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Provisional agenda item 1.7:

Report by the NGO representative

Document prepared by the PCB NGO Representatives

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to:

1. Co-infection Management: HIV and Tuberculosis

- a. UNAIDS Programme Coordinating Board requests UNAIDS to endorse TB prevention diagnosis, and treatment within the context of universal access and therefore including TB prevention, diagnostics, treatment and adherence in all national HIV action frameworks and strategies.
- b. UNAIDS Programme Coordinating Board requests UNAIDS to include the goal of reducing TB mortality as part of the indicators in national target setting processes.
- c. UNAIDS Programme Coordinating Board acknowledges and promotes the right of PLHIV to be able to attend health services without fear of contracting TB.
- d. UNAIDS Programme Coordinating Board recommends UNAIDS to develop and implement strategies to involve communities affected by HIV in the TB response.
- e. UNAIDS Programme Coordinating Board recommends UNAIDS to collaborate with partners to development guidance material to address the human rights issues around treatment of TB, especially in regards to multidrug-resistance TB and extra drug-resistance TB.
- f. UNAIDS Programme Coordinating Board requests UNAIDS to work with relevant partners to accelerate research and development of better tools for prevention, diagnosis, and treatment of TB.

2. Co-infection Management: HIV and Hepatitis C

- a. UNAIDS Programme Coordinating Board requests UNAIDS and WHO to develop and additional component of the guideline module relevant for HIV care for Integrated Management of Adolescent and Adult Illness (IMAI) on Hepatitis Care with Hepatitis-HIV co-management.

3. Meeting the Treatment Target

- a. UNAIDS Programme Coordinating Board requests UNAIDS to collaborate more closely with GFATM on the global mechanism for price negotiation and the cost effective procurement of all HIV related commodities, with special reference to the affordability of second line ARV drugs, paediatric formulations, diagnostic equipment, substitution drugs and clean needles.

4. Meeting the Prevention Target Amongst Injecting Drug Users

- a. UNAIDS Programme Coordinating Board requests UNAIDS and Co-sponsors, as a matter of priority, assist governments in scaling up harm reduction approaches, including needle exchange and substitution therapy, paying particular attention to removing legislation and policy barriers to effective implementation of harm reduction services, which would fall in line with commitment 22 of the Political Declaration on HIV/AIDS.

5. Criminalization of Transmission and Legal Reform

- a. UNAIDS Programme Coordinating Board requests UNAIDS Secretariat to report at the XX board meeting on actions that they are taking with relevant partners at the national level to remediate the human rights violations, and to ensure that the recommendations as outlined in the 2002 Policy Options Paper are implemented.

6. UNAIDS Guidance Note on Sex Work

- a. UNAIDS Programme Coordinating Board requests UNAIDS to monitor and evaluate the implementation of the Guidance Note on HIV and Sex Work in consultation with the Global Working Group on HIV and Sex Work Policy, and networks of sex workers to ensure that the development and maintenance of an enabling environment that respects the rights of sex workers and which promote and support their empowerment, are given equal attention and resources among other priorities.

Cost implications for decisions: *none*

MEETING UNIVERSAL ACCESS COMMITMENTS: A CIVIL SOCIETY PERSPECTIVE

1. This report highlights the following major themes that the Programme Coordinating Board (PCB) Non-governmental Organisations (NGO) Delegation has compiled after broad consultation with global and regional networks and constituencies, and aims to introduce and highlight issues to be addressed if we hope to achieve universal access to prevention, treatment, care and support by 2010, as follows:
 - Co-infection management: HIV and Tuberculosis
 - Co-infection management: HIV and Hepatitis C
 - Meeting the treatment target
 - Meeting the prevention target amongst Injecting Drug Users (IDU)
 - Stigma & discrimination, and human rights
 - Criminalization of transmission, and legal developments
 - Sexual Reproductive Health and Rights of People Living with HIV/AIDS (PLHIV)
 - UNAIDS Guidance note on sex work
2. The latest statistics released by UNAIDS on 20th November 2007 show that in 2007:
 - Global HIV prevalence (the proportion of people living with the virus) appears to have levelled off. However, the number of people living with HIV (PLHIV) has risen to 33.2 million in 2007 from 29 million in 2001.
 - Some 2.5 million people were newly infected with the virus in 2007 and 2.1 million people died of AIDS-related illnesses.
 - Every day, over 6800 person become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services¹.

