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President: Mr. Al-Nasser. . . . . (Qatar)

In the absence of the President, Mr. Thomson (Fiji), Vice-President, took the Chair.

The meeting was called to order at 3.05 p.m.

Agenda item 10 (*continued*)

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

Report of the Secretary-General (A/66/757)

Draft decision (A/66/L.49)

Mr. Wetland (Norway): Global trends regarding HIV/AIDS are pointing in the right direction. The scientific achievements have been remarkable, and unique partnerships have been created. While there is room for celebration, there is no room for complacency. We would like to highlight the following elements that need our attention.

We need to work smarter to ensure that the funds available are spent in the best possible way. In particular, that means we must invest where the needs are greatest. The investment framework developed by the Joint United Nations Programme on HIV/AIDS and others is an important tool for that purpose. Particular emphasis must be put on reaching groups that are at a high risk of becoming infected and infecting others, be they migrant workers, persons who sell sex, men who have sex with men, injecting drug users, prisoners or others.

Working smarter also means ensuring that HIV is not addressed in isolation and that synergies are created with other services, such as tuberculosis detection and treatment. Links with other reproductive health services are of particular importance. Preventing infections from mother to child is an important intervention that must be firmly connected to other health services aimed at women and babies. It is discouraging to learn from the Secretary-General's report (A/66/757) that many women are given treatment that is suboptimal for preventing such transmission. We encourage countries to provide dual prophylaxis and to link services closely to antenatal health services.

Facts and figures tell us that proper sexual and HIV education in schools and other venues is important, and also that we should provide youth-friendly access to sexual and reproductive health services. While condoms will never be the single solution to HIV prevention, they are an indispensable part of prevention, and it is therefore discouraging that they are still hard to find in many places. Female condoms are needed to supplement male condoms, and more efforts should be made to develop new generations of such condoms. In HIV prevention and in order to protect public health interests, we must try to reduce the harm done by negative behaviour and practice. Needle and syringe programmes, medically assisted therapy and other such interventions aimed at injecting drug users should be seen as low-hanging fruit that can be implemented regardless of the legal framework for drug use. We have very good experiences in that area in Norway, where we unfortunately have a high

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number of injecting drug users with, happily, very low HIV infection rates in that group.

Sixty per cent of people with HIV infection are girls and women. We also know that gender-based violence correlates with HIV infection and that it is important to counteract it. Gender work is not only for women, it is very important to work with men and boys to change negative notions of masculinity and promote gender equality.

Over the last decade, an incredible increase in resources has been seen through global mechanisms and large donor-driven programmes. Norway contributes around $75 million annually to the Global Fund alone, and that is only a part of our HIV policy. But we are watching carefully. Some so-called recipient countries still spend little of their own budgets in funding HIV efforts. Now it is time that those countries enter into an active partnership, including on the funding side, as a way of developing even more sustainable responses to HIV. If we all work together, in a smarter and more consolidated way, we may in some years be able to find ourselves in a situation where HIV belongs to history.

Mr. García González (El Salvador) (*spoke in Spanish*): Allow me to express the satisfaction of my delegation upon the President's initiative of convening this plenary meeting on the implementation of the Declaration of Commitment on HIV/AIDS (resolution S-26/2, annex) and the Political Declaration on HIV/AIDS (resolution 65/277, annex), particularly at a time when the international community is making significant progress in the containment, treatment and prevention of the pandemic. El Salvador would like to avail itself of this opportunity to thank the Secretary-General and the entire United Nations system for their efforts in fighting this disease, which has taken the lives of thousands of human beings and which represents a collective challenge of an enormous magnitude.

El Salvador has a 0.8 per cent national prevalence of the epidemic. It is concentrated among sex workers, who represent 4.5 per cent, men who have sex with men, 10.8 per cent, and transgender persons, 23 per cent. Over the past three years, we have witnessed a reduction from 6 to 4.5 in new infections each day, as well as in hospital deaths. El Salvador has adopted the strategy called reaching zero, thereby reaffirming its commitment to the 2011 Political Declaration on HIV/AIDS.

In addition, our Government has made a significant effort to fight stigma and discrimination against sectors of the population vulnerable to the epidemic. In 2010, a presidential decree was adopted against stigma and discrimination on the basis of sexual orientation or gender identity. Similarly, in December 2011, in the context of World AIDS Day, an intense public campaign called "Don't label me" was launched with a view to reducing stigma and discrimination against lesbian, gay, bisexual and transgender people and to promoting the use of health services, which are free for the entirety of our population.

The Government of El Salvador has achieved significant progress with regard to the human rights of those living with HIV. For example, we have gradually taken on the purchasing of antiretroviral drugs and the provision of treatment, in accordance with the World Health Organization guidelines. In 2011, for the fifth time, we held the national day for HIV testing, administering more than 88,000 tests in one day alone. We also have special screenings in all the penitentiary facilities in the country. Those who are detained and living with HIV/AIDS receive treatment like any other patient.

