JAMAICA COALITION
FOR A HEALTHY SOCIETY

JCHS Policy Brief # 1- 2015

JCHS Response to the PANCAP Declaration

'Getting to zero discrimination through Justice for All'

February 26, 2015

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Contact:
The Jamaica Coalition for a Healthy Society (2012) is a local family advocacy NGO, defending the sanctity of life, family and true fundamental rights and freedoms.

Philippa Davies
Advocacy Officer
Email: jchsadvocate@gmail.com
Website: www.jchs.org.jm

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PREAMBLE

The Pan Caribbean Partnership against HIV and AIDS (PANCAP) is a regional umbrella entity overseeing national HIV programmes. It was launched in 2001 through the Declaration of Commitment to the Pan Caribbean Partnership against HIV and AIDS (PANCAP) by the Heads of State and Governments of the Caribbean Community (CARICOM).

PANCAPs "**Justice for All"** programme is specifically designed to achieve one of the goals of the "United Nations High Level Meeting Political Declaration (2011)" which is to "*eliminate stigma and discrimination against people living with HIV by 2015 and to uphold the human rights and dignity of all*." In furtherance of this goal, the **PANCAP Declaration '*Getting to zero discrimination through Justice for All'*** outlines certain actionable recommendations. These have been detailed in an accompanying **Roadmap,** issued in April 2014 at a regional consultation in Jamaica. The Declaration and Roadmap are attached at Appendices 'A' and 'B'.

These documents were presented to the Heads of Government of CARICOM in July 2014 as the supposed outcome of national and regional consultations with various stakeholders - parliamentarians, youth, judiciary, civil society and faith based organisations (FBO's). The national FBO consultation held in Jamaica on March 17, 2014 gave rise to several concerns. The participants in the consultation did not fully represent this stakeholder group, and the presenters and facilitators tried to force pre-determined conclusions on the participants during the group discussions (such as protecting sexual orientation and repealing buggery laws). The presenters and facilitators also appeared resistant to advance recommendations by the participants that promoted Judeo-Christian principles on sexuality and family life. Notably, participants were promised a continuation of the discussions before any final recommendations would be put to the Heads of Government of CARICOM in July 2014.

These above concerns were documented in a letter dated March 20, 2014 to the Rev. Dr. Marjorie Lewis of the United Theological College, who hosted the consultations. The letter spoke to the need for a clear definition of terms such as 'discrimination' and 'gender'; the rejection of any proposal to remove existing laws that protect the natural family, marriage between one man and one woman, the image of God, children and the fundamental human rights

of Caribbean people; and ensuring the preservation of the rights of FBO's to preach their principles in freedom and truth.

To date, there has been no response to this letter, nor has there been any national agreement on the disputed issues. The Concept Note for the FBO consultation is attached at Appendix 'C' and the letter to Rev Dr Marjorie Lewis is attached at Appendix 'D'.

The PANCAP Declaration and Roadmap were nevertheless issued in April 2014 purporting to reflect a regional consensus despite the absence of agreement. These documents were put to the 35th regular meeting of the Conference of the Heads of Government of the Caribbean Community, held from 1-4 July 2014 at Dickenson Bay in Antigua and Barbuda. A pan-Caribbean rejection of these documents in the form of a Statement supported by 140 CARICOM organisations from 11 CARICOM territories, was communicated to the Heads of Government, through the Secretary-General of CARICOM on June 25, 2015. The Heads of Government decided to 'defer full consideration of the Declaration pending consultations at the national level.' The 140 organisation's Statement and list of signatories is attached at Appendix 'E'.

The Jamaica Umbrella Group of Churches (JUGC) also met with Dr Edward Green, UN Special Envoy to the Caribbean region HIV/AIDS, ahead of the CARICOM meeting. At that meeting, the JUGC registered its objections to the draft PANCAP 'Justice for All' Declaration and Roadmap and requested UNAIDS to provide "operational definitions for the following terms: 1. Stigma and discrimination, 2. Sexual orientation, 3. Sexual and reproductive health and rights and 4. The punitive laws PANCAP would like CARICOM to repeal." According to Dr Green, the JUGC's objections were communicated to the CARICOM Heads at the Antigua meeting. Dr Edward Green also arranged for Ms. Kate Spring, UNAIDS Country Representative to meet with the Jamaica Umbrella Group of Churches (JUGC) and other interested parties. The Jamaica Coalition for a Healthy Society (JCHS) participated in this meeting which took place on July 24, 2014. A copy of the minutes of this meeting is attached at Appendix 'F'.

Subsequent to the meeting, Ms. Spring forwarded to the JCHS and JUGC, a soft-copy of a 2013 UNDP study entitled, '*Legal Reforms, Social Change: HIV/AIDS, Human Rights and National*

Development in Jamaica' which set out the recommended legislative changes to address HIV-related discrimination. Excerpts of this study are later referenced on page 19 of this paper.

The PANCAP Declaration and Roadmap in effect require social acceptance of all intimate (sexual) activity as a primary mechanism for ending HIV/AIDS, despite the fact that these behaviours are high risk. **The JCHS rejects this approach as it is fundamentally flawed** - biologically, medically, socially, philosophically, financially, and legally. This approach has been proven to be unsuccessful[1]**,** and the JCHS therefore offers a more balanced/evidence-based approach which is consistent with standard epidemiological and medical practice.

