May 2010

**Re: Report of the Law Commission on the Development of HIV and AIDS Legislation**

Dear Members of the Legal Affairs Committee:

The Canadian HIV/AIDS Legal Network (Legal Network) is Canada's leading advocacy organization working on HIV-related legal and human rights issues and one of the world's leading organizations in this field. The Legal Network has more than 16 years of experience in legal and policy research and analysis, in Canada and internationally. It has been consulted regularly by community-based organizations and governments, and has provided technical advice on HIV-related legal and human rights issues to United Nations agencies, including the Joint United Nations Programme on HIV/AIDS. The Legal Network is a non-governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations.

The International Community of Women Living with HIV/AIDS (ICW-Global) is the only international network, run for and by HIV-positive women, with over 9000 members in 134 countries. It was established as a response to the desperate lack of support, information and services available to women living with HIV worldwide and the lack of influence and input they had on policy development. ICW-Global now campaigns to promote gender equity, access to care and treatment, sexual and reproductive rights and meaningful involvement of HIV-positive women at all levels of decision making affecting our lives.

Enclosed are comments on the December 2008 *Report of the Law Commission on the Development of HIV and AIDS Legislation*. The Legal Network appreciates the opportunity to submit comments to the Legal Affairs Committee on this Report. We hope that our comments will assist the Committee in its work finalizing the *HIV and AIDS (Prevention and Management) Bill* in a manner that fully respects, protects and fulfills the human rights of all persons in Malawi.

Yours sincerely,

Sandra Ka Hon Chu
Senior Policy Analyst, Canadian HIV/AIDS Legal Network

Beri Hull
Global Advocacy Officer, International Community of Woman Living with HIV/AIDS

Maeve McKean
Legal Fellow, International Community of Woman Living with HIV/AIDS

Aziza Ahmed
Advisor on Human Rights, International Community of Woman Living with HIV/AIDS

Ruth Morgan Thomas
Interim Global Coordinator, Global Network of Sex Work Projects

## Comments on the Report of the Law Commission on the Development of HIV and AIDS Legislation

### Introductory Comments

In effective responses to the HIV epidemic, health and human rights are fundamentally linked. When human rights are not respected, HIV prevention efforts are hindered and the impacts of the epidemic on individuals and communities are exacerbated. Given the rapid spread of the virus and the vital importance of implementing effective prevention, care, treatment and support activities, a comprehensive and rights-based framework of laws is essential. Therefore, the Malawi government and the civil society organizations which participated in the development of the *Report of the Law Commission on the Development of HIV and AIDS Legislation* [hereinafter, the Report] should be commended for their actions, including their commitment to preventing discrimination against people living with HIV and to providing free HIV-related medication. However, as discussed throughout this paper, there are fundamental flaws with the *HIV and AIDS (Prevention and Management) Bill* [hereinafter, the Bill] that may both limit its effectiveness and result in human rights violations.

As you shall see, our commentary on the Report and accompanying Bill are informed by international human rights law and policy.[1] We have chosen to restrict our comments to several key issues of concern with respect to the Report and Bill, namely: gender and women's rights, disclosure and privacy, HIV testing, and reckless, negligent and deliberate HIV exposure and transmission. We have also restricted our comments to the proposed legislative provisions, and do not offer commentary on the discussion portions of the Report, noting however that the proposed provisions do not always correspond directly to the commentary and additional issues with potential human rights implications are raised in the commentary sections of the Report.

### Comments on Specific Provisions

#### *Gender and Women's Rights*

We commend the Commission on its acknowledgment of the socio-economic dimensions of the epidemic, including gender-specific vulnerabilities to and impacts of HIV/AIDS. Moreover, we welcome the proposed prohibition of harmful practices that expose individuals—particularly women—to the risk of HIV infection and restrict their rights and autonomy (Article 4) and the proposed provision of paid "compassionate leave" for parents or spouses caring for those living with HIV (Article 33).

