself, do not know. You cannot prove that I know.

So I will like to close with a quote from UNAIDS and UNDP *Policy Brief on the Criminalisation of HIV Transmission* which was presented in August 2008 at the International AIDS Conference in Mexico and I quote:

> "Criminalisation of HIV transmission and exposure will not protect women especially from coercive or violent behaviour such as rape that can transmit HIV. Indeed, many countries that already have strong anti-rape laws fail to enforce them. Instead of addition ineffective HIV specific laws that will be used against them, urgent efforts are needed to ensure timely, effective and aggressive prosecutions of all forms of gender based violence and to ensure that victim of sexual violence received Post Exposure Prophylaxis that will reduce their risk of contracting HIV".

For those person who do not know what Post Exposure Prophylaxis is, it is a drug that is given to persons who are accidently exposed to HIV infection primarily in the health care settings or for rape victims that could be received at least seventy-two hours after it had happened to try to avoid that transmission, because it takes a time for the virus to enter the bloodstream so it is catch before... It is not for people who were unfaithful and found out that they are infected to go and get it. It is just for people who had an accidentally exposure. There is also, already, the Sexual Violence Act that can deal with cases of forced sex and rape , and that kind of thing, that we need to concentrate on and make good so that it can be enforced rather than trying to enforce a law.

I would like a law to be enforced for second-hand smoking which I am not willingly apart of but usually suffer from it. Thank you.

Mr. Chairman: Thanks for that... [*inaudible*]

Dr. Norton: I did not get the last part.

Minister of Public Service [Dr. Westford]: She is requesting that a law be enforced against second-hand smoking.

Mr. Chairman...that you support.

Thanks for that Ms. Edghill. Members, you have heard the presentation, quite eloquent and obviously it is someone who has been passionately engaged in the fight against HIV for as long as twenty years. So this presentation is open for discussion.

Dr. Westford: Thank you very much Mr. Chairman. First of all, I think we ought to clarify that we are not dealing with criminalisation of HIV. That is the first thing we ought to bear in mind, and I heard that terminology throughout the presentation. We are not criminalising HIV. The criminalisation comes in with the action of those persons who "knowingly" – there is an operative word – infect others. So we must get that clear. We then heard Ms. Edghill saying that persons will not want to know their status. They will not want to be tested because they feel that knowing their status will make them a criminal. I think the onus is on all of us, and especially persons such as Ms. Edghill who has been dealing with HIV infected persons for the last, as she said, twenty years, or nearly twenty years, to make them understand that knowing their status does not make them a criminal. It probably might prevent them from being deemed as a criminal, one. And two, they are going to be protecting others as well as themselves. You mentioned something important.

Secondly, you talked about "super infection", so that is important in them knowing their status too to protect themselves, not only others. So I think we have to be careful, and not only look at somebody will be locked up if that person transmits the HIV infection to someone else. We have to look at it holistically to see that in protecting others they will also be protecting themselves.

The mother-to-child transmission, you also said that the mothers may not want to be tested because if they are tested and found to be HIV-positive it may make them a criminal. No, it is going to make them protect their unborn child because, as you rightly said, there is drug available that can prevent that mother-to-child transmission. So if I am HIV-positive and it does not stop me from becoming pregnant, and I choose to become pregnant, I can then inform my health providers that I am HIV-positive so that they will know from the first day the kind of care that I will need to get to prevent that transmission. So I am not really convinced with the argument that as to why persons should not know their status and why they should not be held criminally responsible for their behaviour if they knowingly – operative word – transmit the infection to others.

Mr. Chairman: Let us hear some other comments, but Members I just want to say that this debate is not going to start now. We are going to debate these issues raised. This is just a chance for stakeholders to come and make some presentations, and I will urge that we limit what we have to say to questions, clarifications, and so on. So I am going to go to the next two persons who are Mrs. Lawrence and then Rev. Dr. Gilbert.

Mrs. Lawrence: Thank you Mr. Chairman. Mr. Chairman, through you, to Ms. Edghill, at the beginning you have mentioned that when the motion was laid in the National Assembly your organisation was about to open a clinic in the Kitty area targeting MSM – a testing site. Could you say what has been the response?

Ms. Edghill: It has been good. We do community outreach where we bring them in, encourage them, to come in to be tested. We have had a lot of males coming to get tested at our site since it was opened.

Mrs. Lawrence: So you are saying that while you were scared after hearing the motion in the National Assembly that did not hamper your testing site from operating.

Ms. Edghill: No, because a lot of then did not know about it.

Mrs. Lawrence: My second question to you is that whether any of the visitors to that testing site, or any of your offices, mentioned this particular topic, and what were their demeanours in terms of it? Were they afraid of it? Were they inquisitive to know what it was about? How did they respond?

Ms. Edghill: We did have a meeting with HIV-positive persons, because we also work with HIV-positive persons, and we felt that it was right to have a meeting with them to get from them how they felt about the whole thing. The first thing that came up was stigma and discrimination. People felt that they would be stoned once people found out that they are HIV-positive. People did not even go to the place where they…They did not even think that they had to pass on the virus to someone in order to be attacked. They felt that the fact was that it was criminal to knowingly infect someone. Once someone knows that they were infected they are going to face stigma and discrimination before even before they get involve in act which causes the infected person to pass on HIV to someone. So that was their biggest fear.

They were also concerned whether were going to come out and support them and talk against it, and we did say that we would. But the main concern was stigma and discrimination. They were already facing the stigma and discrimination and they felt that this would make it worst for them even before they would have passed on the virus to someone else.

Mrs. Lawrence: So you are saying overarching this particular motion would be the fear of stigma and discrimination.

Ms. Edghill: Which were something that we were trying curb with all of this work that we were doing, and they felt that the only way one can become a criminal or be criminalised is if that person knows, because knowingly one has to know in order to knowingly infect someone.

Ms. Lawrence: My last question to you would be whether a large percentage of the persons who attend your testing sites and other places where service are offered for persons infected come from within the catchment areas of those offices.

Ms. Edghill: Is as in the Kitty area?

Mrs. Lawrence: It is as in the Kitty area.

Ms. Edghill: No.

Mrs. Lawrence: Are we talking about Kitty/Campbellville people or are we talking about people out of that catchment area?

Ms. Edghill: People come from all over.

Mrs. Lawrence: I am talking about the majority

Ms. Edghill: The majority of our people are from the catchment areas, but it is whole Kitty/ Campbellville area, and Newtown, at wider. It is not only Kitty *per se* but Newtown. There are even people from the military base coming over there to get tested.

Mrs. Lawrence: Thank you.

Rev. Dr. Gilbert: I just want to clarify. I think the work of this Committee primarily is to hear your presentation as well as the others that we are still to hear and not necessarily to pass a judgement on the rightness and wrongness of your views, but to hear your presentation to guide us in this process. However, I think a lot of what you have said, a lot of what you have presented earlier, can be considered pretty anecdotal. We do not have, I think, empirical data that is available to us to guide a lot of what we. What I find, however, is that, not just from your presentation, but from some of the written presentations that I have gone through, there is very strong advocacy on the position you have taken from a number of the other organisations, but I think the area that I would want us to also consider, and I am sharing this as a means by which I think the dialogue can continue, which is, while the burden of responsibility, and you mentioned that the burden of responsibility lies with both individuals, the person who is infected as well as the person who enters into the sexual relation with that person, do you not think that the legislators do have a responsibility to ensure that they regulate, not just for those who may be deliberate and wilful in their conduct and irresponsible as well, but also for those who themselves might need the protection of the State? Because what we do not have is data and evidence of persons who, to this date, have been wilfully and maliciously infected, but it is something that is actually happening.

4.44 p.m.

I, myself, have been privy to the hearing of things that are very frightening, of persons who take advantage of persons who are vulnerable - young people, children - and there is nothing at this point that makes that persons culpable by way of the law to be responsible for their conduct and behaviour regarding that kind of sexual behaviour.

I am thinking therefore that consideration needs to be given to that fact that the legislators do have a responsibility to ensure that they consider that, while what you said does have merit, there is also that great potential that there are persons who can be harmed maliciously, and one has to take that wider responsibility into context as well.

Ms. Edghill: Well, like as I said, I was hoping that sexual violence can deal with that area. Whether it is force, rape, taking advantage of then... [*Interruption*]

I just want to finish saying that the sexual violence - rape, forced sex- all can be addressed under Sexual Violence Act, including HIV/AIDS, because people can have violent sex with other persons and do not know that they themselves are HIV-positive and can still be prosecuted under this Act, without knowing that they are HIV-positive.

Mr. Chairman: We have run out of time, but Dr. Mahadeo, I will just let you address her for a short period.

Dr. Mahadeo: Thank you Mr. Chairman. Ms. Edghill thanks for your presentation and I understand your concerns, in particular with the issue of the mother-to-child transmission, because in spite of all of the drugs which are given, statistics prove that there can be the reduction the number of babies that get infected, but they can still get infected and issues like those in a legislation would need to be clarified. But thanks for your presentation.

Mr. Chairman: Ms. Edghill, thank you for your presentation. Members, we ought to know that Artistes In Direct Support is recognised internationally as one of the best NGOs in the fight against HIV, and this is a global recognition. So thank you very much, Ms. Edghill.

Ms. Edghill left meeting.

Mr. Chairman: We are rapidly depleting our membership, and so I will ask the Committee staff to bring in the next group which is SASOD.

Dr. Norton: Mr. Chairman, you said to bring in the next group, SASOD. I take it that all these members would have to be identified as they pass that gateway there.

Mr. Chairman: I would hope so. It had indicated to us that there will be three members coming, and I would hope that the security would...

Dr. Norton: That would have been its initiative, however.

Mr. Chairman: Yes.

Dr. Norton: And if by chance the Artistes In Direct Support would have had three members and it did not use its initiative of giving you the names of those three persons, would they have been in here?

The Clerk: Representatives from the Artistes In Direct Support said that only one person would have been coming, because I did call and ask the organisations to indicate who would be the persons accompanying the representative, some did, and some did not.

Dr. Norton: It is perfect.

Mr. Chairman: There was a process.

Representatives from Society Against Sexual Orientation Discrimination (SASOD) entered meeting.

Mr. Chairman: Members, we have in our presence the representatives of SASOD, and I think they are ...Is it Ms. Sherlina Nageer? Also, there are Mr. Anton Rocke and Mr. Korey Chisholm who are representing SASOD. I do not know if you know everyone here, but I will identify them. Unfortunately, a few of our Members had to leave, but I believe everyone knows Dr. Frank Anthony, the Hon. Minister of Culture, Youth and Sport; Dr. Vishwa Mahadeo, who is the CEO of the Regional Health Authority, Region No. 6; Rev. Dr. Kwame Gilbert, who is also a Member of Parliament; Dr. George Norton, and Mrs. Volda Lawrence. We are grateful that you have chosen to come and make your presentation. We welcome you, and I am not quite sure who the lead presenter is.