The following will demonstrate why the claims, objectives and recommendations of the PANCAP Declaration 'Getting to zero discrimination through Justice for All' in combating the HIV/AIDS epidemic process are flawed and why they have failed to curtail the epidemic in some high risk groups.

[1] Consider, for example the case of Massachusetts where, despite liberal sexual laws, the MSM population accounted for 41% of all new HIV diagnoses between 2009-2011. www.**mass**.gov/eohhs/docs/.../**aids**/.../epidemic-glance-data. The Centers for Disease Control (CDC) report that although MSM represent about 4% of the male population in the United States, in 2010, this group accounted for 78% of new HIV infections among males and 63% of all new HIV diagnoses *in the U.S. http://www.cdc.gov/hiv/statistics/basics/ataglance.html.*

EXECUTIVE SUMMARY

This document brings to the attention of Caribbean policy makers and the public the facts pertaining to the origin of the HIV-1 & HIV-II lentiviruses that are responsible for the AIDS epidemic, the nature of the virus and the challenges presented in the development of a vaccine. With reference to well respected medical research it posits the view that behavioural change in sexual behaviour is by far the most pragmatic way of successfully addressing the contraction and transmission of HIV/AIDS in our developing societies.

It also highlights the increased vulnerability of "men who have sex with men" (MSM) to infection with the HIV virus due to the high per act rate of transmission of the virus in unprotected receptive anal penetration and the ability of men to play either role (role reversal) in the act of buggery. These two factors are reported to account for 98% of the difference of HIV rates between MSM and the heterosexual population.[2]

Highlighting the conflict created for epidemiological practice by the concept of "sexual rights" as articulated in the Yogyakarta Principles, this document refutes the philosophical approach of the PANCAP Declaration which it considers to be fundamentally flawed It shows how the Declaration mirrors the Yogyakarta Principles in so much that "sexual rights" are given tacit precedence over standard medical practice and fundamental human rights of freedom of speech, freedom of conscience and religious liberty in the proposed formulation of public policy. The document firmly asserts that with regards to HIV control, Caribbean **public policy should be informed by factual statistics on public health data.** It shows the sound logic of actively discouraging, at a regional level, **behaviours that have been established as harmful and destructive through findings of robust, credible, scientific and epidemiological research.**

The document concludes that the PANCAP Declaration and the Yogyakarta Principles are both informed by the fallacious concept that sliding scale sexual orientation and gender fluidity are normal. It points out that this erroneous concept - denying as it does, both anatomy and

[2] "Global epidemiology of HIV infection in men who have sex with men", Chris Beyrer et al. *Lancet Special Issue on HIV in Men who have Sex with Men (MSM) July 2012, Summary Points for Policy Makers,* July 2012

physiology - constitutes the fundamental issue that Caribbean societies must consider and address in an open and transparent manner since its implications are profound and far reaching. The recommendation is that public policy be based on evidence derived from sound research in all relevant disciplines and that the Caribbean provide leadership in reducing HIV by adhering to sound epidemiological practices.

HISTORY OF THE HIV/AIDS EPIDEMICS

The following are duly referenced excerpts from the medical literature.

1.'**Origins of HIV and the AIDS Pandemic', Paul M. Sharp and Beatrice H. Hahn**[3]

"Acquired immunodeficiency syndrome (AIDS) of humans is caused by two lentiviruses, human immunodeficiency viruses types 1 and 2 (HIV-1 and HIV-2). Both HIVs arise from multiple cross species transmissions of simian immunodeficiency viruses (SIVs) which naturally infect African primates. Most of these transfers resulted in viruses with limited effect on human beings. However, one transmission event, involving SIVcpz from chimpanzees in southeastern Cameroon, gave rise to HIV-1 group M—the principal cause of the AIDS pandemic.

Acquired Immune Deficiency Syndrome (AIDS) was first recognized as a new disease in 1981 when increasing numbers of young homosexual men succumbed to unusual opportunistic infections and rare malignancies.

A retrovirus, now termed human immunodeficiency virus type 1 (HIV-1), was subsequently identified as the causative agent of what has since become one of the most devastating infectious diseases to have emerged in recent history. HIV-1 is transmitted by sexual, percutaneous, and perinatal routes (Hladik and McElrath 2008; Cohen et al. 2011); however, 80% of adults acquire HIV-1 following exposure at mucosal surfaces, and AIDS is thus primarily a sexually transmitted disease.

Since its first identification almost three decades ago, the pandemic form of HIV-1, also called the main (M) group, has infected at least 60 million people and caused more than 25 million deaths . Developing countries have experienced the greatest HIV/AIDS morbidity and mortality, with the highest prevalence rates recorded in young adults in sub-Saharan Africa…" It has been reported that the Caribbean has the second highest prevalence rate after sub-Saharan Africa.