---

[1] Much of the spirit and the content of these comments on the Report is derived from applicable international human rights law, as well as the United Nations General Assembly *Declaration of Commitment on HIV/AIDS*, adopted by General Assembly resolution S-26/2 of 27 June 2001, UNAIDS/OHCHR *International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version*, [hereinafter, *International Guidelines*] and UNAIDS/IPU *The Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999 [hereinafter, *Legislator's Handbook*].

We note, however, that the proposed legislation could be improved by including provisions that address other social, cultural, economic and legal factors that render women more vulnerable to HIV infection and aggravate the impact of the disease. For example, in discussing "HIV and AIDS as an Economic Issue," no reference is made to the fact that women shoulder the greater burden of caretaking in families that are affected by HIV/AIDS. Moreover, the *International Guidelines on HIV/AIDS and Human Rights* [hereinafter, *International Guidelines*] highlight the need for legislation addressing discrimination and violence against women. Guideline 8 of the *International Guidelines* ("Women, children and other vulnerable groups") provides:

> Violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated. Positive measures, including formal and informal education programmes, increased work opportunities and support services, should be established…. States should support women's organisations to incorporate HIV/AIDS and human rights issues into their programming…. States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimise that risk, or to proceed with childbirth, if they do so choose.[2]

While the Commission acknowledges social, cultural, economic and legal factors such as the minimum age of marriage and property dispossession in its commentary, the Bill does not feature provisions regarding, for example, domestic violence, women's access to marital property, the minimum age of marriage or women's access to sexual and reproductive health education. In particular, a robust and coordinated national effort to address the causes and consequences of HIV will require that the Bill also address gender-based violence. While gender-based violence is an epidemic in itself, as up to 70 per cent of women experience violence in their lifetime,[3] women who have experienced violence have a risk of contracting HIV that may be up to three times higher than those who have not.[4] This is both because the virus's transmission is more likely during forced intercourse and because violence and fear of violence often prevent women from negotiating safe sex.[5] Violence against women is not only a key driver of the epidemic, but often a consequence of becoming infected.

We note that some of the issues pertaining to gender and women's rights may already be addressed in other legislation (such as Malawi's *Prevention of Domestic Violence Act*), but given their cross-cutting nature, reference to existing provisions, or the inclusion of such provisions in the Bill, would more effectively reinforce the need for coordination in the implementation and enforcement of such provisions. Above all, addressing gender-

---

[2] *International Guidelines*, para 9.

[3] WHO and UNAIDS Global Coalition on Women and AIDS, *Violence Against Women and HIV/AIDS: Critical Intersections Intimate Partner Violence and HIV/AIDS Information Bulletin Series, Number 1*, 2004

[4] WHO and UNAIDS Global Coalition on Women and AIDS, *Stop Violence Against Women, Fight AIDS, Issue 2*, 2005, citing amfAR, "Gender-Based Violence and HIV Among Women: Assessing the Evidence," Issue Brief no. 3, June 2005. Online: http://data.unaids.org/Publications/IRC-pub07/jc1184-stopviolence_en.pdf.

[5] Human Rights Watch, *Just die quietly: Domestic violence and women's vulnerability to HIV in Uganda*, 2003.

based violence in the Bill confirms the Government of Malawi's appreciation of the linkages between gender-based violence and HIV.

***Disclosure and Privacy***

The privacy rights of persons living with HIV are extremely important. Stigma and discrimination against people living with HIV impede the ability of many HIV-positive people to disclose their HIV status. For women in particular, confidentiality of medical information (including HIV status) is essential to the protection of their human rights, because women may find themselves abandoned, subject to domestic violence, ostracized, or blamed for the spread of the virus if their domestic partners, spouses, families or communities discover their HIV status. Protection of the right to privacy is also vital to enable women to consent to HIV tests and treatment for themselves and their children without fear of their domestic partners' or spouses' reactions, particularly if these reactions are physically violent.[6] Research from Africa indicates that the fear of disclosure of HIV status is one of the main barriers to women's use of voluntary counseling and testing services, and that this fear "reflect[s] the unequal and limited power that many women have to control their risk for infection."[7]

Moreover, because of the stigma and shame that are still too often associated with a diagnosis of HIV infection, protecting the privacy of persons living with HIV is essential in order to protect them from discrimination and enable them to access employment, housing and services. The strong wording proposed in Part V of the Bill ("Disclosure of HIV and AIDS Information") protecting the right of a person living with HIV to privacy and confidentiality with regard to information concerning his [or her] state of health is therefore welcomed.