Advocacy and Communications Officer, SASOD [Mr. Anton Rocke]: Good day everyone. Firstly, I have to say thank you very much for opening...

Mr. Chairman: Mr. Rocke, just for the microphone, please indicate your name so that they will have...

Mr. Rocke: Good afternoon, my name is Anton Rocke; I am representing SASOD, which is the Society Against Sexual Orientation Discrimination.

Youth Representative, SASOD [Mr. Korey Chisholm]: Good afternoon, I am Korey Chisholm, Youth Representative for SASOD.

Member, SASOD [Ms. Sherlina Nageer]: Good afternoon. My name is Sherlina Najeer also from SASOD.

Mr. Chairman: If more than one of you is to speak you will still indicate who you are for the records.

Mr. Rocke: I, firstly, want to say thanks to the Committee for giving us this opportunity to make our presentation. SASOD is making a presentation, starting off by saying that we do not support the criminalisation of HIV, other than in non-consenting sexual activities. We represent a marginalised community, the LGBTI community in Guyana which comprises of the Lesbian, Gay, Bi-Sexual, Transgender and Intersex persons. These persons are not visible in our community, because of the stigma and discrimination that exists in Guyana as it relates to this community. This community because of the stigma and discrimination, because of the confidentiality - well, I should not say confidentially - but because it is not openly discussed, the secrecy around it, they are infected and being harmed by HIV and we feel that this motion further stigmatises by removing the confidentiality nature of our law that surrounds HIV.

We understand that parliamentarians and politicians make laws to protect us, and we are in support of that notion. However, as I said, this Bill will only harm us more in terms of moving in steps backwards. My colleague, Mr. Korey Chisholm, is going to deal with the stigma and discrimination as it surrounds HIV and AIDS already. He will deal with how it undermines public health, while Ms. Sherlina Nageer will deal with how it further victimises women and we will look at international positions as it relates to the criminalisation of HIV, and then I will end off our presentation.

Mr. Chairman: Just bear in mind that we have a short period of time.

Mr. Chisholm: Thank you Mr. Rocke, I am Korey Chisholm. Just to continue on the same note that Mr. Rocke would have talked about, criminalisation of HIV transmission it..., we know from our standpoint because of HIV prevention efforts and the marginalised persons who are already vulnerable to the HIV infection. We know that HIV is not a death sentence and it is now a medically manageable disease. Such legislation continues to spread fear and misinformation about HIV. There are other diseases that are lifelong conditions such as, herpes, but the same level of attention is not paid to those, and this is not the attention as it relates to responding to those infections, this is pertaining to this particular action, such as having a law that criminalises persons who transmit, because someone can have sex with another person and transmits syphilis or herpes, which also if that person is not screened, and or have a test, can develop into serious health implications for persons.

The focus on the criminalisation of HIV transmission we believe increases the stigma and discrimination against the persons living with HIV, by making them potential criminals. And if you are to look at that in particular to the population that we are speaking on behalf of today which would already have loads of stigma and discrimination, which already has its own biases about accessing services, having to know that there is a law that if persons are found being HIV-positive they would have distrust in the health care providers, in which they would not want to, and not just this particular community, but others would caution going to do an HIV test.

The other part is that criminalisation undermines public health, because if you look at HIV transmission it makes it more difficult for us to reach hard to reach communities, not just the MSMs, as we want to put it, sex workers, too, who we know are prominent and are doing their work, drug users, persons who use marijuana and crack cocaine in our society, in our depressed areas, who also would be exposed when they are *high*. It will be harder to meet these kinds of persons and then it will undermine those key drivers of this epidemic in our society.

The final point here is on confidentiality between persons and their health care providers as I was mentioning before. It is exactly important especially in the case of HIV-positive individuals who require long term treatment, as such anything that forces doctors and health care providers to reveal patients private health information, or even testify about it, has a negative impact on the patient's trust in the health care system, and the willingness to participate in the health care, or any preventions that we may want to come up with.

These are our positions on the aspects of the criminalising of HIV transmission would have on the stigma and discrimination, and the continuance. We have made so many strides; we have just developed the National Prevention Standards and Guidelines that would even strengthen our response in this country. We are now starting to really get working in these same marginalised communities, and getting to really know them a bit more and this law would really take us more than footsteps back, it would be big steps back. Thank you very much.

Ms. Nageer: As a woman, and as someone who cares deeply for women, we understand and we share Mr. Franklin's desire to better protect women and children who might be victimised by dishonest partners. But the fact is that this law does not protect women. In fact it increases the likelihood of them becoming victimised and the reason for that is, women more often than men access health care services for reproductive care, prenatal care and because women are more active participants in the health care system they are more likely than men to know their HIV status. So in many cases women, if such a resolution is passed, can be accused of transmitting the virus to their male partners, even if the partners are the ones who gave it to them in the first place, because it is about who knows their status.

So we are saying this law, even though the intent is to protect women, the reality on the ground is that it would end up harming women more than helping them. Also, if it is not a well written resolution, mothers who unintentionally transmit HIV to their unborn children could also be prosecuted. And, again, this is not helping, it is not helping the epidemic; it is not helping women. More helpful to women would be to address issues such as gender base violence, inequality, sexual coercion and stigma and discrimination, as my colleagues have talked about.

Looking, worldwide, at some countries which have similar laws, as my colleagues have said, is really a backwards step. If countries which have had laws like this in place for over a decade and several of them are reviewing those laws and taking them off the books..., and we have examples of those, in the Caribbean, regionally, Belize, one of our neighbours. It has those laws, it has reviewed them and found that there was a lot of difficulties in trying to bring these cases before a Court of law, so evidence was an issue and the legal review found that it really detour persons for being tested. Again, the UNAIDS, the world body of setting standards for HIV policies does not support the criminalisation, except in cases of, as we have said, non-consensual sex.

So our position is that there is no evidence that this law does anything to reduce the HIV transmission, stop the spread of HIV and in effect it increases stigma and discrimination and detours persons from getting tested which is one of the key weapons in fighting this epidemic.

We at SASOD support international consensus about applying general criminal offences. We do not need a specific law like this. I hand you over back to Mr. Rocke.

Mr. Rocke: Actually, just going with Ms. Nageer's last point, we believe that there are laws that deal with HIV transmission already. In our Sexual Offences Act it gives the Court leverage to order an HIV test and to have that result shared with all the parties involved, and this is as it relates to non-consensual sex. We believe that such laws should be strengthened to encompass the transmission of HIV when it is forced. So that is our presentation in a nutshell. Thank you very much and we can have an open dialogue now.

Mr. Chairman: I am not quite sure, but thank you very much for being so articulate about your position and we appreciate the fact that you did submit a written version of this presentation. Members, you have heard the presentation, are there any questions or clarifications that you need?

Mrs. Lawrence: Mr. Chairman, through you, to either of the persons representing SASOD here this afternoon, can you say that as an outreach organisation whether persons came to you out of their concern having heard this motion debated in the National Assembly? Or was it you who, as a body, took it to the persons who you interact with and who you are seeking to assist?

Mr. Rocke: It was SASOD, as a body, that would have taken it to the community we represent and we would have discussed it with them. They all feel strongly that this is a backward move. They have all shared the stigma and the discrimination that they already face because of their sexual orientation, and having any move that takes away the confidentiality, which is the only thing they have as positive persons to actually exist, will be really harmful, it will have a negative impact on how they deal with this already dreadful disease that they are coping with.

Mrs. Lawrence: So are you saying that these persons felt that they would rather go along with someone infecting them, than they coming public to say that by consensual sex I was infected by X or Y?

Mr. Rocke: These persons are already infected. The persons that we are talking about are persons who are already infected. They are already dealing with stigma and discrimination as it is. Stigma and discrimination exists as it relates to HIV and AIDS. We have not yet, as a country, removed that stigma and discrimination, so confidentiality is the only mechanism these persons have in coping with this disease. So coming out to say that I am positive and this person is the person who has infected me exposes them to further stigma and discrimination, which is something they cannot cope with, and I believe... I would not want to say as negative persons, because we should assume we are all positive persons, but the reality is some of us who are negative probably would never understand where these persons, who are dealing with the stigma and discrimination, are coming from and it is through their experience that we have to make strides in assisting them, because in the actuality the persons who spread this disease are spreading it unknowingly; they have not been tested; they do not know. This Bill has proven to detour persons from getting tested, so in actuality what is going

to happen is that persons are not going to get tested, they are going to continue in sexual activities and they are going to continue to unknowingly spread the virus.

Our position is to educate the public in order to remove the stigma and discrimination so that persons can feel free to get tested, to know their status and to take actions in not spreading the virus further. The persons who do spread it knowingly are just a small percentage. There are exceptional cases.

5.14 p.m.

Dr. Norton: To any person. Let us say the clientele, the persons who you have met in the public, before you approach them or have you met persons who are already informed about this resolution or are you the persons that would tell them about this resolution?

Mr. Rocke: We would have told them about this resolution. We would have made a copy of it. We would have shared it around our community so that they would have read it first-hand and they are all informed as to what it says.

Dr. Norton: No. My question is: Did they know about it before you told them?

Mr. Rocke: No.

Mr. Chisholm: Just to add to that, in my case, I facilitated the particular initiative we started last month which looks at Men Who Have Sex with Men (MSM) who are living with HIV. I facilitated that group and I had, in our last support group which was held last month, a discussion to ask if they did know about, but they said that just heard of it in the newspapers. We went into asking about what were some of the feelings as it pertains to particular things. In that light, they are sort of aware that these people are arguing and it is our normal citizenship; it is Parliament that they hear it from.

We as leaders go into the in-depth aspect. Adding to Mr. Rocke's point, what we are trying to do is to deal with the MSMs who are positive and, who, do not want to know that when they come to the support groups that there are topics that deal with positive living telling them that they also have that shared responsibility with the person who they are going to have sex with. We have taken on that role and will continue to do that; to ensure that knowingly transmitting HIV in the community is something that is stopped.

Mr. Chairman: Thank you very much, Mr. Chisholm.

Dr. Anthony: Are you familiar with the term "Revenge Behaviour"? Can you explain what that means?

Ms. Nageer: What I think it means is somebody gets infected with HIV, then out of revenge they go and knowingly infect other people without disclosing their status.

Dr. Anthony: So how do we deter such behaviour?

Ms. Nageer: Not by having a law such as this.

Dr. Anthony: But how?

Ms. Nageer: It is how we stop the spread of HIV in any situation. If people can communicate with their partners, get tested before hand, which are things that anybody who is sexually

active should be doing and speaking with their partners. It is not just in those specific cases. This is something that should be across the board.