CO-INFECTION MANAGEMENT: HIV AND TUBERCULOSIS (TB)

3. An estimated one-third of PLHIV worldwide are co-infected with TB, and many more are at greatly increased risk of contracting and dying of TB, with the majority of people who are co-infected living in sub-Saharan Africa. About 90% of people with healthy immune systems with latent TB infection do not develop disease; however, there is a 10% chance of people with latent TB infection to develop into TB disease.
4. TB kills up to half of all AIDS patients worldwide. PLHIV infected with TB are up to 50 times more likely to develop active TB in their lifetime than people who are HIV-negative. On top of which, HIV infection is the most potent risk factor for converting latent TB into active TB disease, moreover, TB disease can accelerate the progress of HIV infection.
5. Many people infected with HIV in developing countries develop TB as the first manifestation of AIDS. The two diseases represent a deadly combination, since they are more destructive together than either disease alone:
 - TB is harder to diagnose in PLHIV, and a late diagnosis of TB combined with untreated HIV results in one-third of PLHIV patients dying within weeks of being treated for TB in countries with high TB and HIV burdens;
 - TB progresses faster in PLHIV;

¹ UNAIDS/ WHO (2007). AIDS Epidemic Update.

- TB in PLHIV is almost certain to be rapidly fatal if undiagnosed or left untreated;
 - TB can occur early in the course of HIV infection²; and
 - Even PLHIV who are on effective antiretroviral treatment are at increased risk of developing TB.
6. A reality in places with high burden of TB and HIV, has data showing that TB patients have high rates of HIV infection (example, in Swaziland, the rate is 50% of all TB cases). Therefore, providing HIV testing or at least screening and then testing for TB patients will allow for the identification of previously undiagnosed HIV patients, who would be able to benefit from access to ARVs. This is recommended by WHO's Policy for TB/HIV Collaborative Activity in settings where there is a generalized HIV epidemic or a concentrated one. However, because this policy is not being implemented, precious time is lost in getting previously undiagnosed people to access ARV care.
 7. In recent years the alarming surge in multidrug-resistant tuberculosis (MDR-TB) and the emergence of extensively drug-resistant tuberculosis (XDR-TB) has put pressure on some governments to forcibly quarantine people in an attempt to stop transmission. But these control measures, which pit individual rights against community rights, are being questioned in countries facing widespread epidemics. In South Africa, after being diagnosed with MDR-TB, patients are sent back home to die, and potentially spread the infection to others, because there are not enough hospital beds and adequate infection control to take care of these patients in the hospital. Therefore, governments need to provide people with appropriate access to care to protect others. Quarantining MDR-TB patients can not be seen as a strategy for health care provision.
 8. More than a quarter of the MDR-TB cases in the world are found in the Asia Pacific region³, with a majority of them – approximately 140 000 cases – concentrated in China. The high costs of MDR-TB treatment options and monitoring, and HIV drug therapy will pose an even greater financial challenge to the region where 84% of PLHIV are not on ARV treatment.
 9. According to a report published by the Forum for Collaborative HIV Research, as of October 2007, XDR-TB had been confirmed in 41 countries, up from 17 countries in March 2006. There are an estimated 400 000 individuals infected with MDR-TB and 26 000 infected with XDR-TB; however, these are underestimates because there are no data from many high HIV prevalence areas.⁴
 10. Injecting drug use is the main factor for TB, HIV and HCV infection in Manipur, which is the eastern most state of India bordering Myanmar⁵, moreover, in Russia, where injecting drug use is the major mode of HIV transmission, Injecting Drug Users (IDUs) represent 87% of the total number of registered HIV cases.⁶ 35% of PLHIV in the Russian Federation have died of TB.⁷ Yet only 48% of people living with

² <http://www.who.int/tb/challenges/hiv/qa.pdf>

³ It is most prevalent in Cambodia, China, Laos, Mongolia, Papua New Guinea, Philippines and Vietnam.