However, this Part features several broad exceptions. For example, Article 10 of the Bill permits a health service provider to disclose one's HIV status, where he [or she] reasonably believes that it is medically appropriate, to "any person he reasonably believes has been or will be exposed to the risk of infection in the course of his duties or emergency services" or "the spouse or the sexual partner of the infected person."
With respect to partner notification, the *International Guidelines* recommend voluntary partner notification, but with provision for exceptional circumstances. According to the *International Guidelines*:

> Public health legislation should authorize, but not require, that health-care 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. Such a decision should only be made in accordance with the following criteria:
>
> - The HIV-positive person in question has been thoroughly counselled;

[6] UNAIDS and WHO, *Violence against Women and HIV/AIDS: Critical Intersections*, undated. Online: www.who.int/gender/violence/en/vawinformationbrief.pdf.
[7] S. Maman et al, "Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counseling and testing," *AIDS Care*, Vol. 13, No. 5, p. 601.

- 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.[8]

According to *The Handbook for Legislators on HIV/AIDS, Law and Human Rights* [hereinafter, "*Legislator's Handbook*"], "[i]t is recognized that coercive strategies are inappropriate, ineffective and counter-productive because they deter those at risk of infection from presenting early for counselling, testing, treatment and support."[9]

We would therefore encourage the Commission to revise the proposed disclosure provisions to better protect the rights of persons living with HIV. In particular, there should be a requirement that, prior to breaching the confidentiality of a person living with HIV by disclosing his or her HIV infection to a third party, a health service provider should "reasonably believe" not only that the individual's behaviour puts another person at risk of infection, but that, as stipulated above: (i) in the case of a spouse or sexual partner, he or she has been thoroughly counselled and the person has not altered his or her behaviour; (ii) the risk to another person is a serious or significant risk in the circumstances; (iii) the HIV-positive individual is given reasonable advance notice; (iv) the identity of the person living with HIV is concealed from the individual at risk of infection, if this is possible in practice; and (v) follow-up is provided to ensure support to those involved. Article 10 would also benefit from including explicit requirements that (1) before breaching confidentiality, a health service provider make reasonable efforts to convince the person perceived to be at risk to seek information about HIV and HIV testing, preserving to the extent possible the anonymity of the person living with HIV and (2) in cases involving domestic violence, health service providers should never be authorized to notify a spouse or sexual partner on a woman's behalf, thereby placing her well-being and life at great risk.

Article 11 of this Part also permits disclosure of an individual's HIV-positive status where he or she consents to such disclosure, and subsequently provides that where he or she is "unable to give consent," the consent of a parent, legal guardian, immediate family member or health service provider may be substituted. Conceivably, a woman in labour or a person living with a disability may be deemed to be "unable to give consent" and may thus no longer benefit from the confidentiality guarantees afforded elsewhere in the Bill. We are concerned that this provision is overbroad and may lead to violations of the rights of women, people living with disabilities and others.

[8] *International Guidelines*, Guideline 3(g).
[9] *Legislator's Handbook*, pg. 45.

***HIV Testing***

The Report includes an extensive discussion of HIV testing issues and recommends compulsory testing of persons charged with sexual offences, sex workers, persons in polygamous unions, pregnant women and their sexual partners or spouses, and donors of blood and tissue. HIV testing without consent, however, is almost never justified. Because of the invasive nature of compulsory HIV testing, this practice violates fundamental rights to the security of the person[10] and the highest attainable standard of physical and mental health[11] protected by international treaties to which Malawi is a party. Moreover, by distinguishing between certain population groups and the community in general, provisions of the laws permitting compulsory testing may in some cases unjustifiably violate the principle of non-discrimination.