Mr. Chairman: Ok, Ms. Nageer, do not struggle. I think Mr. Rocke made reference to the response because there are regular laws that can deal with some of these situations as well. I am just allowing you because we have two other groups waiting and we have to finish by 6:00 p.m.

Mr. Rocke: I just wanted to quickly say to the panel that we were just discussing it outside that we feel strongly, reading the resolution, that the resolution speaks to all that is going on and still the HIV rate is till high. We believe that it is still high because persons are not changing. We are not getting behavioural change and I do not believe that we will get behavioural change when HIV continues, especially in Guyana, not to have a "face". I have spoken with several persons who have contracted the virus and it is like, "Oh, My God! I have a couple of hours to die." These persons could have only found hope in Magic Johnson, imagine that. They have to go all the way to America to find hope in Magic Johnson because for HIV in America, Magic Johnson is the "face" and we do not have any face attached to HIV. So persons feel hopeless. Persons do not know where to turn. Persons feel that HIV is not a real problem because one hears the politicians talk about HIV. One hears our National AIDS Committee say that the statistics are grave and this sort of thing, but when we look at our society there are a lot of healthy people going about their business as usual. That does not change behaviour. I think that once we remove stigma and discrimination and persons feel free to say, "I am HIV positive" without being isolated and excluded from society, then persons will realise, "Oh, my gosh! My best friend is positive." "Oh! My mother is positive. I need to take steps to secure my negative status." I think that is the way to go and, as a country, we are on the right track. We just need to work more at removing stigma and discrimination and then, hopefully, we see HIV starting to have faces and persons openly having discussions on it.

Mr. Chairman: Thank you very much. 5,000 of our sisters and brothers are among us with HIV. We are very grateful for the presentation. Your remarks will inform our discussion. Thank you very much.

I think that we have our next group; this would be UNAIDS. Could we invite UNAIDS to come in please?

Let me welcome UNAIDS to this Meeting of the Special Select Committee. Whilst Dr. Del Prado is getting seated, for Members, the person standing up, trying to get ready, is Dr. Ruben Del Prado, the country representative of UNAIDS. Next to him, in what I think is a green shirt, is Mr. Trevor McIntosh. Next to the two of them – I am not seeing her but I think I saw her outside with a red shirt – is Ms. Jennifer Ganesh.

For the UNAIDS delegation that is here, the Members of the Special Select Committee are – those who are still here – Dr. Frank Anthony, Minister of Culture, Youth and Sport, Dr. Vishwa Mahadeo who is the CEO of the Regional Health Authority 6 and Members of Parliament: Rev. Dr. Kwame Gilbert, Dr. George Norton, Mrs. Volda Lawrence and myself.

We want to welcome you. Dr. Del Prado, you can make your presentation seated or if you want to stand up that is okay.

Dr. Ruben Del Prado: I will stand up and face you from this side if that is okay. Thank you, Hon. Members, for giving us the opportunity to give a quick oral presentation.

Mr. Chairman: Dr. Del Prado, we are limiting this engagement to 20 minutes. That will include questions.

Dr. Del Prado: Excellent. My question is: Is this the Answer – Criminalisation? A very wise man said, "AIDS makes us angry but in law we must be rational. We must take as our guiding principle for law something more than the creation of a response to a dangerous epidemic. We must look for effective and just laws that contribute to slowing the spread of HIV."

In 2002 UNAIDS published Criminal Law, Public Health and HIV Transmission – a Policy Options Paper. This was 2002, exactly nine years ago, and in 2008 – I am sure that the previous speakers may have made reference to this policy brief from UNDP and UNAIDS in July 2008 and I will make reference to the policy brief every once in a while.

What is a sound policy response? We are talking about a policy response that Guyana is proposing to make. Does the enactment of criminal law and prosecution represent a sound policy response of conduct that carries the risk of HIV infection?

The second question: Individual cases of willful transmission with accompanying media coverage may prompt calls for criminalization – is it happening?

It is a very complex problem and there is not simple solution. In life, we always look for a simple solution to sometimes a very complex issue. Before proceeding along this path of criminalisation there is a need to consider a number of issues.

Four guiding principles, Hon. Member of Parliament:

1. The best available scientific evidence regarding HIV transmission, modes and risk must be the basis for rationally determining, if and when, conduct should attract criminal liability.

2. Preventing transmission should be the primary objective. Once again preventing HIV must be the primary objective.

3. All legal and policy responses should conform to international human rights norms. Guyana is a signatory to all of the international human rights treaties.

4. State action – The State of Guyana that infringes on human rights must be adequately justified. It should adopt the least intrusive measure possible to achieve demonstrably justified objectives of preventing HIV transmission.

What are the policy considerations? The policy considerations must consider functions of criminal law to assess to what extent criminalisation will contribute to the objective of prevention of transmission. Remember that that was the principle objective. It must weigh other policy factors that might mitigate against use of criminal sanctions. This is probably one of the most important statements this afternoon – must weigh other public policy factors that might mitigate against the use of criminal sanctions.

What are the functions of criminal law?

1. Removal of society. We lock up people. That does not prevent transmission of HIV because there is, if you like it or not, HIV and sexual activity in prisons.

2. Rehabilitation: This will probably be unlikely to be sustained long-term behavioural change. Rehabilitation of criminals, we know where that leads us. Sex is a very complex human behaviour. We do not think that locking up people will rehabilitate against sexual crimes.

3. Retribution: Very often called for by society. It might make us feel better but it will not prevent transmission. We lock up the person and we feel good about it.

4. Deterrence: The prevention for it to occur again.

There will be calls for law and order and the war on AIDS. Beware of those who cry out for simple solutions, for in combating HIV there are no simple solutions. In particular, do not put faith in the enlargement of the criminal law.

I want to address a very important concept – positive health, dignity and prevention. To eliminate HIV in Guyana – this is the foundation for positive health, dignity and prevention as called for by the Ministry of Health, Hon. Dr. Ramsammy – it is logical and smart that people with HIV are considered to be the solution. One can only get HIV from a person who has HIV so why make them the problem. If you are looking for a solution those are the people you look to for the solution; you do not lock them up.

The public health and human rights goal of preventing new HIV infections can only be achieved when the human, sexual and reproductive rights of people with HIV are protected and supported and when the broader health and dignity needs of people with HIV, anybody living with it, are met and when access to timely and uninterrupted treatment and care are ensured greater responsibility for others and self are encouraged. You must be aware of the recent findings. This is actually an endorsement of old science – treatment as prevention. Putting people on treatment as early as the time they are diagnosed with HIV can reduce transmission of HIV by as much as 96%. Positive health, dignity and prevention encompasses the full range of health and social justice issues for people living with HIV and embraces the fundamental principles of the responsibility for HIV prevention must be shared. If Guyana makes the move to criminalise HIV transmission, there is no shared responsibility. We are putting the onus of transmission on one person – a person living with HIV. Someone who drives a car is locked up when they run over a someone, but that does not mean that I can cross the street with my eyes closed. I have a responsibility to keep my eyes open.

What works? What works is, and this is proven, ensuring that undiagnosed and diagnosed people along with their partners and communities are included in programmes to achieve HIV prevention that highlight shared responsibilities regardless of known or perceived HIV status and have opportunities for rather than barrier to empowering themselves and their sexual partners. This is the way forward. This is not UNAIDS speaking, this is global evidence, this is global truism.

This also works. If you want to go to work you can do the Flintstone thing, as in the stone age, but do we want to go back to the stone age? I am not sure. What is it that Guyana wants and needs to go forward?

Look at this: the Low Carbon Development Strategy (LCDS), Guyana records success stories, Guyana's highly active retroviral prevention, **International Monetary Fund** (IMF) lauding Guyana's progress to now be a middle income country. A letter from by boss directed to this country as the first one in the world that can score the quality of prevention, activities and strategies. That is the way forward. Guyana's success in the prevention of parent-to-child

transmission where there is the policy of no child being born with HIV in the country. That is the way forward.

To summarise:

1. There is no evidence that criminalization of HIV transmission has any public health benefit. Criminalization may actually harm the response. I mentioned the policy brief; it is available online.

2. Criminalisation will not lead to behaviour change. Contrarily, punitive laws will put people underground. Nobody would want to get tested. People will no longer want to get tested because willful transmission means that you know that you are infected and you have the intent to infect. If you do not get tested then you cannot be prosecuted because you did not know that you were positive so there is no willful intent to transmit.

3. Guyana has a success story. Guyana is a success story, not just in the region but everywhere in the world. People are looking more and more to Guyana. We do not want to go back to the Flintstone age when we had no bottom in our cars and we used our feet to go forward.

The former President of Botswana, a very wise man said,

> "Criminalisation is futile. The key to prevention is knowing one's status. Knowing your status triggers access to treatment and care and it triggers empowerment to stay HIV free. If you criminalise HIV transmission people will not come forward for free of being further stigmatized and discriminated against. What we want to do is to de-stigmatise people so that they can come forward."

In addition, Hon. Members of Parliament, the world is going back on criminalisation. These are countries that are reverting. They are changing back the laws. They are abolishing the laws that criminalise and these are positive reactions and developments. This indicates that Parliamentarians, prosecutors, judges, health experts, people living with HIV and key stakeholders across the world are becoming increasingly aware and concerned about the negative public health and human rights impact of the overly broad criminalisation of HIV transmission and exposure. Do we want to be seen as a backward country where these countries are observing and looking at the laws that they established? Guyana as the sole country will come up with the criminal law. We do not want to be backwards, do we?

My boss, a very smart man said, "Instead of embracing universal access towards HIV prevention and treatment, many countries have put up universal obstacles with bad laws." Thank you very much.

Mr. Chairman: Thank you very much, Dr. Del Prado. Members that was a very articulate and passionate presentation. We have two more groups waiting for us and we have 25 minutes.

Dr. Norton: Just for you to, not necessarily fix a favour, you gave a brief account of Guyana as a success story but that has occurred at a cost. I am interested in the cost.

Dr. Del Prado: At a great cost, both for the people of Guyana that are paying for public health, but probably the most important value that the people can put towards, is paying for your health. In the beginning the drugs were extremely expensive. The price of drugs has come down, dramatically. A lot of the cost invested in HIV is utilised to also build and

strengthen the health system, the regional health services, for a betterment of the overall public health of the people. Again the cost of drugs has come down tremendously so that cost is not as high as it used to be. I am not sure how much prevention costs, but there has been substantive support from development partners in this area as well.

Mr. Chairman: Dr. Norton could have asked me that question when we started our discussion.

Dr. Del Prado: The money was well spent in Guyana; that I can tell you.

Dr. Mahadeo: I saw a whole list of countries there that had these laws, were any of them previously beneficiaries of donor funding?

Dr. Del Prado: Yes, three of the Southern Africa Development Communities (SADC) were beneficiaries, but we also saw the United States, Norway, Sweden, Denmark…

Dr. Mahadeo: But my question is if there would be any implication, if I may ask, if Guyana passes this law tomorrow?