⁴ The Lancet Volume 7 December 2007: Forced isolation of tuberculosis patients in South Africa. P771.

⁵ Birjit Konjengbam, Social Awareness Service Organisation. kbirjit@gmail.com

⁶ UNAIDS, http://www.unaids.org/en/Regions_Countries/Countries/russian_federation.asp Accessed 18 July 2006.

⁷ WHO (2003:3) Colombani P, Banatvala N, Zaleskis R, Maher D. European framework to decrease the burden of TB/HIV.

HIV/AIDS are screened for TB in the former Soviet countries and only 34% of people with TB are tested for HIV there.⁸

11. In many countries, there is little or no coordination between TB treatment, HIV treatment and substitution therapy, often forcing former IDUs to choose between these treatments as drug treatment and TB services are rarely available in the same facility.
12. Currently in much of Eastern Europe and the former Soviet Union, drug users are not able to enter drug rehabilitation unless they can prove they do not have TB. At the same time, TB patients are not allowed to use drugs (and are not given drug rehabilitation or withdrawal support) in a TB hospital, threatening TB treatment adherence.
13. Community mobilization for TB care has become very important due to the rise in MDR-TB and XDR-TB. With the lack of TB treatment adherence, and poor motivation to stay on treatment, there is an urgent need for community influencers and leaders to understand the critical aspects of TB prevention and care in communities, to fight stigma and discrimination, and to provide an enabling environment for patients to access and utilize treatment services.
14. TB focused civil society movements at national level can demand for and ensure quality care and services in the communities, and especially motivate patients with HIV, to access and utilize the services. However, besides services, it is clear that the current tools for TB are inadequate to meet the challenges of TB/HIV. The role of community advocacy in HIV research was vital in bringing about these major innovations. Similarly, leadership is needed from the TB/HIV community, especially because TB is a disease of the poor and profits, if any, are not an incentive for this innovation. At the same time, the new WHO TB Control Strategy includes empowerment of people with TB as a key component and this can be used to hold the National Tuberculosis Programmes (NTPs) accountable in engaging with civil society players that can organise infected/affected communities.
15. UNAIDS should therefore further engage civil society organizations in TB control, recognizing existing Civil Society Tuberculosis Programmes as fully engaged partners in scaling up towards universal access as reflected as a commitment of the 2006 High Level Political Declaration⁹. UNAIDS and WHO need to follow up with monitoring efforts to make sure that this commitment is being lived up to.

⁸ Stop TB Partnership. The Global Plan to Fight TB 2006-2015. Stop TB Partnership. 2006. http://www.stoptb.org/globalplan/assets/documents/GP_P1_S2.pdf 93. Accessed 10 May 2007

⁹ (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 for investment in new drugs, diagnostics and vaccines that are appropriate for people with TB-HIV co-infection

Therefore, the UNAIDS PCB NGO delegation recommends that the PCB take the following decisions, and:

- requests UNAIDS to endorse TB prevention diagnosis, and treatment within the context of universal access and therefore including TB prevention, diagnostics, treatment and adherence in all national HIV action frameworks and strategies.
- requests UNAIDS to include the goal of reducing TB mortality as part of the indicators in national target setting processes.
- requests UNAIDS acknowledges and promotes the right of PLHIV to be able to attend health services without fear of contracting TB.
- recommends UNAIDS to develop and implement strategies to involve communities affected by HIV in the TB response.
- recommends UNAIDS to collaborate with partners to development guidance material to address the human rights issues around treatment of TB, especially in regards to multidrug-resistance TB and extra drug-resistance TB.
- requests UNAIDS to work with relevant partners to accelerate research and development of better tools for prevention, diagnosis, and treatment of TB.