"*Although antiretroviral treatment has reduced the toll of AIDS- related deaths, access to therapy is not universal…"* Therapy is extremely expensive, and prospects for an effective vaccine are uncertain. Despite the global decrease of HIV related deaths, the epidemics have

[3] Cold Spring Harb Perspect Med. Sep 2011; 1(1): a006841. doi: 10.1101/cshperspect.a006841.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3234451/

been increasing in certain high risk populations over the last 2 decades. "***Thus AIDS, will continue to pose a significant public health threat for decades to come."***

THE HUMAN IMMUNODEFICIENCY VIRUS (HIV VIRUS)

The Human Immunodeficiency Virus (HIV Virus), Paul M. Sharp and Beatrice H. Hahn[4]

"HIV-1 is not just one virus, but comprises four distinct lineages, termed groups M, N, O, and P, each of which resulted from an independent cross-species transmission event. Group M was the first to be discovered and represents the pandemic form of HIV-1; it has infected millions of people worldwide and has been found in virtually every country on the globe.

Group O was discovered in 1990 and is much less prevalent than group M (De Leys et al. 1990; Gurtler et al. 1994). It represents less than 1% of global HIV-1 infections, and is largely restricted to Cameroon, Gabon, and neighboring countries (Mauclere et al. 1997; Peeters et al. 1997). Group N was identified in 1998 (Simon et al. 1998), and is even less prevalent than group O; so far, only 13 cases of group N infection have been documented, all in individuals from Cameroon (Vallari et al. 2010). Finally, group P was discovered in 2009 in a Cameroonian woman living in France (Plantier et al. 2009). Despite extensive screening, group P has thus far only been identified in one other person, also from Cameroon (Vallari et al. 2011). Although members of all of these groups are capable of causing CD4+ T-cell depletion and AIDS, they obviously differ vastly in their distribution within the human population.

Since its first discovery, HIV-2 has remained largely restricted to West Africa, with its highest prevalence rates recorded in Guinea-Bissau and Senegal (de Silva et al. 2008). However, overall prevalence rates are declining, and in most West African countries HIV-2 is increasingly being replaced by HIV-1 (van der Loeff et al. 2006; Hamel et al. 2007).

Viral loads tend to be lower in HIV-2 than HIV-1 infected individuals, which may explain the lower transmission rates of HIV-2 and the near complete absence of mother-to-infant transmissions (Popper et al. 2000; Berry et al. 2002). In fact, most individuals infected with

[4] Cold Spring Harb Perspect Med. Sep 2011; 1(1): a006841. doi: 10.1101/cshperspect.a006841.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3234451/

HIV-2 do not progress to AIDS, although those who do, show clinical symptoms indistinguishable from HIV-1"

THE ORIGIN OF THE AIDS PANDEMIC

"HIV-1 evolves around one million times faster than mammalian DNA (Li et al. 1988; Lemey et al. 2006), because the HIV-1 reverse transcriptase is error prone and the viral generation time is short (Ho et al. 1995; Wei et al. 1995). This propensity for rapid genetic change has provided a unique opportunity to gain insight into when and where the AIDS pandemic had its origin.

Phylogenetic and statistical analyses have dated the last common ancestor of HIV-1 group M to around 1910 to 1930, with narrow confidence intervals (Korber et al. 2000; Worobey et al. 2008). This indicates that after pandemic HIV-1 first emerged in colonial west central Africa, it spread for some 50 to 70 years before it was recognized. The probable location of the early epidemic has also been identified.

Molecular epidemiological studies have indicated that most, if not all, of the early diversification of HIV-1 group M likely occurred in the area around Kinshasa, then called Leopoldville. All of the known HIV-1 group M subtypes were identified there, as well as additional lineages that have remained restricted to this area (Vidal et al. 2000)."

"HIV-1 group M is currently classified into nine subtypes (A–D, F–H, J, K), as well as more than 40 different circulating recombinant forms (CRFs), which were generated when multiple subtypes infected the same population It has been possible to trace the migration pathways of some of these subtypes and CRFs. For example, subtypes A and D originated in central Africa, but ultimately established epidemics in eastern Africa, whereas subtype C was introduced to, and predominates in, southern Africa from where it spread to India and other Asian countries.

Subtype B, which accounts for the great majority of HIV-1 infections in Europe and the Americas, arose from a single African strain that appears to have first spread to Haiti in the 1960s and then onward to the US and other western countries (Gilbert et al. 2007)

It thus appears that not only the genetic but also the biological diversity of HIV-1 group M subtypes and CRF is increasing."

2. THE VACCINE

A. 'A global approach to HIV-1 vaccine development', Kathryn E Stephenson and Dan H Barouch [5]

"A global human immunodeficiency virus-1 (HIV-1) vaccine will need to elicit durable, potent, and comprehensive immune responses to provide protection against highly diverse HIV-1 variants.

While there are many challenges in HIV-1 vaccine development, a key hurdle is the tremendous genetic diversity of globally circulating strains of HIV-1 . Because of the ability of HIV-1 to evade immune responses through mutational escape, there is constant viral evolution within populations and individual hosts. The genetic diversity of HIV-1 is attributable in part to the low fidelity of its reverse transcriptase, the large number of replication cycles of the virus, the influence of innate and adaptive immune responses, and the ability for HIV-1 to tolerate this diversity.