Dr. Del Prado: It is a very good question. At a profession level this very same man will lose all respect for this country that he respects greatly. Number one, we will lose respect for Guyana. We respect Guyana greatly and Guyana is not a country that is known for going backwards. Guyana is a forward looking country, on the verge of becoming a developing country pretty soon. You will lose respect.

Mr. Chairman: Okay. If there are no other questions, let me thank Dr. Del Prado and UNAIDS, for that very passionate and well-informed presentation. Thank you very much.

Dr. Del Prado: If you need a copy of the presentation I could leave it behind if necessary. Thank you once again.

Mr. Chairman: You can give me later and I will pass it onto the Committee.

Let me first of all introduce the Members of the Select Committee just in case you do not know them: Dr. Frank Anthony, Minister of Culture, Youth and Sport and Member of Parliament, Dr. Vishwa Mahadeo, Rev. Dr. Kwame Gilbert, Dr. George Norton and Mrs. Volda Lawrence.

Members, these are the representatives of the National AIDS Committee (NAC) and they are lead by Ms. Hyacinth Sandiford as the Chairperson of the National AIDS Committee, the National Vice Chairperson is Jacqueline Delph – it is better that you indicate so that the Members would know you – Mrs. Merle Mendonca, from the NAC and the GHRA and Ms. Chrystal Albert who is also a Member of NAC and is also a member for the now resuscitated G-Plus.

We welcome you. We are appreciative. We have a very short time. We have another group and have to get this in before 6:00 p.m. so we are going to limit you to 20 minutes. Who is making the presentation?

Head of National AIDS Committee [Ms. Hyacinth Sandiford]: We all are. We divided it into 4 parts.

Mr. Chairman: Who is starting?

Ms. Albert: I am. Good afternoon. The NAC appreciates this opportunity to come before this Committee and prior to addressing the substantive matters we would like to make some general points:-

The NAC believes that this motion referred to the Special Committee on Criminal Responsibility of HIV infected individuals is ill informed, dangerous and ultimately counter productive. It will work against us.

We are somewhat mystified as to why this motion was given the merit and seriousness to come before this Committee because the present Government has already adopted an enlightened National AIDS Policy which contains recommendations and renders this resolution, redundant. In addition to these reasons, the motion encourages reactionary opinion in the Caribbean to continue to avoid the progressive legislation needed to confront stigma and discrimination with which the people with HIV have to grapple with on a daily basis including protection of women and girls against sexual violence, buggery, laws and legal recognition of sexual identity.

We will now turn to some substantive issues of which Ms. Delph will speak on.

5.44 p.m.

National Vice Chairperson [Ms. Jacqueline Delph]: We, the National AIDS Commission (NAC) and other organisations, feel that many positive women cannot disclose their status without the likelihood of violence from their partner, nor can they negotiate safe sex. They may, therefore, technically break the law proposed in the motion even though they may, themselves, be victims. For these reasons, legislation to criminalise transmission may work against women. Moreover, in the Guyana case, the modern Sexual Offences Legislation of 2010 provides more effective protection from sexual violence that can be contemplated by legislation criminalising transmission.

I wish to re-emphasize the importance of the United Nations Development Programme (UNDP) and the UNAIDS Policy Brief on Criminalisation of HIV Transmission which concludes with the following recommendations for Governments:

1. Repeal HIV-specific criminal laws – laws directly mandating disclosure of HIV status and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups.

2. Apply general criminal laws only to the intentional transmission of HIV, and audit the application of general criminal law to ensure that it is not used inappropriately in the context of HIV.

3. Redirect legislative reform and law enforcement towards addressing sexual and other forms of violence against women.

Mrs. Merle Mendonca: The second substantive point is:

Rather than criminalising transmission, it is better to create enabling legal, social and policy frameworks.

If we were to be guided by the message which was adopted and fully supported by member states in the United Nations in the message contained in the Political Declaration on

HIV/AIDS from the recently concluded high level meeting on HIV/AIDS in New York. The focus there, according to article 77 of that document is:

> "To eliminate stigma, discrimination and violence related to HIV…"

Furthermore, Clause 78 states:

> "Review as appropriate laws and policies that adversely affect the successful and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV…"

There is informed international opinion that is, more or less, in agreement that people who set out intentionally to harm other people commit a criminal act. However, there is an equally strong consensus that exists internationally that existing criminal law is perfectly adequate for this task. The problem is routinely taken care of by applying laws that address "causing bodily harm" or "actual bodily harm". Where the harm is sexual in nature, the Guyana Sexual Offences Act of 2010 – a very recent Act – already provides a remedy within the ambit of the issue of consent. This approach both recognises that the threat to public health of individuals intentionally setting out to harm others should be addressed, but equally important, that it should be done in a manner which protects the great majority of responsible people living with HIV from further being stigmatised by the implication that they, simply by virtue of being HIV-positive, constitute a threat to the rest of the society.

We have seen the revised policy document on HIV/AIDS in Guyana which was first accepted in the National Assembly in 1998 and then revised in 2003 and 2006, which members of the Committee may wish to consult. It contains details progressive recommendations in protecting non-infected partners and avoiding the demonising HIV-infected persons. The relevant paragraphs are quoted. Similarly, the difficult situation of how to deal with a person whose behaviour is a threat to the community is also referenced in the submission. Finally, the detailed steps set out in section 2.2.6.1 addresses the situation in which medical or others with appropriate authority may override the persistent refusal of an infected person to notify a partner.

The partner notification procedure, not yet incorporated into law will authorise but not require health care professionals to decide on the basis of each individual case and ethical considerations, to inform their patients' sexual partners of the HIV status of their patient. The criterion to be applied in arriving at such a decision is also set out in the policy document, and is referenced on page 11.

Ms. Chrystal Albert: Turning from these in-principle issues, I now go to some specific resolutions.

Firstly, the worldwide debate over the issue of intentional transmission of HIV which has concluded that legal remedies are complex to fashion, difficult, costly to apply and ultimately counter-productive.

Secondly, the demand that patient-physician confidentially be waived if so invoked by the courts would force HIV-infected persons to go to great lengths to conceal their status from persons the courts may oblige to reveal it, thereby driving the virus even further underground.

Thirdly, confidential and accurate information on the number of HIV positive persons is an indispensible tool for effective public health strategies to combat HIV. The core of the

government's preventative strategy, namely the Voluntary Counseling and Testing would be devastated.

Fourthly, the motion called for the transmission of HIV to any other person to be an indictable offence once a person knows that he/she is infected. The motion does not require intent. If a condom breaks, for example, and transmission occurs, the transmitter would be liable. In this respect, the motion places Guyana in the community of nations which have little regard for the humanitarian standards.

Fifthly, the central prevention message is that everyone has a responsibility to take precautionary measures when engaging in sexual activity with persons with whom they are not in a stable relationship. In a settled relationship when a partner has a reasonable expectation that an infection-free status is being maintained, the onus to inform is greater on a partner who becomes infected under whatever circumstance. The willful refusal to inform, or to intentionally harm through deception when the possibility of transmission exists, may provide grounds for criminal proceedings as described above.

Ms. Hyacinth Sandiford: In conclusion, the NAC and organisations associated with this submission are completely opposed to the misguided premise underlying this motion. Penalising HIV- infected positive persons, in general, for the criminal behaviour of those who would intentionally attempt to transmit the virus is as irrational as penalising shop-keepers for providing opportunities

The NAC has worked over the past six years without any subvention and we all volunteer our service. This motion would put all of our hard work back to where we started. We will not sit here and allow this motion to be passed. We are opposed to it.

Mr. Chairman: For persons taping this meeting, I know you will have some difficulties. Hyacinth Sandiford was the last speaker and she was also the first speaker. She was followed by Jacklyn Delph who was the second speaker, followed by Merle Mendonca and Ms. Chrystal Albert.

Members of the NAC, you should know that this motion was presented to the National Assembly. The National Assembly did not act on the motion but, instead, selected a Special Select Committee to make recommendations to the National Assembly. Your presentation, therefore, will help to inform us in terms of the recommendations we will make to the National Assembly.

This Committee would not only like to express gratitude for your presentation today but our gratitude for the documents you have submitted. As always, the NAC has always been meticulous in presenting the documents and we are appreciative.

Members here are well aware that the NAC has been critical in the development of the first national policy. Guyana was one of the first and still remains one of the first countries in the Caribbean to have developed a formal policy document. It was first published in 1998. Not only that, but it has been reviewed twice – in 2003 and 2006. That, studies that have been done and recommendations made have informed us. We want to thank you very much and congratulate you and encourage you to continue your work.

Members, the two persons representing the UNDP are Dr. Michelle Summer Williams and Mr. Trevor Benn. Dr. Williams is the HIV Coordinator at the UNDP and Mr. Benn is the programme Analyst on Governance.

The members of the Committee present are Dr. Frank Anthony who is well known as the Minister of Culture, Youth and Sports and Members of Parliament: Dr. Vishwa Mahadeo, Rev. Dr. Kwame Gilbert, Dr. George Norton and Mrs. Volda Lawrence.

We want to welcome you. You are the last group for today.

Mr. Benn: My name is Trevor Benn and I am the Programme Analyst at the UNDP.

Dr. Michelle Williams: Good afternoon to everyone. My presentation would be based on the written submission that we presented to the Committee on the Criminal Responsibility of HIV infected Individuals.

Over the next 10 to 15 minutes I will be addressing the following areas:

1. Resolution 129
2. Criminalisation of HIV transmission
3. Issues that may be involved with criminalization
4. The negative impact on public health
5. Law Reform
6. A few country examples
7. Our recommendations.

Resolution 129

Part of Resolution 129 seeks, among other issues, legislation to criminalise any person who transmits HIV to another where they have prior knowledge of their HIV infected status. The words "prior and knowledge" are highlighted for a reason and I will seek to address that later.

Criminalising HIV transmission

Criminalisation is only justified where individuals maliciously transmit the virus with intent to harm. That is only justification we propose for criminalisation and intentional transmission would be a very difficult one to prove. Some of the issues that the Committee may want to address in considering criminalisation are:

1. The actual HIV status of the person at the time the alleged offence would have occurred - Knowledge of their HIV status at the time, whether the person was HIV positive or negative
2. Non-disclosure due to any threat of violence
3. Knowledge of the person on modes of transmission of the virus at the time
4. Any consent to risk of exposure by the partners – it may have been consensual sex
5. Whether the use of risk reducing measures such as condom use were taken
6. Mother to child transmission and criminalisation of HIV for a pregnant mother

There are some things that criminalisation would address and some things that it would not.

Criminalisation does not rehabilitate. It does not reduce the spread of HIV. However, it would undermine prevention efforts and could jeopardise efforts that we have made thus far.