CO-INFECTION MANAGEMENT: HIV AND HEPATITIS C

16. In some countries¹⁰ where Injecting Drug Use (IDU) fuels at least 70% of HIV transmission, the risk of Hepatitis co-infection is very high. Regrettably, HIV and Hepatitis C co-infections are rarely reported and detected in time. WHO estimates that 2.5 to 4.9% of China's population is Chronic Hepatitis C (HCV) positive¹¹, in Brazil, one-third of PLHIV are co-infected with HIV, but overall few have access to proper treatment, or are able to afford it.
17. The effects of HCV infections in PLHIV are more serious and can result in the following:
- Damaged or crippled liver functions which affect the treatment of HIV.
 - The ineffectiveness of ARV treatment, resulting in the slowing down of the rate of increase in CD4 cell counts.
 - Patients co-infected with HCV and HIV need to monitor indicators of HIV progression, such as their CD4 count, which when falls below 200, renders HCV treatment less effective, and with more pronounced side effects.
18. However, treatment of HCV is extremely expensive and inaccessible to most patients. More importantly, the choice treatment of the co-infection of HIV and HCV is extremely challenging and hepatotoxic, therefore, there is the urgent need to make available a wider variety of ARVs in countries where it is most needed to lower the levels of liver toxicity and reduce occurrences of cirrhosis and death.

¹⁰ These countries are namely China, Indonesia, Malaysia, Myanmar and Vietnam, and post-soviet countries

¹¹ World Health Organization. Hepatitis C: global prevalence. *Wkly Epidemiol Rec* 2000;**75**:19.

19. The importance of diagnosis and treatment of co-infections extend to Hepatitis C and Chronic Hepatitis C (HCV), which as an emerging issue needs rapid actions to be taken for the achievement of Universal Access to prevention, treatment, care and support, and further can be reflected in the WHO Integrated Management of Adolescent and Adult Illness (IMAI) modules.¹²

Therefore, the UNAIDS PCB NGO delegation recommends that the PCB take the following decision and requests UNAIDS and WHO to develop an additional component of the guideline module relevant for HIV care for Integrated Management of Adolescent and Adult Illness (IMAI) on Hepatitis Care with Hepatitis-HIV Co-management.

MEETING THE TREATMENT TARGET

20. In 2003, the World Health Organization (WHO) and UNAIDS set a goal for three million people in the developing world to receive anti-retroviral treatment (ART) by 2005. Three years later than planned, this milestone is likely to be met. However, despite this provision, progress remains far too slow if the G8 goal of universal access by 2010 is to be achieved.
21. As highlighted in the 2007 Millennium Development Goals (MDG) Report¹³ on Goal 6, regarding expansion on access to AIDS treatment, it is undeniable that the need continues to grow. However, the reality on the ground shows that only 28% of those in need of treatment in Sub-Saharan Africa, 26% on Eastern Asia, 10% in Oceania and 9% in Southern Asia are receiving ART by the end of 2006.¹⁴
22. A report which looked at AIDS treatment access in 14 countries, released in December 2007 entitled "Missing the Target #5: Improving AIDS Drug Access and Advancing Health Care for All"¹⁵ produced by the International Treatment Preparedness Coalition (ITPC) warns that meeting the "near universal target" to AIDS drugs access by the 2010 deadline will require an enormous effort by governments, global agencies, and drug companies.
23. Even though PLHIV are accessing treatment than ever before, in the most affected countries, patent and registration barriers, and ongoing stock-outs are core issues impeding AIDS drug delivery.
24. At the end of 2006, Thailand decided to make use of its right to issue compulsory licenses in order to ensure access to medicine for its population and the sustainability of its universal medical coverage. In doing so, Thailand demonstrated its sense of accountability toward its patients. By implementing a thoughtful policy, based on the needs of the country in terms of access to medicine, its experts and political leaders offered an example to other countries, showing that it is possible for

¹² Please refer to <http://www.who.int/3by5/publications/documents/imai/en/>

¹³ Available at <http://www.un.org/millenniumgoals/pdf/mdg2007.pdf>

¹⁴ Millennium Development Goals Report 2007, pg 19

¹⁵ Available at <http://www.aidstreatmentaccess.org/itpc5th.pdf>

developing countries to enforce international intellectual property agreements while at the same time using lawful flexibilities when needed (as allowed by the TRIPS Agreement and restated by the Doha Declaration¹⁶).