There are thirteen distinct HIV-1 subtypes and sub-subtypes that are linked geographically or epidemiologically, with within subtype variation of envelope proteins of 15–20%, and between subtype variation of up to 35%. Moreover, there are additional circulating recombinant forms (CRFs) generated from genetic mixing in persons dually infected with different subtypes. HIV-1 also diversifies extensively within each host. For example, Korber et al have demonstrated that the variability of HIV-1 within one host is comparable to the global variation of influenza A.
The tremendous global diversity of HIV-1 poses one of the greatest challenges for the development of an effective global HIV-1 vaccine."

B. 'More surprises in the development of an HIV vaccine'. José Esparza and Marc H. V. Van Regenmortel [6]

"When HIV was discovered and established as the cause of the Acquired Immune Deficiency Syndrome (AIDS) in 1983–1984, there was an expectation that a preventive vaccine would be rapidly developed.

[5] Immunol Rev. Jul 2013; 254(1): 295–304. Published online Jun 16, 2013. doi: 10.1111/imr.12073
[6] Front. Immunol., 14 July 2014 | doi: 10.3389/fimmu.2014.00329 .
http://journal.frontiersin.org/Journal/10.3389/fimmu.2014.00329/full

Vaccines against several major human viral diseases (polio, measles, mumps, rubella, etc.) were successfully developed during the preceding two or three decades, mostly using live-attenuated viruses, and designed to induce the same type of protective immune responses that develop after natural infection. Moreover, recent advances in molecular biology and recombinant DNA technologies were offering exciting new opportunities for vaccine development, first achieved with the licensure in 1986 of a recombinant vaccine against hepatitis B.

Since the use of whole-inactivated or of live-attenuated vaccines was considered too risky for a pathogen such as HIV, the molecular approach was the one selected by early HIV vaccine developers. That decision was also based on the confidence that new knowledge on the structure and function of the virus, as well as of the pathogenesis of the disease, [would have] provided the information needed for the rational development of a much needed HIV vaccine.

In that environment of optimism, the first phase I clinical trials of HIV vaccines started in the United States in 1988. Since then, more than 200 clinical trials have been conducted globally, the majority of them phase I and II trials, to assess the safety and immunogenicity of different vaccine candidates. Those candidate vaccines were developed and tested according to prevailing paradigms that sequentially explored the role of neutralizing antibodies, cell-mediated immunity (CMI) and, more recently, other potential mechanisms of immune protection.

Although much has been learned from those small-scale clinical trials, the results from phase IIb/III efficacy trials are the ones that have driven major changes on how HIV vaccine research is advanced. Those trials have also given us a few surprises. Fortunately, the field has been able to learn from those lessons and steadily move forward.

Perhaps the first major surprise was when in 1994, we [researchers] learned that field isolates of HIV were more difficult to neutralize in vitro than laboratory-adapted strains, and that proposed existing candidate vaccines could not induce the appropriate type of neutralizing antibodies, a problem that we (researchers) are still struggling to solve. Nevertheless, in the early 2000s, two gp120 candidate vaccines from VaxGen were tested in efficacy trials and, as many predicted, they failed to protect. That failure shifted the field to CMI vaccines and to the

suggestion that perhaps ***the best that an HIV vaccine could do is to decrease virus load in vaccinated individuals who became infected."***

3. POPULATIONS AT SPECIAL RISK

- **3.1 Sex workers – UNAIDS Global Report 2013** [7]

The epidemic continues to have a profound effect on female, male and transgender sex workers. Globally female sex workers are 13.5 times more likely to be living with HIV than other women. Median prevalence among male sex workers gleaned from published literature from 24 countries since 2006 is 14%.

- **3.2 Men who have sex with men (MSM)**

A. Lancet Special Issue on HIV in Men who have Sex with Men (MSM) July 2012, Summary Points for Policy Makers

"The Lancet MSM and HIV series show us that HIV epidemics among MSM are fundamentally different from other groups at risk. These differences help explain why HIV epidemics among MSM expanding in low, middle, and high income countries, including the U.S., and why current HIV prevention and treatment programs for MSM are not working as well as they should. Biological, network, and social/structural factors combine for MSM and lead to more rapid and efficient HIV spread in MSM communities—individual risk behaviors for HIV infection contribute only modestly to these dynamics.

B. Global epidemiology of HIV infection in men who have sex with men, Chris Beyrer et al.

- *In 2012, HIV epidemics in MSM are expanding in countries of all incomes. Available incidence data from Thai, Chinese and Kenyan samples of MSM suggest those epidemics are in rapid expansion phases.*
- *HIV infection rates among MSM are substantially higher than those of general population adult males in every epidemic assessed. A comprehensive review of the burden of HIV disease in MSM worldwide found that pooled HIV prevalence ranged from a low of 3% in the Middle East and North Africa to a high of 25.4% of MSM in the Caribbean.*