Targeted testing exacerbates stigma and discrimination against already marginalized groups and may result in their scapegoating. Forced testing of sex workers, for example, has often led to their degrading treatment by state officials, including health service providers.[12] This may in turn lead to the redirection of scarce government and other resources from community-wide treatment, care and prevention efforts, which would have a disproportionate impact on groups with traditionally higher rates of HIV, such as sex workers. Furthermore, where police extortion and abuse of sex workers are frequent, compulsory testing or the threat thereof gives more leverage to police to commit such abuses, since a positive HIV test result often has punitive consequences for sex workers, again rendering them more vulnerable to police corruption and abuse.[13]

Not only are compulsory testing provisions for certain population groups discriminatory, but could undermine the health of third parties, which is the Commission's stated rationale of such testing. Compulsory testing of pregnant women, for example, potentially exposes women to the risk of intimate partner violence and abandonment by male partners, especially when there is the likelihood that health service providers will disclose women's HIV status to sexual partners. Compulsory testing of sex workers has also been found to impede sex workers' ability to enforce condom use with clients who

---

[10] Article 9 of *International Covenant on Civil and Political Rights* (ICCPR), adopted December 16, 1996, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, acceded to by Malawi on 22 December 1993.

[11] Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), adopted December 16, 1996, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, acceded to by Malawi on 22 December 1993 and Article 16(1) of the *African Charter on Human and Peoples' Rights* (African Charter), adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986, ratified by Malawi on November 17, 1989.

[12] Submission from Sex-Workers Forum of Vienna to the United Nations Committee Against Torture pertaining to Austria's 5th periodic report CAT/C/AUS/4-5 at the 44th session (26 April to 14 May 2010), 19 February 2010. Online: www.sexworker.at/sexworker_uncat.pdf

[13] Center for Advocacy on Stigma and Marginalization (CASAM), *Rights-Based Sex Worker Empowerment Guidelines: An Alternative HIV/AIDS Intervention Approach to the 100% Condom Use Programme*, July 2008 and A. Crago, *Arrest the Violence: Human Rights Abuses Against Sex Workers in Central and Eastern Europe and Central Asia*, Sex Workers' Rights Advocacy Network in Central and Eastern Europe and Central Asia, November 2009.

believe that routine testing means that they are HIV-negative.[14] Compulsory testing of pregnant women and sex workers will also impede HIV treatment and care by creating an antagonistic relationship between health care providers and women; women will be less likely to access such treatment and care if they are compelled to undergo HIV testing and have their HIV status involuntarily disclosed. And in all cases involving compulsory testing, misinformation about one's HIV status could arise if a test is conducted during the "window period" of HIV infection. In the case of compulsory testing of persons charged with sexual offences, this could undermine rape survivors' ability to make informed decisions about their health by providing misinformation about alleged offenders' HIV status. Because of a false negative HIV test of an accused, a survivor might not be inclined to obtain HIV post-exposure prophylaxis. Similarly, a false negative HIV test in the context of polygamous unions could deter polygamous spouses from using condoms, inadvertently increasing their vulnerability to HIV infection.

The recommendations in the Report to allow HIV testing as a pre-condition for employment in certain situations (described in Article 28) should also be reconsidered. Such tests could result in discrimination and could constitute a violation of the prospective employee's right to privacy, while offering little, if any, indication of one's "fitness to serve" and little, if any, public health benefit.

The *International Guidelines* state that "[p]ublic health, criminal and anti-discrimination legislation should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups" such as women and sex workers.[15] The UNAIDS/WHO policy statement on HIV testing clearly states:

> The conditions of the '3 Cs', advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be:
>
> - Confidential;
> - Be accompanied by counseling;
> - Only be conducted with informed consent, meaning that it is both informed and voluntary.
>
> UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals.[16]

According to the WHO, compulsory testing of particular population groups can damage efforts to prevent HIV transmission—and is thus not in the interest of public health—for the following reasons:

- Because of the stigmatization and discrimination directed at people living with HIV, individuals who believe they might be living with the disease tend to go

[14] Submission from Sex-Workers Forum of Vienna to the United Nations Committee Against Torture, supra.
[15] *International Guidelines*, para 30(j).
[16] UNAIDS and WHO, *Policy Statement on HIV Testing*, 2004, p 2.