25. At the 18th PCB Meeting in June 2006, the board had requested “UNAIDS to cooperate as appropriate with initiatives based on innovative financing mechanisms, including the International Drug Purchase Facility/UNITAID, that aim to contribute to universal access on a sustainable and predictable basis”.

Therefore, to hold governments accountable, and more importantly, to accelerate the delivery of their commitments in the Political Declaration on HIV/AIDS¹ at the sixtieth session of the General Assembly on commitments 42¹, 43¹ and 44¹, the UNAIDS PCB NGO delegation recommends that the PCB take the following decisions, and requests UNAIDS to collaborate more closely with GFATM on the global mechanism for price negotiation and the cost effective procurement of all HIV related commodities, with special reference to the affordability of second line ARV drugs, paediatric formulations, diagnostic equipment, substitution drugs and clean needles.

MEETING THE PREVENTION TARGET AMONGST INJECTING DRUG USERS

26. An estimated 10% of all new HIV infections worldwide (30%) outside of Africa occur through injecting drug use. Effective public health prevention measures have been available to governments and the international community for 20 years. However, these are currently only available to less than 5% of the target population. This low and insufficient response has largely been due to the lack of leadership on this issue emanating from the UN system, as health measures that enable drug users to inject more safely have been seen as undermining the core message of drug control.
27. In Asia and the Pacific, UNAIDS estimates that 1 million of PLHIV in the region were infected through injecting drug use which fuels at least 70% of HIV transmission in some countries¹⁷. Other countries¹⁸ are beginning to face severe IDU epidemics concentrated in specific zones. In Eastern Europe and Central Asia, UNAIDS reported in 2007 that nearly 90% of newly reported HIV diagnoses in 2006 were from Russia Federation (66%) and Ukraine (21%). Of the new HIV cases reported in 2006 in the region, nearly two-thirds (62%) were attributed to injecting drug use and more than one third (37%) were ascribed to unprotected heterosexual intercourse. The often neglected overlapping risks of injecting drug use and unprotected sex are prominent drivers of the epidemic in the region, where at the same time, many IDUs who buy or sell sex do not use condoms. In addition, the lack of social services and rehabilitation remains one of the barriers to HIV prevention and adherence to ARV therapy amongst IDUs in Central Asia.

¹⁶ For more information, refer to: http://www.wto.org/english/tratop_e/dda_e/dohaexplained_e.htm

¹⁷ These countries are China, Indonesia, Malaysia, Myanmar and Vietnam.

¹⁸ These countries are Bangladesh, India, Nepal and Pakistan.

Therefore, the UNAIDS PCB NGO delegation recommends that the PCB take the following decision and requests UNAIDS Secretariat and Co-sponsors, as a matter of priority, assist governments in scaling up harm reduction approaches, including needle exchange and substitution therapy, paying particular attention to removing legislation and policy barriers to effective implementation of harm reduction services, which would fall in line with commitment 22 of the Political Declaration on HIV/AIDS.