It provides a disincentive to disclosure and testing. Persons may not want to go for testing and they may not want to disclose their HIV status to their partners.

It creates a false sense of security in the public arena undermining the public health message that everyone should take measures to reduce HIV transmission and, of course, the responsibility for your own health and protection.

It increases risk of violence and discrimination against vulnerable groups in addition to women who may also be considered vulnerable in some instances.

I further oppress women as they are more likely to know their HIV status and, therefore, be prosecuted. Why? Because women are more likely to be testing for pre-natal care, they have better health seeking behaviours.

It also promotes fear and stigma than is already attached to the disease.

A few country examples

These are a few country examples that we can learn from before we make the same mistakes.

In 2009, the Brazilian Ministry of Health decided to recommend cessation of prosecutions to focus on psychosocial aspects of HIV and shared responsibility of sexual health.

Trinidad and Tobago has also decided not to criminalise based on the basis to do so can create a false sense of security, as I mentioned previously. This is just an example to support that.

Criminalisation can also prevent engagement of deeper issues. The fact that criminalisation is to deter some sort of behaviour, cannot happen. It you want to use criminalisation to prevent the transmission, we have seen already that it does not work.

In 2001 the South African Law Commission concluded that there was neither benefit to be gained from nor any justification for an HIV specific offence.

Reform, not criminalisation

Criminalisation ignores the real challenges of HIV prevention. Laws against drug use, sex work and homosexuality often push marginalised groups away from HIV support services and introducing such a law will even push them further underground. Consider reforming laws that stand in the way of HIV prevention and using public health policy as an alternative to criminalisation.

Here is our stance:

The UNDP argues that criminal law should only ever be used as a last resort in situations of HIV transmission to deal with the rare cases of intentional HIV transmission. UNDP is concerned that the adoption of specific legislation to criminalise HIV transmission could jeopardise achievements made in Guyana.

Our recommendations are that Guyana does not introduce legislation to criminalise HIV exposure or transmission by infected persons. We also recommend that we address the deeper social, economic and political inequalities that are at the root of women and girls' disproportionate vulnerabilities to HIV, reform existing laws to reduce discrimination and support AIDS awareness and treatment programmes as an alternative to criminalisation.

That is the end of our presentation. Thank you.

Mr. Chairman: Members, the presentation is before us. Are there any questions and clarifications? If not, I would like to thank the representatives from the UNDP for being here. It is not that members are not curious. We have read all of the documents and throughout the afternoon, all of the groups have, with some variation, presented basically the same arguments.

From the first presentation to the last, we have heard the arguments reiterated. This presentation also had some additional information. I think that the ones who presented first, got the questions.

Dr. Norton: In addition to what the Chairman just said, I must say that your presentation was more exact and to the point and we could have done with much more presentations like yours and I am not usually in the habit of doing so.

Dr. Williams: Thank you.

Mr. Chairman: In spite of the fact that we have the documents, we will appreciate it if you could send us the power point presentation. Let me thank you again. This has been a good afternoon listening to what people have to say. The next step is that we will take all of these presentations and we will have our own debate and then the Guyanese public, particularly those who made presentations, will hear what we have to say. A report would be submitted to the National Assembly. There is no Bill before us. There was a motion but it was amended to send the matter to a Special Select Committee for consideration. Our job is to come up with the recommendations of how to deal with this issue to the National Assembly. We hope that we can do a good job and take into consideration all of the views expressed today and those that are contained in the document. Thank you very much.

Today at least two groups made power point presentation and I will ensure, through the Committees Division, that members have both the electronic and hard copies. I do know that Ms. Edghill spoke from her notes and I followed the document that was circulated as she went through those points. In terms of Society Against Sexual Orientation Discrimination (SASOD), I think that they also distributed their presentation and pretty much followed it. I gather that the NAC also read by and large from a summary of what they have. If they want to share that, I will distribute that.

We will now have to figure out when we will meet again. I was at a meeting earlier this afternoon and I know that the Special Select Committee on the Access to Information Bill will meet next Wednesday at 1:30 pm. We can follow suit and meet again following their meeting or we could wait until the Committees Division advise me and then I could round robin and decide when we will meet again. Do members want us to decide now?

Dr. Norton: Let us wait.

Mr. Chairman: The Committees Division and I will try to see what an available date is. I will then ask the Committees Division to consult members and we can work out a date that is convenient. I know all of you will want to participate and I want to make sure that you are all present.

Mrs. Lawrence: Please allow me to make a suggestion. Most of the persons that came here had very little deviation in their presentations. Can we get those points highlighted so that when we come to do our deliberations, we do not have to go back through all of the documents? We will have a pointer that we can use for reference. Can we ask the researchers,

through the Committees Division, to put that together? In the same breath, I would just like to inform you that I would not be around for sometime but I hope that I can follow by email.

Mr. Chairman: I will work with the Committees Division and make sure that we summarize all of the points so that we can see what the common points were so that we would not have to go through all of them. We will make a matrix of all of the points so that it will inform our discussion. I am sorry that you will not be here Mrs. Lawrence because I particularly wanted everyone to be here. The Minutes will be circulated and if there is anything that you want to include, you can do so.

MEETING ADJOURNED ACCORDINGLY AT 6.15 P.M.

APPENDIX V

THE NATIONAL ASSEMBLY OF THE FIRST SESSION
OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE
1ST MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS
(RESOLUTION No. 129 OF 2010)
HELD ON THURSDAY, 10TH MARCH, 2011
IN THE SPEAKER'S CHAMBERS,
PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)

The Hon. Hari N. Ramkarran, S.C., M.P., Speaker
(As Presiding Officer for the election of the Chairman)

From the People's Progressive Party/Civic (PPP/C) (6)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Ministry of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P., - (Absent)
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P.

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNC/R – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P. - (Absent)

Mrs. Volda A. Lawrence, M.P. - (Absent)

Ms. Africo Selman, M.P.

From the Alliance For Change (AFC) (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P.

Officers

Mr. Sherlock E. Isaacs	-	Clerk of the National Assembly
Mrs. Claudia Daniels-Greenidge	-	Clerk of Committees
Mr. Nickalai Pryce	-	Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Speaker as Presiding Officer for the election of a Chairman for the Committee called the meeting to order at 4.45 p.m.

ITEM 2: ELECTION OF CHAIRMAN OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL REPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION No. 129 OF 2010)

2.1 The Speaker called for nominations of a Chairman for the Committee.

2.1.1 The Hon. Dr. Frank C.S. Anthony, M.P. proposed and the Hon. Jennifer R. A Westford, M.P., seconded the nomination of the Hon. Dr. Leslie S. Ramsammy, M.P.

2.1.2 There being no other nomination, the Speaker declared the Hon. Dr. Leslie S. Ramsammy, M.P., as Chairman of the Committee.

ADJOURNMENT

At 4.46 p.m. the meeting was adjourned *sine die.*

Confirmed this ..3rd..... day of June, 2011

.....

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health,
Chairperson

THE NATIONAL ASSEMBLY OF THE FIRST SESSION OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE 2ND MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010) HELD ON FRIDAY, 3RD JUNE, 2011, IN COMMITTEE ROOM NO 1, COMMITTEES DIVISION PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)
(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P., - Excused
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P.

Rev. Dr. Kwame Gilbert, M.P. - Excused

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P.

Mrs. Volda A. Lawrence, M.P. - Excused

Ms. Africo Selman, M.P.

From the Guyana Action Party/Rise, Organise and Rebuild (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P. - Excused

Officers

Ms. Sherene Warren - Clerk of Committees
Ms. Darlene Marshall - Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Chairman called the Meeting to order at 3.20 p.m.

ITEM 2: ANNOUNCEMENTS

2.1 Excuses

2.1.1 The Chairman informed Members that the following Members had asked to be excused from the meeting:

(i) The Hon. Manzoor Nadir, M.P.,
(ii) Rev. Dr. Kwame Gilbert, M.P., and
(iii)Mrs. Volda A. Lawrence, M.P.

2.1.2 The Chairman also informed Members that due to Mr. Everall Franklin's illness he would also be excused from the meeting.

ITEM 3: CIRCULATION OF DOCUMENTS

3.1 The following documents were circulated prior to the meeting:

(i) Notice of the 2nd Meeting dated 27th May, 2011; and

(ii) Minutes of the 1st meeting held on 10th March, 2011.

3.2 The following document was circulated at the meeting:-

- Resolution No. 129 of 2010 on Criminal Responsibility of HIV Infected Individuals

ITEM 4: CORRECTIONS AND CONFIRMATION OF MINUTES OF THE 1st MEETING HELD ON 10TH MARCH, 2011

4:1 The Minutes were confirmed, without corrections, on a motion moved and seconded by Dr. Frank C.S. Anthony, M.P and Dr. Vishwa D.B. Mahadeo, respectively.

ITEM 5: MATTERS ARISING

5:1 There were no matters arising from the Minutes.

ITEM 6: TO CONSIDER THE METHODOLOGY, TIME AND DATE OF THE COMMITTEE'S PROCEEDINGS

6.1 Preliminary Remarks

6.1.1 Before considering the above item, Members expressed the general view that the Resolution would be extremely difficult to legislate.

6.1.2 The Chairman indicated to Members that five years ago his Office held consultations with various non-governmental organizations and interest groups and had drafted legislation aimed at tackling the same issue, However he advised that the legislation was delayed due to lack of consensus.

6.1.3 The Chairman agreed to circulate a copy of the draft legislation created by his office to Members before the next meeting of the Committee.

6.2 Methodology

6.2.1 After discussions with regard to a suitable strategy, Members agreed that due to the sensitive nature of the Resolution, the widest possible contributions should be sought from the public.

6.2.2 The Committee agreed to publish in the press a notice inviting organizations and individuals to present written and oral submissions to the Committee.

6.2.3 The Clerk of Committee was requested to prepare the notice on behalf of the Committee and to have the notice published in the print media, as soon as possible.

6.2.4 Members agreed to discontinue the collection of submissions two weeks after publishing the notice.

6.2.5 The Committee agreed that at its next meeting it would commence discussions on the written submissions received and set dates along with time restrictions for receiving oral submissions.

6.3 Statutory Meetings

6.3.1 Members agreed that subsequent meetings of the Committee should be held on Mondays at 3.00 p.m.

6.3.2 The Committee agreed that the Chairman and the Clerk of the Committee would set a date for the next meeting.

Adjournment

At 4.20 p.m. the meeting was adjourned *sine die.*

Confirmed this ...27th... day of June, 2011.

.....

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health,
Chairman.

THE NATIONAL ASSEMBLY OF THE FIRST SESSION OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE 3RD MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010) HELD ON MONDAY, 27TH JUNE, 2011, IN COMMITTEE ROOM NO. 1, COMMITTEES DIVISION, PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)
(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P.,
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P. - Absent

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P.