"underground" to escape mandatory testing. As a result, those at highest risk for HIV infection may not hear or heed education messages about AIDS prevention;
- Testing without informed consent damages the credibility of the health services and may discourage those needing services from obtaining them;
- Mandatory testing can create a false sense of security especially among people who are outside its scope and who use it as an excuse for not following more effective measures for protecting themselves and others from infection;
- Mandatory testing programmes are expensive, and divert resources from effective prevention measures.[17]

While we applaud the proposed provisions explicitly prohibiting compulsory and mandatory HIV testing and requiring health service providers carrying out HIV tests to conduct free pre- and post- test counselling, we recommend that the exceptions to compulsory and mandatory testing stipulated in Articles 19(2) and Article 28 be removed from the Bill.

Finally, Article 15 permits HIV testing of another person when he or she "has a disability by reason of which he appears incapable of giving consent," as long as the consent of a legal guardian, partner or spouse, or immediate family member is provided. This provision fails to provide a clear definition of what constitutes being "incapable of giving consent", thus giving unfettered discretion to a health service provider to determine an individual's ability to consent to testing. As with Article 11 of the Bill, we are concerned that this provision is overbroad and may lead to violations of the rights of person living with disabilities and others.

***Reckless, Negligent and Deliberate HIV Exposure and Transmission***

Article 43 of the Bill criminalizes a person who knows he or she is HIV-positive and does an act or omits to do an act "which is likely to transmit or spread HIV to another person" unless, before the act or omission takes place, the other person "has been informed of the risk of contracting HIV from him or her" and "has voluntarily agreed to accept that risk." Those contravening this Article face five years' imprisonment. Without defining an act (or the omission of one) "which is likely to transmit or spread HIV to another person," an HIV-positive person who takes all the available precautions may still be criminally liable for the mere risk of HIV transmission. This provision may also have a disproportionate impact on women, especially those in abusive relationships, who may not be in a position to "voluntarily" accept the risk of HIV infection, though their male partners may claim this to be the case and consequently escape prosecution.

For those who "deliberately" infect another person with HIV, Article 44 imposes a lengthier period of 15 years' imprisonment. For those who "recklessly or negligently" infect another person with HIV, Article 45 imposes a punishment of 10 years' imprisonment. In both provisions, the language is sufficiently vague that knowledge of one's HIV status does not appear to be a necessary condition. This ambiguity may be used to prosecute traditionally marginalized groups who could be deemed to have

[17] WHO, *Statement from the Consultation on Testing and Counselling for HIV Infection*, 1992, at 3–4.

constructive knowledge of their HIV status.

There has been much concern expressed internationally about the desirability of using criminal law to deal with the issue of HIV exposure and transmission, even if there may be some limited situations where it is justifiable to do so. Criminal law is generally viewed as "a blunt instrument that can neither adequately capture the complexity of the contexts in which HIV transmission occurs nor deal effectively with matters such as the relative probability of transmission."[18]

The *International Guidelines* recommend to States that:

> Criminal and/or public health should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application 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.[19]

In a more detailed examination of this issue undertaken to guide policymakers in dealing with this difficult and complex issue, UNAIDS has reiterated the recommendation that, if States decide to resort to criminal law to address HIV exposure or transmission, they should not enact HIV-specific legislation, but instead apply general criminal offences.[20] UNAIDS points out that existing offences are likely adequate to deal with such exceptional cases, and that an HIV-specific law is unlikely to have any additional deterrent effect. In a subsequent policy brief on criminalization of HIV transmission, UNAIDS urges government to limit criminalization to cases of intentional transmission, i.e. where a person knows his or her status, acts with the intention to transmit HIV, and does in fact transmit it.[21]