STIGMA & DISCRIMINATION, AND HUMAN RIGHTS

28. The UN Secretary General Ban Ki Moon at the World AIDS Day observance in New York on 30 November 2007, called for renewed leadership in eradicating HIV-associated stigma.
29. Overcoming stigma remains one of the greatest challenges, and is still the single biggest barrier to public action on AIDS. Stigma and discrimination are also a factor in TB, creating a dangerous synergy. HIV-related, on top of TB related social stigma and various forms of discrimination are two separate concepts, and must be addressed as such to have any impact on either.
30. Stigma is still most frequently conflated with negative attitudes towards marginalized populations, and may be reinforced by legislation and legal systems that deny basic human rights. There is an even more urgent need to protect vulnerable groups and PLHIV from stigma and discrimination, especially transgressions committed by health care providers, law enforcement agencies and the general public.
31. Whereas an increasing number of Community Based Organisations (CBOs) are committed to provide access to care and prevention to vulnerable groups, especially MSM, police violence and arbitrary arrests are being reported by members of these CBOs. There is therefore an urgent need to promote policies that will secure the work of the MSM community, as well as other vulnerable populations in the fight against HIV and AIDS.
32. The British Broadcasting Cooperation (BBC) reported on 6 February 2008, a group of arrested men were given HIV tests without their consent in Egypt, and subjected to anal tests to “prove” their homosexual conduct. According to Human Rights Watch (HRW), two of the men tested HIV-positive, and were handcuffed to hospital beds for 23 hours a day.¹⁹ Even though not explicitly referred to in the legal code of Egypt, homosexuality can be punished under several different laws covering obscenity, prostitution and debauchery.
33. Dakar is set to host the International Conference on AIDS and STIs in Africa (ICASA) in Dec 2008, which might “...leave little room for an open and inclusive discussion on the human rights dimensions of HIV in face of such harassment.”²⁰ In Senegal, homosexual acts are illegal, with punishment ranging from one to five years in

¹⁹ http://news.bbc.co.uk/1/hi/world/middle_east/7231082.stm

²⁰ Quoted by Mr. Danilo da Silva, Co-Chair of Pan Africa International Lesbian and Gay Association.

prison, and fines from \$200 to \$3 000.²¹ The government had included a commitment to fighting HIV among men who have sex with men (MSM) in its 2005 national AIDS response plan²². Notwithstanding this commitment, five men were recently arrested after they appeared in photographs from a marriage ceremony between two men in November 2006 that were published in February 2008.

34. In Papua New Guinea, HIV is mostly spread through heterosexual intercourse, polygamy, rape and sexual violence are widespread.²³ In the past, church leaders have described AIDS patients being thrown off bridges or left to starve in back gardens. Even more alarming has been the reporting as recent as from August 2007 of how PLHIV were being buried alive when they became very sick and people could not look after them.
35. Current indicators suggest that globally, less than one in twenty men (<5%) MSM have access to the HIV prevention and care services they need. Furthermore, traditional norms of masculinity and femininity contribute strongly to homophobia and the related stigma and discrimination against MSM, transgendered and 'third-gender' people. Even as the face of AIDS has changed, the driving forces behind public opinion about HIV remain strongly influenced by the prejudices against the gay community. Homophobia has thus been identified as one of the primary obstacles to effective HIV responses in moving forward towards universal access to treatment. Stigma and discrimination are also seen as major barriers to effective HIV prevention interventions and strategies. UNAIDS was encouraged at the 16th PCB Meeting to address stigma reduction by advocating for the adoption, strengthening and enforcement of antidiscrimination measure at country level.²⁴
36. According to the World Legal Report, more than 80 countries in the world criminalize same-sex behavior between men. Criminalizing certain sexual behaviors has proved to be an obstacle to prevention and treatment. We would recommend to develop a working group for researching the situation of LGBT communities which could present reliable data to strengthen the argument that homophobia, transphobia and criminalization of certain sexual behaviors are the major barriers to HIV prevention and treatment in these communities.
37. Therefore, it is proposed that a theme of discussion at the next PCB be the further development of joint initiatives, including the possible establishment of a working group for researching the situation of LGBT communities (for reliable data) to work towards combating homophobia, discrimination and criminalization of same sex behaviour, which are hampering HIV efforts in many countries, including examining areas of good practice.

²¹ http://www.xtra.ca/public/viewstory.aspx?AFF_TYPE=1&STORY_ID=4291&PUB_TEMPLATE_ID=2

²² According to Mr. Joel Nana, Programme Associate for West Africa, International Gay and Lesbian Human Rights Commission

²³ Available at <http://news.bbc.co.uk/2/hi/asia-pacific/6965412.stm>

²⁴ Taken from the Decision, Recommendations and Conclusions of the 16th PCB Meeting.