Mrs. Volda A. Lawrence, M.P. - Excused

Ms. Africo Selman, M.P. - Excused

From the Guyana Action Party/Rise, Organise and Rebuild (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P. - Excused

Officers

Ms. Sherene Warren - Clerk of Committees
Ms. Darlene Marshall - Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Chairman called the Meeting to order at 3.30 p.m.

ITEM 2: ANNOUNCEMENTS

2.1 Excuses

2.1.1 The Chairman informed Members that the following Members had asked to be excused from the meeting:-

(i) Mrs. Volda A. Lawrence, M.P, and

(ii) Ms. Africo Selman, M.P.

2.1.2 The Committee also agreed to excuse Mr. Everall Franklin from the meeting due to his illness.

ITEM 3: CIRCULATION OF DOCUMENTS

3.1 The following documents were circulated prior to the meeting:

(i) Notice of the 3rd meeting dated 22nd June, 2011;

(ii) Minutes of the 2nd meeting held on 3rd June, 2011;

(iii) Record of Proceedings of the 2nd Meeting of the Special Select Committee on the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010) held on the 3rd June, 2011;

(iv) Draft HIV Legislation from Hon. Minister Dr. Leslie S. Ramsammy; (circulated to Members electronically)

(v) Written Submission from Joint United Nations Programme on HIV/AIDS (UNAIDS) re: Submission on Resolution No. 129 of 2010;

(vi) Written Submission dated 14th June, 2011, from Nevica Wray to the Clerk of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals;

(vii) Written Submission dated 17th June, 2011, re: Criminalization Willful HIV Infection, to the Clerk of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals;

(viii) Written Submission dated 21st June, 2011, from Nasimul Hussain to the Clerk of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals;

(ix) Written Submission from Artistes in Direct Support to the Special Select Committee on Criminal Responsibility of HIV Infected Individuals;

(x) Written Submission from The Society Against Sexual Orientation Discrimination (SASOD) to the Special Select Committee on Criminal Responsibility of HIV Infected Individuals;

(xi) Written Submission dated 18th June, 2011, from Isahak Basir to the Clerk of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals; and

(xii) Written Submission dated 22nd June, 2011, from National AIDS Committee (NAC) to the Clerk of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals.

ITEM 4: CORRECTIONS AND CONFIRMATION OF MINUTES OF THE 2ND MEETING HELD ON 3RD JUNE, 2011

4.1 Page 3. Paragraph 4.1

4.1.1 Insertion of **"M.P.,"** after the name **"Dr. Vishwa D.B. Mahadeo"** in line 2.

4.2 Thereafter, the Minutes were confirmed on a motion moved and seconded by Dr. George A. Norton, M.P., and the Hon. Manzoor Nadir, M.P., respectively.

ITEM 5: MATTERS ARISING

5.1 Page 3, Paragraph 6.2.3

5.2 The Committee was informed that the notice inviting organizations and individuals to make written and/or oral submissions was published in all print media, except for the Kaieteur News, on Wednesday, 8th June, 2011, Sunday, 12th June, 2011 and Monday, 13th June, 2011, respectively.

ITEM 6: TO COMMENCE DISCUSSIONS ON THE SUBMISSIONS RECEIVED

6.1 Request by the National AIDS Programme Secretariat (NAPS)

6.1.1 The Chairman informed the Committee that he was in receipt of a letter dated 20th June, 2011, from Dr. Shanti Singh, Director of the National AIDS Programme Secretariat (NAPS), requesting permission for the following:

(i) The Programme Manager and Staff of NAPS to be present at the hearings; and

(ii) To respond to any submissions they deemed necessary.

6.1.2 After much discussion, it was agreed that the staff of the NAPS will not be granted such permission but should be thanked for their interest and be invited to make an oral presentation.

6.1.3 The Chairman undertook to contact the Director of the NAPS on behalf of the Committee.

6.2 Written submissions received

6.2.1 The Committee was informed that the Committees' Division had received submissions from the following individuals and organisations:

- Ms. Nevica Wray,
- Mr. Nasimul Hussain,
- Mr. Isahak Basir,
- Artistes in Direct Support,
- Society Against Sexual Orientation Discrimination (SASOD),
- Joint United Nations Programme on HIV/AIDS (UNAIDS), and
- The National AIDS Committee (NAC).

6.2.2 The Chairman also informed Members that the Committee was in receipt of one other submission, however, the person did not indicate their name on the document.

6.2.3 The Clerk was requested to ascertain whether the individual had intentionally omitted his/her name from the document.

ITEM 7: TO SET DATES AND TIME RESTRICTIONS FOR RECEIVING ORAL SUBMISSIONS

7.1 After considering the written submissions received, the Committee requested that the Clerk of the Committee contact the individuals and organisations who had not indicated their willingness to give oral submissions to ascertain whether or not they were desirous of doing so.

7.2 Thereafter, the Committee agreed to invite one individual and three organisations to appear before it to give oral evidence on **Monday, 11th July, 2011,** and suggested that the presenters be given 30 minutes each for their presentations.

ITEM 8: ANY OTHER BUSINESS

8.1 Draft Comprehensive HIV/AIDS Legislation - Guyana

8.1.1 Upon request, it was agreed that hard copies of the draft HIV legislation that was circulated electronically should be printed and dispatched to the following Members:

- The Hon. Dr. Jennifer R.A. Westford, M.P.,
- Rev. Dr. Kwame Gilbert, M.P., and
- Dr. George A. Norton, M.P.

8.2 Meetings of the Committee

8.2.1 The Committee agreed that future meetings would be held at 3:00 p.m.

Adjournment

At 4.05 p.m. the meeting was adjourned to **Monday, 11th July, 2011.**

Confirmed this ...3rd..... day of July, 2011.

.....

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health,
Chairman.

THE NATIONAL ASSEMBLY OF THE FIRST SESSION OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE 4TH MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010) HELD ON WEDNESDAY, 13TH JULY, 2011, IN COMMITTEE ROOM NO 1, COMMITTEES DIVISION PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)
(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P.,
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P.

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P.

Mrs. Volda A. Lawrence, M.P.

Ms. Africo Selman, M.P.

From the Guyana Action Party/Rise, Organise and Rebuild (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P. - Excused

Officers

Ms. Sherene Warren - Clerk of Committees
Ms. Tanzadell Bentinck - Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Chairman called the Meeting to order at 4.20 p.m.

ITEM 2: ANNOUNCEMENTS

2.1 Excuses

2.1.2 The Chairman informed Members that due to Mr. Everall Franklin's continued illness, he was excused from the meeting.

ITEM 3: CIRCULATION OF DOCUMENTS

3.1 The following documents were circulated prior to the meeting:-

(i) Notice to attend the 4th Meeting of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010) to be held on Wednesday, 13th July, 2011.

(ii) Minutes of the 3rd Meeting of the Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010) held on Monday, 27th June, 2011.

(iii) Written submission dated 29th June, 2011, received from the United Nations Development Programme, to the Clerk of the National Assembly, re: Resolution No. 129 of 2010.

(iv) Verbatim records of the 3rd Meeting held on 27th June, 2011.

(v) Incoming correspondence from the Programme Manager, M.D., M.P.H., National AIDS Programme Secretariat, to the Hon. Dr. Leslie Ramsammy.

(vi) Outgoing correspondence dated 6th July, 2011, to the following

organizations/agencies inviting them to appear before the Special Select Committee on Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010):-

a) Artiste In Direct Support;
b) Society Against Sexual Orientation Discrimination (SASOD);
c) National AIDS Committee (NAC);
d) United Nations Development Programme (UNDP); and
e) Joint United Nations Programme on HIV/ AIDS (UNAIDS).

(vii) Written summary of intended presentation by the Society Against Sexual Orientation Discrimination (SASOD).

3.2 The following document was circulated at the meeting:-

- A handout captioned "Positive Health, Dignity and Prevention – Guiding Principles and Values".

ITEM 4: CORRECTIONS AND CONFIRMATION OF MINUTES OF THE 4TH MEETING HELD ON 27TH JUNE, 2011.

4:1 The Minutes were deferred to a subsequent meeting of the Committee.

ITEM 5: TO RECEIVE ORAL PRESENTATIONS FROM THE FOLLOWING ORGANISATIONS:

5.1 Preliminary Remarks

5.1.1 The Chairman welcomed Members and reiterated that the purpose of the meeting was to receive oral presentations from a number of organisations with reference to Resolution No. 129 of 2010. Thereafter, he outlined the organisations that were invited to make oral presentations.

5.1.2 The presentations were made in the following order:

(i) Artiste In Direct Support (AIDS);
(ii) Society Against Sexual Orientation Discrimination (SASOD);
(iii) Joint United Nations Programme on HIV/AIDS (UNAIDS);
(iv) National AIDS Committee (NAC); and
(v) United Nations Development Programme (UNDP).

5.2 Presentation by Artiste In Direct Support

5.2.1 At 4.21 p.m., the Chairman of the Committee welcomed Mrs. Desiree Edghill – Chief Executive Officer of **Artiste In Direct Support,** to the meeting of the Committee and introduced Mrs. Edghill to the Members of the Committee.

5.2.2 Thereafter, Mrs. Edghill was advised that she should commence her presentation after which, if necessary, questions might be asked for the purpose of clarification and/or information.

5.2.3 In commencing the presentation, Mrs. Edghill noted that her organisation has been in the fight against HIV since 1992 and had recently opened a testing site in Alexander Street, Kitty to cater for the needs of the vulnerable population which includes Men Who Have Sex With Men (MSN) and commercial sex workers. Her presentation was mainly **"against"** the Resolution since she felt that criminalization of HIV will:-

(i) make people become fearful of being tested since not knowing one's status, removes the responsibility of, or proof of "knowingly" infecting others ;

(ii) removes the issue of confidentiality currently shared between the client and care providers/doctors etc., since health care workers would have to provide the evidence/information to prove that the accused had prior knowledge;

(iii) put additional burden on the Court System due to lengthy trial dates, it might also put the accused life in jeopardy since others may be planning to harm him/her upon their incarceration;

(iv) affect the Pregnant Mother To Child Transmission (PMTCT) programmes country wide since mothers may be criminalized for knowingly infecting their children;

(v) contribute to the increase stigma and discrimination of HIV infected persons and their family members;

(vi) result in broken homes since children could take their mothers to court; husbands might take wives to court for unfaithfulness and *vice versa*; and

(vii) contribute to a lack of protection for women since they are more likely to be abused by their partners upon disclosure of their status.

5.2.4 At 4.55 p.m., Mrs. Edghill concluded her presentation and Members asked questions for the purposes of clarification and/or information.

5.2.5 During the discussions which followed, a Member advised Mrs. Edghill that the Resolution was intended to criminalize those who willfully infect others, hence, ***criminalization*** only comes with the action of those persons who ***"knowingly"*** infect others. At the end of the discussions, the Chairman thanked Mrs. Edghill for her presentation.