[7] Page 20

- *Biological and behavioral factors make the dynamics of the MSM epidemic different than for general populations.*
- *The disproportionate HIV disease burden in MSM is explained largely by the high per act and per-partner transmission probability of HIV transmission in receptive anal sex. Modeling suggests that If the transmission probability of receptive anal sex was similar to that associated with unprotected vaginal sex, five year cumulative HIV incidence in MSM would be reduced by 80-90%.*
- *Many MSM practice both insertive and receptive roles in sexual intercourse, which helps HIV spread in this population. Were MSM limited to one role, HIV incidence in this population over five years would be reduced 19-55% in high-prevalence epidemics.*
- *Together, both factors (per act transmission probability and role versatility) account for 98% of the difference between HIV epidemics among MSM and heterosexual populations—behavioral differences account for 2% of the difference.*

C. Urgent need to address "resurgent" gay global epidemic, Professor Kevin Fenton, National Director of Health and Wellbeing at Public Health England, [8]

According to Fenton, *"gay men everywhere have higher rates of HIV than in the general population .It is estimated that the HIV rate in MSM is eight times that of the general population in low-income countries and 23 times the general-population rate in high-income countries."*

[8] http://www.aidsmap.com/page/2805378/

AN EVALUATION OF THE PHILOSOPHICAL APPROACH OF THE PANCAP DECLARATION

The underlying premise of the PANCAP Declaration and Roadmap is a distortion of two legitimate concepts; (i) human rights and (ii) elimination of HIV-related stigmatization and discrimination.

The danger of this distortion is that it exploits the average Caribbean citizen's ordinary interpretation and understanding of these concepts.

Human rights is justifiably understood as restricted to the rights and freedom identified in the Universal Declaration of Human Rights, 1948. The term 'Human rights' is not ordinarily understood to include the right to engage in all kinds of unwholesome behaviour, including sexual behaviour, without limitation. PANCAP, however, is advancing an expanded framework of legitimizing 'rights' to engage in any sexual behaviour of one's choosing, regardless of its consequences, as a civil 'right'. If applied equally to other non-sexual behaviours, such an expanded framework 'would be boundless in scope and harmful to the common good if facilitated by the State and its citizens.

HIV-related stigma and discrimination is commonly presented with a human face, that of the need to interface with persons living with HIV/AIDS with respect and dignity. This is a legitimate goal. **The PANCAP Declaration and Roadmap, however, are promoting the elimination of any stigma and discrimination towards the high risk behaviours that have strong statistical association with HIV/AIDS**. These documents fail to distinguish between the discrimination against people with HIV and discrimination against the behaviours that are high risk for HIV. Ethical behavior towards all human beings is indeed a human right. However, discrimination against behaviour is absolutely essential, and is standard medical practice for disease prevention and control. For example, medical practice encourages discrimination against tobacco smoking in order to prevent and control lung cancer.

Any review of HIV/AIDS statistics will show that:

1. Not all persons living with HIV/AIDS are homosexuals. Heterosexuals represent a larger proportion of the HIV/AIDS community than homosexuals.
2. Not all homosexuals have HIV/AIDS although men who have 'sex' with men (MSM) have higher prevalence rates than any other population group.

However, the PANCAP strategy leverages the moral weight attendant on 'human rights', and the legitimate public health objectives of caring for the sick. This effectively manipulates the sympathies of the Caribbean public and policy makers. Further, scientific data is misrepresented in order to achieve the acceptance of high risk sexual behaviours of a minority (some of whom do not have HIV/AIDS), by exploiting a larger number of persons who actually have the disease.

The fundamental premise of the Declaration and Road Map is therefore flawed, and substitutes ideology for standard epidemiological practice in addressing a public health epidemic. This approach asserts that among fundamental human rights is a right to sex as one chooses or "sexual rights". **Such "sexual rights" do not exist in binding international law.**

THE CONCEPT OF SEXUAL 'RIGHTS'

The concept of 'sexual rights' as human rights, and the accompanying demand that all Governments and international bodies give effect to these claims, is articulated in the *Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity* ('the principles'). These 'principles' were the outcome of a privately convened meeting in 2006 in Yogyakarta, Indonesia, attended by self-selected representatives from various non-governmental organizations and United Nations treaty monitoring committee members who are activists for the lesbian gay, bisexual and transgender community.

The objective of the meeting was to create a framework document projecting a desired revision of established human rights concepts, from the perspective of LGBT interests. Additionally the desired revisions were entitled 'recommendations' to national and international institutions for endorsement and incorporation into their respective legal texts and working policies.

Some of the principles are:

PRINCIPLE 2. The Rights to Equality and Non-discrimination

States are to;

a) Embody the principles of equality and non-discrimination on the basis of sexual orientation and gender identity in their national constitutions or other appropriate legislation …

b) Repeal criminal and other legal provisions that prohibit or are, in effect, employed to prohibit consensual sexual activity among people of the same sex who are over the age of consent, and ensure that an equal age of consent applies to both same-sex and different-sex sexual activity;

c) Adopt appropriate legislative and other measures to prohibit and eliminate discrimination in the public and private spheres on the basis of sexual orientation and gender identity…

f) Take all appropriate action, including programmes of education and training, with a view to achieving the elimination of prejudicial or discriminatory attitudes or behaviours which are related to the idea of the inferiority or the superiority of any sexual orientation or gender identity or gender expression.