(5) Welcoming the action taken on the decision of the 15th Programme Coordinating Board(PCB) in June 2004 for UNAIDS to develop a revitalized prevention strategy, the PCB:

(5.5) Recognizes that stigma and discrimination are major barriers to effective HIV prevention and encourages UNAIDS to address stigma reduction in the strategy, including by advocating for the adoption, strengthening and enforcement of antidiscrimination measure at country level.

CRIMINALIZATION OF HIV TRANSMISSION AND LEGAL DEVELOPMENTS

38. In recent years, there has been an increasing tendency to criminalize and penalize the exposure and/or transmission of HIV. This has led to at least three detrimental outcomes which are devastating NGO HIV-prevention and HIV-related work:
- Penalization and criminalization of HIV-transmission is counter productive to the very logic of HIV-prevention work that demands that HIV prevention is a shared responsibility of all sexually active persons, not just of PLHIV.
 - People may be dissuaded from taking an HIV-test because they might subsequently be penalized if HIV-transmission should occur, therefore forfeiting their chances for quality treatment and counselling before developing AIDS.
39. In view of the evolving literature on the low probability of transmission of HIV by PLHIV under suppressive HIV-therapy, doubts should be raised whether the criminalization of PLHIV can even be upheld any longer.
40. This tendency towards criminalization of HIV exposure and/or transmission has been reflected in recent HIV and AIDS legislation in West and Central Africa. These legislative developments have been part of an effort to promote a “model law” on HIV/AIDS. The model law itself contains several provisions which contravene key human rights standards (including the UNAIDS/OHCHR *International Guidelines on HIV and Human Rights*), including:
- language that could severely restrict educational activities around HIV prevention in schools;
 - allowing for mandatory HIV testing in a variety of situations, such as where pregnant women go for a medical check-up, and including “to solve a matrimonial conflict”;
 - imposing a blanket duty on health care practitioners to disclose the HIV status of their patients to their patients’ spouses or sexual partners, regardless of the actual risk of transmission; and
 - criminalizing “the willful transmission of HIV” (with a corresponding definition of HIV transmission to be transmission of the virus “by any means”).
41. The broad language criminalizing “willful transmission of HIV” could impose criminal penalties even on individuals who practice safer sex and/or disclose their HIV status to their sexual partners, or on mothers who transmit HIV to their children, either in utero or during labor and delivery.
42. Such laws may have particularly detrimental implications for women. They may expose women to risks of violence upon mandatory disclosure provisions of their status. Language criminalizing HIV transmission that either implicitly or explicitly criminalizes mother to child transmission also puts women in a more vulnerable position. For example, such laws may lead to criminal sanctions against women where women were unable to disclose because of the fear of violence and/or abandonment.
43. Despite repeated expressions of concern from civil society organizations working on HIV/AIDS, this model law has been used as the basis of HIV laws in at least ten countries in West and Central African countries, and continues to be actively promoted. However, this model law is also impacting other countries in the continent,

at the recent UNAIDS/UNDP consultation held in Geneva in October 2007, a Zimbabwean MP presented how some of their laws could pose as problematic for women.²⁵ In Zimbabwe, there is an HIV-specific offence that imposes criminal liability on a person even if s/he has not been positively diagnosed with HIV, but merely “realizes there is a real risk or possibility that he or she is infected with HIV” and “does anything” that s/he realizes “involves a real risk or possibility of infecting another person with HIV”.

Therefore, the UNAIDS PCB NGO delegation recommends that the PCB take the following decision and requests UNAIDS Secretariat to report at the 23rd board meeting on actions that they are taking with relevant partners at the national level to **remediate** the human rights violations, and to ensure that the recommendations as outlined in the 2002 Policy Options Paper are implemented.