In addition and perhaps most significantly, UNAIDS cautions that enacting HIV-specific legislation contributes to already widespread HIV-related stigma and invites further discrimination against people living with HIV by singling them out as potential criminals. In particular, the criminalization of HIV exposure or transmission can be used to target marginalized communities including women and sex workers whose ability to negotiate condom use or take other precautions against HIV exposure or transmission may be hindered. The Inter-Parliamentary Union (IPU) has joined with UNAIDS in recommending that lawmakers avoid enacting HIV-specific criminal legislation, and further recommends that "[p]unishment under the criminal or public health law should be reserved for the most serious culpable behaviour."[22] In those cases where a new offence is created, they have recommended that "the coverage of the legislation should be limited to deliberate or intentional acts."[23]

---

[18] WHO Europe, *WHO technical consultation in collaboration with European AIDS Treatment Group and AIDS Action Europe on the criminalization of HIV and other sexually transmitted infections* (Copenhagen, 16 October 2006), p. 3, accessible at: www.euro.who.int/Document/SHA/crimconsultation_latest.pdf.
[19] *International Guidelines,* Guideline 4, para. 21(a).
[20] *Criminal Law, Public Health and HIV Transmission*, pp. 30–32.
[21] UNAIDS, *Policy brief, criminalization of HIV transmission*, August 2008.
[22] *Legislator's Handbook,* p. 51.
[23] Ibid.

Moreover, while the Commission's intention to apply criminal law to HIV exposure and transmission may be driven by a well-intentioned wish to protect women and to respond to serious concerns about the ongoing rapid spread of HIV in Malawi, applying criminal law to HIV exposure or transmission does nothing to address the epidemic of gender-based violence or the deep economic, social, and political inequalities that are at the root of women's and girls' disproportionate vulnerability to HIV. On the contrary, applying criminal law to HIV exposure or transmission is likely to heighten the risk of violence and abuse women face, since women are typically blamed for introducing HIV/AIDS into families and relationships; strengthen prevailing gendered inequalities in healthcare and family settings; further promote fear and stigma against people living with HIV; increase women's risks and vulnerabilities to HIV and to HIV-related violations of rights, and result in the disproportionate prosecution of women, since they are more likely to be tested for and thus know their HIV status, either through routine gynecological exams or antenatal care.[24]

In light of these recommendations, we urge the Commission to reconsider its proposed approach of applying criminal liability broadly for exposure to, or transmission of, HIV.

***Criminal penalties***

We commend the Law Commission for prohibiting harmful practices, discrimination, non-consensual disclosure of HIV status and compulsory testing, and for discouraging the dissemination of "false or inaccurate" information about HIV/AIDS. However, the imposition of a fine and imprisonment as penalties for offences related to these acts may be excessively harsh in some situations, and civil remedies may be a more appropriate form of redress and of greater social benefit. For instance, to require a person to perform community service at a local AIDS organization or contribute an article to the local media about an issue related to the offence could be of greater educational value than incarceration.

For example, Article 26 of the Bill criminalizes a person "who gives or publishes false or inaccurate information concerning HIV and AIDS to any person or the public" with the imposition of a fine and five years' imprisonment. Article 27 of the Bill also imposes a fine and five years' imprisonment on those who give or publish information on HIV and AIDS "which is not accredited by the [National AIDS] Commission". Although greater regulation of unsubstantiated claims of HIV cures is necessary, this provision is overly broad and could be potentially applied to prosecute, for example, AIDS-service organizations engaged in public education campaigns not accredited by the Commission, or persons disseminating scientific findings which lack wide scientific consensus.

[24] ATHENA Network, *10 reasons why criminalization of HIV exposure or transmission harms women,* 2009. Online: www.reproductiverights.org/en/document/10-reasons-why-criminalization-of-hiv-exposure-or-transmission-harms-women

As such, we recommend a review of all the criminal penalties imposed in the Bill and suggest the imposition of civil remedies for some prohibited practices, as well as a revision of the broad definition of some of the activities being criminalized, especially those related to the dissemination of HIV-related information.