PRINCIPLE 12. The Right to Work

a) Take all necessary legislative, administrative and other measures to eliminate and prohibit discrimination on the basis of sexual orientation and gender identity in public and private employment, including in relation to vocational training, recruitment, promotion, dismissal, conditions of employment and remuneration…

PRINCIPLE 16. The Right to Education

d) Ensure that education methods, curricula and resources serve to enhance understanding of and respect for, *inter alia*, diverse sexual orientations and gender identities, including the particular needs of students, their parents and family members related to these grounds…

PRINCIPLE 18. Protection from Medical Abuses

States shall:

a) Take all necessary legislative, administrative and other measures to ensure full protection against harmful medical practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance or perceived gender norms…

PRINCIPLE 19. The Right to Freedom of Opinion and Expression

d) Ensure that notions of public order, public morality, public health and public security are not employed to restrict, in a discriminatory manner, any exercise of freedom of opinion and expression that affirms diverse sexual orientations or gender identities…

PRINCIPLE 27. The Right to Promote Human Rights

Everyone has the right, individually and in association with others, to promote the protection and realization of human rights at the national and international levels, without discrimination on the basis of sexual orientation or gender identity. This includes activities directed towards the promotion and protection of the rights of persons of diverse sexual orientations and gender identities, as well as the right to develop and discuss new human rights norms and to advocate their acceptance…

The ideology articulated in Yogyakarta 'Principles' is reflected in the PANCAP Declaration and Roadmap.

Twenty-nine individuals from 25 countries, not including any Caribbean territory, were signatories to these 'principles'. Among them, however, were known LGBT activists such as Professor Robert Wintemute who delivered lectures at the Law faculties of each of the three UWI campuses in 2014. It must be noted that these 'principles' were neither proposed by nor negotiated among the 192 sovereign states of the world, or by the Member States of any international norm-making forum such as the UN.

The 'principles' have not been formally recognised by the UN General Assembly, nor adopted as binding in any international Treaty or human rights Treaty. In fact, at the 65th sitting of the UN

General Assembly, Third Committee (Social, Humanitarian and Cultural), on 25 October 2010, UN Member States from Africa, CARICOM, Russia and the Organisation of Islamic Conference rejected attempts by a UN Special Rapporteur on Education to promote "controversial notions that do not enjoy universal recognition". The Report of the UN Special Rapporteur on the right to education, July 2010, A/65/162, page 10, paragraph 23, sought to endorse the Yogyakarta Principles, in particular principle 16 proposing that sexual education classes in school be used as 'a basic tool for ending discrimination against persons of diverse sexual orientations.'

Finally, the Yogyakarta 'principles' are neither part of customary international law, common law nor Caribbean law. Caribbean Governments are therefore under no obligation to recognize or adhere to these flawed philosophies which must be wholly rejected.

The sexual 'rights' claims of these 'principles' sanction behaviours which are inimical to good health, under the rubric of human rights. The philosophy at its core denies the presence of design in the universe and the utility of design in serving the common good. For example, the practice of buggery is accepted under these 'principles' yet this act inherently represents a rejection of design and inevitably leads to harmful outcomes. It is therefore understandable that neither the Universal Declaration of Human Rights, 1948, which is considered a constituent document for human rights, nor any UN Treaty, recognizes or mandates the decriminalisation of anal penetration as a human right.

This denial of design was also endorsed by the American Psychiatry Association (APA) when it removed homosexuality from the Diagnostic Statistical Manual (DSM) in 1973 and declared it to be a normal aspect of human sexuality. This was the first occasion and remains the only context in which normality is defined without reference to anatomy and physiology. However, four decades after the APA declared same-sex behaviour to be normal, the scientific data shows that HIV and other sexually transmitted diseases are disproportionately high and increasing among men who have sex with men. This also obtains in countries such the US, France and the UK that do not have 'buggery laws'. The intractable nature of HIV epidemics among men who have sex with men (MSM) is due, at large measure to behaviour which is unique to this community, that is anal penetration and role reversal.

EXPERIENCES IN VARIOUS COUNTRIES

The increasing rates of HIV in the MSM population in countries such as France, USA and in the UK strongly suggest that the association between the decriminalization of anal penetration and reduced rates of HIV is tenuous.

In AIDS Behav. 2011 Apr; 15 Suppl 1:S9-17 entitled **"**Sexual health, HIV, and sexually transmitted infections among gay, bisexual, and other men who have sex with men in the United States" it was stated that, *"The sexual health of gay, bisexual, and other men who have sex with men (MSM) in the **United States** is not getting better despite considerable social, political and human rights advances"*.