5.3 Presentation by Society Against Sexual Orientation and Discrimination (SASOD)

5.3.1 At 4.57 p.m., the members of the Society Against Sexual Orientation and Discrimination (**SASOD)** were welcomed to the meeting.

5.3.2 The Chairman then introduced himself and Members of the Committee to the team, after which he advised the members of SASOD to introduce themselves and commenced their presentation. He also indicated to them that questions might be asked at the end of their presentations for the purpose of clarification and/or information.

5.3.3 The members comprising the SASOD team were as follows:-

(i) Mr. Anton Rocke – Advocacy and Communications Officer
(ii) Ms. Sherlina Nageer – Member
(iii) Mr. Korey Anthony Chisholm – Youth Representative.

5.3.4 In commencing their presentation, SASOD noted that they represented a marginalized community which they referred to as the LGBTI. A community which comprise Lesbians, Gays, Bi-Sexuals, Transgender and Intersex persons. They felt that the motion would only seek to further stigmatize and discriminate against this community: a community that is already being stigmatized for their sexual orientation and blamed for the spread of HIV.

5.3.5 A SASOD member noted that while he recognized that HIV is a medically manageable disease, he believed that the implementation of such a legislation would spread fear and misinformation about HIV. SASOD made it clear that they were ***"against"*** the Resolution.

5.3.6 Highlighted in their presentation were some of the following points:-

(i) criminalization of HIV transmission increases stigma and discrimination against the person living with HIV by making them potential criminals;

(ii) it undermines public health efforts by breaking the client - care giver confidential relationship which could negatively impact the patient's trust in the health care system and his/her willingness to participate in health care of any nature;

(iii) it would also undermine the successful health initiatives that have already been implemented;

(iv) it would victimize women since women more often than men access health care services for e.g., prenatal care and reproductive care;

(v) it works counter to the official UNAIDS position on HIV policies and it would be inconsistent with international guidelines on human rights; and

(vi) there are laws already in place to deal with non consensual sex and those laws should be strengthened to encompass the transmission of HIV.

5.3.7 At 5.25. pm, the members of SASOD concluded their presentation by noting that some countries which had enforced similar laws (Belize) had discarded them due to difficulties they experience in trying to bring cases before the Court and a lack of evidence to prove "knowingly" or "wilful" transmission.

5.3.8 Following their presentation, questions were asked for the purpose of clarification and/or information. After responding to all the questions asked by Members, the Chairman then thanked the team from SASOD for their presentation.

5.4 Presentation by the United Nations HIV/AIDS Programme (UNAIDS)

5.4.1 At 5.26 p.m., the Chairman welcomed the members of the United Nations HIV/AIDS Programme (**UNAIDS)** to the meeting of the Committee**.** He then introduced the Members from UNAIDS to the Committee after which he introduced the Members of the Committee to the UNAIDS Team.

5.4.2 The UNAIDS group was then invited to commence their presentation and was advised that following their presentation, questions for the purpose of clarification and/or information might be asked.

5.4.3 The members comprising the UNAIDS team were as follows:-

(i) Dr. Reuben F. del Prado, M.D., M.P.H., - Country Coordinator (UNAIDS)

(ii) Ms. Jennifer Ghanesh - Prevention Coordinator (NAPS/MoH)

(iii) Mr. Trevor McIntosh - Regional VCT Supervisor (NAPS/MoH)

5.4.4 In his opening remarks to the Committee, Dr. del Prado noted that in 2002 UNAIDS published a policy brief to address Criminal Law, Public Health and HIV Transmission to which he would be referring to from time to time.

5.4.5 Dr. del Prado noted that Guyana is proposing a policy response to the AIDS epidemic in response to the cries from the public on the war on AIDS. He noted that there will be such calls, especially in individual cases of wilful transmission which have been given media coverage. He, however, questioned whether the enactment of criminal laws and prosecution represent a sound policy response.

5.4.6 He opined that before proceeding along the line of criminalization, there is need to consider a number of issues such as whether the policy response confirms to international human rights norms and whether its primary objectives is about preventing transmission.

5.4.7 According to him, a sound policy must consider the functions of criminal law (rehabilitation, retribution, deterrence and removal from society) to assess the extent to which criminalization would contribute to the objectives of preventing transmission.

5.4.8 In summary, UNAIDS was ***"against"*** the Resolution. Some of the issues highlighted in the presentation were as follows:-

(i) there is no evidence that criminalization of HIV transmission has any public health benefits;

(ii) criminalization would not lead to behavioural change, something that is needed to curb transmission;

(iii) criminalization would deter people from getting tested;

(iv) criminalization fosters stigma and discrimination; and

(v) criminalization of HIV transmission puts the onus of transmission on one person – the person living with HIV, hence, there is no shared responsibility;

5.4.9 In closing, Dr. del Prado noted that the world is going back on criminalization of HIV transmission. People across the world are recognizing the negative public health and human rights impact of criminalization and as such Guyana should not be talking a step backwards.

5.4.10 He suggested that a way forward would be to ensure undiagnosed and diagnosed persons along with their partners and communities are included in programmes to achieve HIV prevention that highlights shared responsibilities regardless of known or perceived HIV status and be given opportunities to empower themselves and their sex partners.

5.4.11 At. 5.40. pm., Dr. del Prado concluded his presentation after which questions for the purposes of clarification and/or information were asked. At the end of the responses given and the discussion which followed, the Chairman thanked UNAIDS for its written submission and oral presentation.

5.5 Presentation by the National AIDS Committee (NAC

5.5.1 At 5.45 p.m., the Chairman welcomed the representatives of the National AIDS Committee **(NAC)** to the meeting and after the reciprocal introductions were made, he invited the designated leader of the group to commence the presentation.

5.5.2 The members comprising the National AIDS Committee (NAC) team were as follows:-

(i) Ms. Hyacinth Sandiford - Chairperson (NAC)

(ii) Ms. Jacqueline Delph - Vice-Chairperson (NAC) and member of GHRA

(iii) Mrs. Merle Mendonca - Secretary (NAC) and member of GHRA

(iv) Ms. Chrystol Albert - Member (NAC) and G+

5.5.3 In her opening remarks, Ms Albert stated that NAC believes that the motion which seeks to criminalize the willful transmission of HIV was ill informed, dangerous and ultimately counter-productive. She believes that the government has already adopted an enlightened National AIDS Policy which contains recommendations and renders the Resolution redundant. Hence, NAC is ***"against"*** the Resolution.

5.5.4 Highlighted in the presentation were some of the following points:-

(i) the motion encourages reactionary opinion in the Caribbean to continue to avoid the progressive legislation needed to confront stigma and discrimination with which the persons living with HIV are already dealing with;

(ii) criminalizing HIV transmission might have a negative feedback against women since many of them cannot disclose their status without the likelihood of violence from their partners nor can they negotiate safe sex;

(iii) criminalizing HIV transmission would undermine all the successful public health initiatives undertaken thus far; and

(iv) that adequate criminal laws are in place to deal with people who intentionally set out to harm others as well as the Sexual Offenses Act of 2010 which provides for harm done in a sexual nature.

5.5.5 The NAC also re-emphasized the importance of the UNAIDS and UNDP Policy Brief on Criminalization of HIV transmission and the recommendations found therein for governments to consider, as well as, the message contained in the

just concluded Political Declaration of HIV/AIDS in New York.

5.5.6 At. 6.00 pm, the members of the NAC concluded their presentation. Thereafter, the Chairman thanked them for their presentation.

5.6 Presentation by the United Nations Development Programme (UNDP)

5.6.1 At 6.05 p.m., the Chairman welcomed the delegation from the United Nations Development Programme (**UNDP)** to the meeting and after the reciprocal introductions were made invited them to commence their presentation.

5.6.2 The members comprising the UNDP team were as follows:-

(i) Mr. Trevor Benn - Programme Analyst (Governance) UNDP; and

(ii) Dr. Michelle Sumner -Williams HIV Coordinator - UNDP

5.6.3 Dr. Sumner-Williams in commencing her presentation stated that criminalization was only justified where individuals maliciously transmit the virus with intent to harm and noted that intentional transmission would be difficult to prove.

5.6.4 She further noted that in considering the path of criminalization, the Committee might need to consider some of the following issues:-

(i) the actual status of the person at the time the alleged offence would have occurred;

(ii) knowledge of the person on the modes of transmission of the virus;

(iii) non disclosure due to any threat of violence; and

(iv) whether the use of risk reduction measures such as condom use were taken into consideration.

5.6.5 Dr. Sumner-Williams stated that criminalization would not address important issues such as *rehabilitation* and the *reduction of the spread of HIV* but rather it would seek to:-

(i) provide a disincentive to disclosure and testing;

(ii) create a false sense of security in the public arena undermining public health initiatives and taking away the responsibility of individuals to protect their health;

(iii) increase the risk of violence and discrimination against vulnerable groups; and

(iv) promote fear and stigma that is already attached to the disease.

5.6.6 In closing, Dr. Sumner-Williams noted that criminalization does not work, making reference to Brazil, and Trinidad and Tobago, as examples that Guyana can learn from before making the same mistakes.

5.6.7 Alternatively, she noted that the UNDP was more supportive of efforts which sought to address the deeper social, economic and political inequalities that are the root of women and girls' disproportionate vulnerabilities to HIV; the reforming of existing laws to reduce discrimination; and support AIDS awareness and treatment programmes.

5.6.8 At. 6.15 p.m., the members of UNDP concluded their presentation after which the Chairman thanked them for their presentation.

5.7 Thereafter, the Chairman reiterated that all of the views of the presenters would be taken into consideration and anticipated a very robust debate from which a report would then be presented to the National Assembly.

5.8 Details of the presentations including the questions asked and responses given can be found in the Record of Proceedings at this date.

ITEM 6: ANY OTHER BUSINESS

6.1 Next Meeting

6.1.1 The Chairman undertook to liaise with the Committee's Clerk to decide on an available date for the next meeting of the Committee.

6.2 Absence of Member

6.2.1 Mrs. Lawrence informed the Committee that she would not be available for some time but undertook to follow the work of the Committee via email.

ADJOURNMENT

At 6.20 p.m. the meeting was adjourned *sin die*.

Confirmed this 31st day of August, 2011.

.....

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health,
Chairman

THE NATIONAL ASSEMBLY OF THE FIRST SESSION OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE 5TH MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010) HELD AT 5.10 PM ON WEDNESDAY, 3RD AUGUST, 2011, IN COMMITTEE ROOM NO. 1, COMMITTEES DIVISION, PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)
(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P.,
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P., - Excused
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P. - Excused

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P.

Mrs. Volda A. Lawrence, M.P.

Ms. Africo Selman, M.P.