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (SRHR) OF PLHIV

44. The 2006 Political Declaration on HIV/AIDS commits all Member States to striving towards universal access to HIV prevention, treatment, care, and support by 2010²⁶, and “intensifying efforts to enact, strengthen or enforce...legislation, regulations and other measures to eliminate all forms of discrimination against...people living with HIV and members of vulnerable groups...”.
45. Regardless of HIV status, the ability to express oneself sexually and the desire to experience parenthood are, for many, central to what it means to be human. Therefore, acknowledging these needs and aspirations is essential to achieving the basic human rights of HIV-positive people.²⁷ At the same time, because the large majority of HIV infections worldwide occur as a result of sexual intercourse, successful global HIV prevention efforts must address the SRHR needs of PLHIV. For both of these reasons, meeting the sexual and reproductive health goals and service needs of people with HIV must be considered a global priority.
46. Over 60 PLHIV gathered at the Global Consultation on Sexual and Reproductive Health and Rights (SRHR) of PLHIV²⁸ held in Amsterdam, Netherlands, from 5 – 7

²⁵ Zimbabwe Criminal Law Codification and Reform (CAP 9:03sect 79)

79. Deliberate transmission of HIV

(1) Any person who

(a) knowing that he or she is infected with HIV; or

(b) realizing that there is a real risk or possibility that he or she is infected with HIV;

intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realizes involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person, and shall be liable to imprisonment for a period not exceeding twenty years.

(2) It shall be a defense to a charge under subsection (1) for the accused to prove that the other person concerned

(a) knew that the accused was infected with HIV; and

(b) consented to the act in question, appreciating the nature of HIV and the possibility of becoming infected with it.

²⁶ See Political Declaration on HIV/AIDS (2006) article 11, 15,20,24 and 49

²⁷ Technical Policies of the UNAIDS Programme. Meeting the sexual and reproductive health needs of People Living with HIV. (http://www.gutmacher.org/pubs/IB_HIV.pdf)

²⁸ Organised by GNP+, ICW and Young Positives, and held in Hotel Arena, Amsterdam, Netherlands, from 5 – 7 December 2007.

December 2007, to bring the GIPA Principle directly to bear on SRHR issues in areas of advocacy, legal and policy issues, and health systems.

47. Participants emphasized their rights to "...fully enjoy sexual and reproductive health and rights, including the enjoyment of sexual pleasure, and to enjoy the freedom of choice regarding reproduction, marriage and family planning,"²⁹ and emphasized that the SRHR needs of PLHIV are not being addressed.
48. Finding ways to provide integrated services for PLHIV is challenging in fragile health care systems, but nonetheless important in meeting the needs of PLHIV. Bridging the divide between sexual and reproductive health of everyone PLHIV or not is important in achieving universal access to prevention, treatment, care and support.

UNAIDS GUIDANCE NOTE ON SEX WORK

49. Following the UNAIDS Guidance Note on HIV and Sex Work was released in April 2007, there has been extensive criticism from networks of sex workers and sex work projects from across the world due to the undermining of a human rights based approach and the promotion of repressive approaches to sex work and HIV, which are known to have an adverse impact on working conditions, and increasing stigma surrounding sex work.
50. The 20th PCB meeting recommended "UNAIDS to continue consultation with relevant stakeholders, including affected groups, in developing this guidance."
51. While this guidance is still being developed, it is urged that the consultation with networks of sex workers and sex projects and the effectiveness of the approaches outlined in the guidance note be documented. It is recommended that UNAIDS **will** (text clarification issue: guidance note is not yet finalized and out) monitor and evaluate the implementation of the Guidance Note in consultation with sex workers to ensure the development and maintenance of an enabling environment that respects the rights of sex workers, and which promotes and supports their empowerment are given equal attention and resources among other priorities.

Therefore, the UNAIDS PCB NGO delegation recommends that the PCB take the following decision and requests UNAIDS to monitor and evaluate the implementation of the Guidance Note on HIV and Sex Work(same comment as above as the guidance is not yet finalized- One suggestion is that "PCB report back on this in next PCB" in consultation with the Global Working Group on HIV and Sex Work Policy, and networks of sex workers to ensure that the development and maintenance of an enabling environment that respects the rights of sex workers and which promote and support their empowerment, are given equal attention and resources among other priorities.

²⁹From the draft report of the Global Consultation on Sexual Reproductive Health and Rights meeting of PLHIV.