The Lancet 2011 [Lancet Infect Dis. 2010 Oct;10(10):682-7. doi: 10.1016/S1473-3099(10)70167-5. Epub 2010 Sep 9.] noted that in **France,** which repealed its buggery law in 1791 and has high quality health care, *"HIV transmission disproportionately affects certain risk groups and seems to be out of control in the MSM population."*

Similarly in the **United Kingdom**, the National Director of Health and Wellbeing, warned in 2013 of "*the increasing and potentially catastrophic HIV epidemic in homosexual men in every part of the world…despite an increasing number of tools to combat HIV infection*". He further stated that, "*it is estimated that the HIV rate in MSM is eight times that of the general population in low-income countries and 23 times the general-population rate in high-income countries… the MSM HIV epidemic was driven by two factors: receptive anal intercourse and promiscuity*." [http://www.aidsmap.com/page/2805378/]

In **Singapore**, which retained its sodomy law for men who have sex with men (MSM) in 2007, the HIV epidemic is classified as low level with a prevalence rate of 2.6% among men who have sex with men. Retention of the sodomy law has not impacted the access to treatment by men who have sex with men. The Singaporean Ministry of Health organises outreach to key risk groups including Men who have sex with Men, Illegal sex workers (street and entertainment based), Inmates and Drug Rehabilitation clients, and Male and Female Migrant workers. The

Government's "*objective is to create an environment in which MSM are empowered to take personal responsibilities to reduce risk behaviours and undergo regular testing*." (UNAIDS Global AIDS Response Progress Reporting (GAPR) 2012, country progress report for Singapore, (3rd May 2012)). **Singapore's intensive outreach programme to men who have sex with men has been unhampered by the sodomy law which is still in force.**

In **Jamaica,** the buggery law has not proved to be a barrier to MSM accessing health care. The Minister of Health, Dr. Fenton Ferguson, publicly stated that "*HIV-infected men who have sex with men (MSM) now experience little or no barrier in accessing services at the island's public health facilities despite Jamaica's stringent buggery laws which criminalizes the practice.*" [Jamaica Observer, May 6, 2014]

It is clear that where laws have been changed and new 'rights' created for homosexuals, the HIV prevalence and incidence have not decreased. This indicates that it is behavioural choice that drives the spread of the HIV and not laws. **There is no international evidence that repealing the buggery law is either necessary or sufficient to reduce HIV/AIDS rates among Men who have Sex with Men.**

SPECIFIC AREAS OF CONCERN regarding the PANCAP Declaration (PCD)

1. The PCD uses certain terms and expressions which are not precisely defined. Such terms include,

a. Stigma
b. Discrimination
c. Sexual Orientation
d. Sexual rights
e. Reproductive rights
f. Normal sexual behaviour
g. Gender equality
h. Gender inequality
i. Discriminatory acts
j. Faith driven stigma and discrimination
k. Age appropriate information on stigma and discrimination
l. Punitive Laws
m. Disability
n. Differently abled

2. The PCD uses vague expressions which lack clear explanation. Such expressions include;

a. *"…commitment to inclusive, respectful and systematic support for partners of Faith and Faith based groups in eliminating faith driven stigma and discrimination…*"
b. *"…changing attitudes and beliefs that help to fuel stigma and discrimination…*"
c. "*demystifying cultural myths that reinforce stigma and discrimination…*"

These terms skillfully harbor hidden philosophical assumptions which are not being articulated. These assumptions must be clearly defined in order to have a transparent and meaningful dialogue. Policy makers would be irresponsible to endorse this document and impose its recommendations on the public without being fully aware of these assumptions.

3. Clarification is required with regard to whether the current laws against incest are among the punitive laws that are recommended for repeal.

4. We urge caution in amending existing equal opportunity acts. We are opposed to the establishment of sexual orientation as a prohibited ground for discrimination in employment. This may have adverse effects on the employer and make the employer(s) potentially vulnerable to abuse and an abrogation of the employer's rights.

5. We warn that the enactment of an overarching Anti-discrimination Act has in other jurisdictions compromised fundamental human rights such as freedom of speech, freedom to act according to conscience, freedom of expression, religious freedom and parental rights. Examples abound in the UK, US, Canada and other Western democracies. We refer to the case of Owen and Eunice Johns heard in the High Court of England in 2010 a copy of which is attached at Appendix 'G'.[9]

In January 2007 the Johns applied to the Derby City council to be approved as foster carers of a Christian child between age 5-7 years. Following their application they were assessed by a social worker. During the assessment the social worker asked about the John's attitude towards a hypothetical case of a child aged 5-8 years who self-identified as 'gay'. While expressing their unconditional love for such a child, the Johns also expressed their inability to affirm homosexuality. As a result of this position they were effectively disqualified and their appeal was disallowed. Mrs. Johns was quoted as saying, "I will love and respect [every child] no matter what sexuality… but I cannot tell a child that it is ok to be a homosexual." The Court upheld the Council's decision and stating *inter alia* freedom of religion provides a qualified right to manifest religious belief and that certain interferences can be justified. "This will be particularly so where a person in whose care a child is placed wishes to manifest a belief that it inimical to the interest of children." The clear inference was that Christian beliefs on homosexuality fell within the category of beliefs that were inimical to the interests of children.

[9] Eunice Johns and Owen Johns v Derby City Council and Equality and Human Rights Commission, 2011 [EWHC]375

For Jamaica, we draw attention to the 2013 UNDP study, 'Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica'. As part of its recommendations to Jamaica to effectively address HIV-related discrimination, the study recommended that Jamaica enact legislation to *punish* HIV-related '*hate speech'*.