From the Guyana Action Party/Rise, Organise and Rebuild (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P. - Excused

Officers

Ms. Sonia Maxwell - Clerk of Committees
Ms. Darlene Marshall - Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Chairman called the Meeting to order at 5.30 p.m.

ITEM 2: ANNOUNCEMENTS

2.1 The Chairman informed the Committee that Ms. Sonia Maxwell would be deputizing as Clerk of the Committee in the absence of Ms. Sherene Warren.

2.2 Excuses

2.2.1 The Chairman informed Members that the following Members had asked to be excused from the meeting:

- The Hon. Manzoor Nadir, M.P.
- Dr. Vishwa Deva Budhram Mahadeo, M.P., and
- Mr. Everall Franklin, M.P.

ITEM 3: CIRCULATION OF DOCUMENTS

3.1 The following documents were circulated prior to the meeting:

(i) Notice of the 5th meeting dated 29th July, 2011;

(ii) Minutes of the 4th meeting held on 13th July, 2011;

(iii) Record of Proceedings of the 4th meeting of the Special Select Committee on the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010) held on the 13th July, 2011;

(iv) PowerPoint Presentation received from Dr. Michelle Sumner-Williams, VCT Coordinator (UNDP); and

(v) PowerPoint Presentation received from Dr. Reuben F. Del Prado, M.D., M.P.H., Country Coordinator (UNAIDS).

3.2 The following document was circulated at the meeting:

- Matrix containing highlights of oral presentations.

ITEM 4: CORRECTIONS AND CONFIRMATION OF MINUTES OF THE 3rd MEETING HELD ON 27TH JUNE, 2011.

4.1 The Minutes were confirmed, without corrections, on a motion moved and seconded by Rev. Dr. Kwame Gilbert, M.P., and Dr. Frank C.S. Anthony, M.P., respectively.

ITEM 5: MATTERS ARISING

5:1 There were no matters arising from the Minutes.

ITEM 6: CORRECTIONS AND CONFIRMATION OF MINUTES OF THE 4TH MEETING HELD ON 13TH JULY, 2011

6.1 The Minutes were confirmed, without corrections, on a motion moved and seconded by Dr. Frank C.S. Anthony, M.P., and Rev. Dr. Kwame Gilbert, M.P., respectively.

ITEM 7: MATTERS ARISING

7:1 There were no matters arising from the Minutes.

ITEM 8: DISCUSSIONS ON WRITTEN AND ORAL SUBMISSIONS RECEIVED IN CONJUNCTION WITH THE RESOLUTION

8.1 Discussion on Oral Presentations

8.1.1 Members opined that the motion had attracted the attention of various members of society who were opposed to drafting legislation aimed at criminalising HIV exposure and transmission.

8.1.2 The Committee noted that the issues raised during the presentations were similar and agreed that passing such legislation would place the progress Guyana has made in combating the disease in regression.

8.1.3 Members agreed that such legislation, if passed, by the National Assembly, could potentially decrease testing rates and could result in women being placed in a vulnerable position, as they were more likely to know their HIV status through various prenatal tests. It was also noted that most countries that had similar legislation to prosecute offenders in this regard were repealing the laws, realizing that it was difficult to adjudicate.

8.1.4 The Committee indicated that the issue was complex and expressed regrets that the mover of the motion was unable to be present at its deliberations to provide the Committee with the rationale for such a motion. However, Members agreed to consider the points he raised during the debate on the motion when preparing the Report.

ITEM 9: ANY OTHER BUSINESS

9.1 Draft Report of the Committee

9.1.1 Members agreed that the Draft Report should be prepared and circulated to Members, for consideration, before the next meeting. The Chairman undertook to collaborate with the Clerk of the Committee in the preparation of the Report.

9.1.2 The Committee agreed that the Report should contain a response to the concerns expressed by Mr. Everall Franklin, M.P., during his debate on the motion in the National Assembly.

9.1.3 The Committee further agreed to append the submissions received from stakeholders to the Report.

9.2 Next Meeting of the Committee

9.2.1 The Committee decided to meet on Wednesday, 10th August, 2011 at 5.00 p.m. to consider the Draft Report.

Adjournment

At 5.40 p.m. the meeting was adjourned to **Wednesday, 10th August, 2011.**

Confirmed this ...10th... day of August, 2011.

.....

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health,
Chairman.

THE NATIONAL ASSEMBLY OF THE FIRST SESSION OF THE NINTH PARLIAMENT OF GUYANA (2006- 2011)

MINUTES OF THE 6TH MEETING OF THE SPECIAL SELECT COMMITTEE ON CRIMINAL RESPONSIBILITY OF HIV INFECTED INDIVIDUALS, (RESOLUTION NO. 129 OF 2010) HELD AT 5.00 PM ON WEDNESDAY, 10TH AUGUST, 2011, IN COMMITTEE ROOM NO. 1, COMMITTEES DIVISION, PUBLIC BUILDINGS, BRICKDAM, GEORGETOWN.

MEMBERS OF THE COMMITTEE

CHAIRMAN (1)
(Nominated by the Committee of Selection on 21st October, 2010)
(Elected by the Committee on 10th March, 2011)

The Hon. Dr. Leslie S. Ramsammy, M.P.,
Minister of Health

From the People's Progressive Party/Civic (PPP/C) (5)
(Nominated by the Committee of Selection on 21st October, 2010)

The Hon. Dr. Jennifer R.A. Westford, M.P.,
Minister of Public Service

The Hon. Dr. Frank C.S. Anthony, M.P., - Excused
Minister of Culture Youth and Sport

The Hon. Manzoor Nadir, M.P.,
Minister of Labour

Dr. Vishwa Deva Budhram Mahadeo, M.P. - Excused

Rev. Dr. Kwame Gilbert, M.P.

From the People's National Congress Reform – 1 Guyana (PNCR – 1G) (3)
(Nominated by the Committee of Selection on 21st October, 2010)

Dr. George A. Norton, M.P. - Absent

Mrs. Volda A. Lawrence, M.P. - Excused

Ms. Africo Selman, M.P. - Absent

From the Guyana Action Party/Rise, Organise and Rebuild (1)
(Nominated by the Committee of Selection on 21st October, 2010)

Mr. Everall N. Franklin, M.P. - Excused

Officers

Ms. Sherene Warren - Clerk of Committees
Ms. Darlene Marshall - Assistant Clerk of Committees

ITEM 1: CALL TO ORDER

1.1 The Chairman called the Meeting to order at 5.00 p.m.

ITEM 2: ANNOUNCEMENTS

2.1 Excuses

2.1.1 The Chairman informed the Committee that the following Members had asked to be excused from the meeting:

(i) The Hon. Dr. Frank C.S. Anthony, M.P.,
(ii) Dr. Vishwa Deva Budhram Mahadeo, M.P.,
(iii) Mrs. Volda A. Lawrence, M.P., and
(iv) Mr. Everall Franklin, M.P.

ITEM 3: CIRCULATION OF DOCUMENTS

3.1 The following documents were circulated prior to the meeting:

(i) Notice of the 6th meeting dated 5th August, 2011;

(ii) Minutes of the 5th meeting held on 3rd August, 2011;

(iii) Draft Report of the Special Select Committee on the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010). (Circulated electronically)

3.2 The following document was circulated at the meeting:

- Draft Report of the Special Select Committee on the Criminal Responsibility of HIV Infected Individuals, (Resolution No. 129 of 2010). (Hard copy)

ITEM 4: CONFIRMATION OF MINUTES OF THE 5TH MEETING HELD ON 3RD AUGUST, 2011.

4.1 The Minutes were confirmed, without corrections, on a motion moved and seconded by the Hon. Dr. Jennifer R.A. Westford, M.P., and Rev. Dr. Kwame Gilbert, M.P., respectively.

ITEM 5: MATTERS ARISING

5:1 There were no matters arising from the Minutes.

ITEM 6: CONSIDERATION OF THE DRAFT REPORT OF THE COMMITTEE.

6.1 The Committee proceeded to consider the Draft Report paragraph by paragraph.

6.2 **Paragraphs 1** to **13** were ***accepted*** as ***presented***.

6.2.1 **Paragraph 14**

6.2.2 The following amendments were made:

- Deletion of the word **"*Consultation*"** after the word **"*from*"** in the sub-heading and in line 1 of the paragraph.

6.2.3 Thereafter, *paragraph 14* was ***accepted*** as ***amended.***

6.3. **Paragraph 15**

6.3.1 **Subparagraphs (i)** and **(ii)** were ***accepted*** as ***presented.***

6.3.2 The following amendment was made in **Subparagraph (iii):**

- Deletion of paragraph 2.

6.3.3 The following amendments were made in **Subparagraph (iv):**

Paragraph 3

- Deletion of the words ***"Developing an isolated law to criminalise HIV transmission intensifies the climate of denial, secrecy and fear and provides an ever more fertile ground for the spread of HIV"***.

Paragraph 4 was deleted and subsequent paragraphs renumbered accordingly.

Paragraph 5

- Substitution of the word ***"negatives"*** for the word ***"complexities"*** in line 4.

6.3.4 Thereafter, *paragraph 15* was ***accepted*** as ***amended.***

6.4 **Paragraph 16**

6.4.1 The following amendment was made in **Subparagraph (i):**

- Substitution of the word ***"State"*** for the words ***"National Assembly"*** in line 1.

6.4.2 **Subparagraph (ii)** was deleted and subsequent paragraphs renumbered accordingly.

6.4.3 The new **subparagraph (ii)** was reworded as follows**:**

> ***"The Committee commended the passage of laws in the National Assembly addressing sexual offences and other forms of violence against women and recommends that the National Assembly direct legislative reform towards addressing discrimination and other human rights violations against people living with HIV and people most at risk of exposure to HIV."***

6.4.4 The new **subparagraph (iii)** was ***accepted*** as ***presented.***

6.4.5 The new **subparagraph (iv)** was deleted.

6.4.6 Thereafter, *paragraph 16* was ***accepted*** as ***amended.***

6.5 Paragraph 17

6.5.1 The following amendment was made:

- Substitution of the word **"*undermine*"** for the words **"misrepresent – to the national and international opinions -"** in line 3.

6.5.2 Thereafter, *paragraph 17* was ***accepted*** as ***amended.***

6.6 Paragraphs 18 to **21** were ***accepted*** as ***presented***.

6.7 Thereafter, the Committee adopted the Report and agreed that it should be tabled at a subsequent sitting of the National Assembly.

ITEM 7: ANY OTHER BUSINESS

7.1. Closing Remarks

7.1.1 The Chairman, in closing, thanked Members for the fruitful and cordial deliberations and the earnestness with which they considered the motion. He also expressed strong appreciation to the staff of the Committees Division and the Hansard Department for their invaluable support to the Committee during its deliberations.

TERMINATION

At 5.30 p.m. the meeting was terminated.

(Unconfirmed)