Two illustrations of the meaning of 'hate speech' were provided. The first was former Prime Minister Bruce Golding's 2008 comment on BBC Hard Talk that he would not have 'gays' in his Cabinet. The second was a 2013 Gleaner interview with the Chairman of JCHS, Dr Wayne West about the Coalition's media campaign entitled 'Speaking Truth is Not Homophobic'. The relevant excerpts of the study are attached at Appendix 'H' and the Gleaner interview at Appendix 'I'.

It must be pointed out that Mr. Golding's comment was not about persons living with HIV/AIDS but about homosexuals in general. Additionally, the JCHS media campaign cited publicly available medical statistics on the rates of HIV/AIDS among MSMs. The conflation of categories of persons and the labeling as 'hateful', the provision of factual information, is evidence of the flawed and misguided philosophy undergirding the UN's approach to addressing the epidemic. Should such anti-discrimination legislation be enacted as directed by the UN via PANCAP, the ordinary citizen's freedom of conscience, speech, religious freedom and parental rights will be curtailed.

6. We are concerned about the proposed mechanisms for determining what constitutes age appropriate sex education in the HFLE curriculum and training modules for the delivery of HIV and AIDS education activities. These mechanisms need to be transparent and have parental input.

As the Declaration sets the framework for the Roadmap, it would be futile to comment on the Roadmap unless the underlying philosophies are first addressed.

JCHS RECOMMENDATIONS - "GETTING TO ZERO HIV/AIDS"

As was indicated above, the HIV-1 M virus, the agent responsible for the global pandemic mutates frequently, has 4 sub-types and 40 different sub-subtypes. This makes the development of a vaccine challenging and even after 200 clinical trials, no successful candidate has been identified. Considered alteration of behaviour is therefore of fundamental importance to successfully addressing the contraction and transmission of HIV/AIDS in any population.

Public policy should be informed by factual statistics on public health data, particularly by the medical and harmful outcomes of the practice of high risk sexual behaviours to the individual and the society. **Behaviours that have been established as harmful and destructive on the basis of robust, credible, scientific and epidemiological research must be actively discouraged.** In this regard, the active discouragement and prohibition of buggery by way of law, the Offences against the Person Act of Jamaica serves as a guide to society on what should be considered as healthy intimate behaviour and will thereby provide health benefits to those who obey the law.

It is recommended that a public health policy and programme intending to achieve real uplifting societal change, must embody the following elements:

- Affirmation of the inherent dignity of all persons, as bearers of the image of God.
- Practical demonstration of sympathy and care for persons living with HIV/AIDS and a national response which encourages these practices.
- Design and implementation of public education programmes based on Behaviour Change theories that emphasize the importance of creating a social environment that enables the practice of abstinence, delayed onset of sexual activity and mutual fidelity in marriage as critical to a reduction in the incidence of HIV.
- Extensive promotion of the critical importance of responsible sexual behaviour that demonstrates respect for the health and well-being of others.
- Extensive promotion of the transmission of sound values and morally wholesome sex education to children as an integral part of any such national response.
- The retaining of laws that currently exist that protect the structure of the family, marriage between one man and one woman, the image of God, our children and the fundamental human rights of Caribbean people.

- Preserve the fundamental rights and freedoms as currently enshrined in the Jamaican Constitution and the Constitutions of other regional territories, especially the freedom of Faith Based Organizations to teach, preach and practice principles which they hold in good conscience.

The Kingston Declaration which was promulgated on December 2, 2012 comprehensively effectively responds to the false premises, claims and recommendations of the PANCAP Declaration. A copy of the Kingston Declaration is attached at Appendix 'J'.

CONCLUSION

The PANCAP Declaration and the Yogyakarta Principles are both informed by the fallacious concept that sliding scale sexual orientation and gender fluidity are normal. This idea rejects anatomy (form) and physiology (function) as a basis for normality.

This is the fundamental issue that Caribbean Societies must consider and address. The decision must be made in an open and transparent manner, as the implications are profound and far-reaching.

The experience of nations that have embraced the sexual 'rights' philosophy, has seen the suppression of genuine fundamental human rights, in particular the freedoms of conscience, speech and religion and punishment for citizens who disagree with this flawed philosophy.

The actionable recommendations of the PANCAP documents which are substantially informed by the Yogyakarta 'Principles' reflect a blueprint for an extensive public outreach through which the UN and its donors can disseminate a philosophy of sexual 'rights', in Caribbean thought, law and policy. Especially targeted are children and youth who are the next generation of Caribbean citizens and leaders.

The perspective of UNAIDS, the overseeing body for PANCAP is clear as it states that "Homophobia confers a monopoly of normality on heterosexuality, thus generating and encouraging contempt for those who diverge from the reference model"[10]. Thus UNAIDS and PANCAP has declared that all sexual behavior is equal and has ignored the complementarity of male and female form and function.

We reject the PANCAP Declaration, its underlying ideology and its attendant recommendations. Instead, we recommend that public policy be based on evidence derived from sound research in all relevant disciplines and that the Caribbean provide leadership in reducing HIV by adhering to sound epidemiological practices.

[10] UNAIDS OUTLOOK 2010, pge. 123