At the institutional level, we created a secretariat for sexual diversity and an office for HIV in the office of the Public Defender of Human Rights. Furthermore, we have redoubled our efforts to incorporate sexual education into our school curricula in order to support adolescents and youth in their efforts to make responsible decisions with regard to their sexuality.

With regard to mother-to-child transmission, we have trained health-care workers to promote the prevention of HIV/AIDS in the population in general and particularly among pregnant women. That includes diagnoses that facilitate detection and timely treatment, which have made it possible for us to reduce the transmission of HIV and congenital syphilis. Free antiretroviral therapy is provided to mothers and breast milk is also provided to children of HIV-positive mothers for a full year in order to prevent transmission through breastfeeding. There is also an 18-month period of medical follow-up for those children.

Despite the challenges posed by our vulnerability to climate change and natural disasters, our country has maintained a constant focus on this issue. During the national emergency caused by the tropical storm 12E at the end of 2011, we included the prevention of sexual

abuse and the provision of care for those with HIV as strategic components in the guidelines for managing the shelters. We also established a contingency plan so that no patient would lack antiretroviral medications.

We are also working with the national programme for tuberculosis and cooperative efforts are being undertaken to reduce coinfection. There are two mobile units for HIV testing in areas where there is no clinical facility or among the most vulnerable groups. And since March of this year, a mobile unit has been deployed that takes X-rays and detects cases of tuberculosis.

On the regional and international levels, it is worth pointing out that in 2011 El Salvador was a leader in the presidency of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS, together with Brazil and Mexico, the other members of the Group of Latin American and Caribbean States on the Board. We were able to ensure the issuance of a ministerial declaration by Central American ministers of health in which they reiterated the region's commitment to fighting HIV/AIDS in close cooperation with civil society organizations and the networks of people living with HIV/AIDS. The declaration also called for promoting South-South cooperation and urged donor countries and entities to not punish with budget cuts those countries that have brought about substantive reductions in their epidemics.

On the Central American level, during El Salvador's temporary presidency of the Council of Ministers of Health of Central America and the Dominican Republic, it was noted that the subregion was close to controlling the pandemic and that progress against HIV in the subregion required an additional and sustained effort from Governments and their respective societies in order to not fall behind on the progress achieved. There was also a reaffirmation of the commitment to advance all of the resolutions adopted at the June 2011 High-level Meeting of the General Assembly, as well as of the Central American commitment to strengthen the regional response to HIV. The commitment also involved other governmental sectors and civil society organizations in order to strengthen national information systems, with a view to developing periodic and timely reporting on indicators, with strategic information to be used in the decision-making process.

Since 2011, El Salvador has presided over the regional coordination mechanism for Central America, which has allowed us to make progress in the regional strategic plan and work closely with the ministers of health, cooperation agencies and regional representatives of civil society and people living with HIV.

Allow me to conclude by ensuring the consistency of all of the activities undertaken in El Salvador in the fight against HIV/AIDS and in compliance with the Declaration adopted in New York in June 2011. We therefore reiterate our country's political will to support the commitments adopted globally in the Declaration, so that we can achieve the goal of zero new HIV infections, zero stigma and discrimination and zero HIV-related deaths.

Ms. Mweemba (Zambia): May I begin by thanking the President for convening this important exchange on agenda item 10. Let me also say that Zambia welcomes the report of the Secretary-General (A/66/757) and commends him for its comprehensive nature.

My delegation aligns itself with the statements made by the representative of Botswana on behalf of the African Group and by the representative of Angola on behalf of the Southern African Development Community.

The 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (resolution 65/277, annex) highlights the situation on the ground in terms of HIV incidence, prevalence and the factors that lead to reinforcing the epidemic. It also elucidates measures for the accelerated achievement of the Millennium Development Goal on HIV. Our leaders declared 2012 as a year for universal access to prevention, treatment and care and support. Zambia equally realized that treatment is essential to prolonging the lives of people living with AIDS, and that it is an adjunct to prevention.

Whenever we speak of the three themes for HIV, we need to emphasize prevention, so that it cuts across all three themes, namely, prevention; treatment and prevention; and impact mitigation support and prevention. The Government of Zambia has made efforts to reposition prevention centre stage in the fight against HIV and AIDS. Numerous prevention symposiums have been held across the country in order to give prominence to prevention strategies, starting with the 2010 high-level symposium attended by the President and Vice-President of Zambia, as well as the meeting of the Champions for an HIV-Free Generation.

As the world races towards the Millennium Development Goal of reducing sexual transmission of HIV by 50 per cent and the elimination of new infections in children and other prevention outcomes, let us find synergies with the post-Rio sustainable development agenda. In addition, I wish to reiterate the calls for enhanced research for a multiprotection product with high public health efficiency and effectiveness. Treatment is a type of prevention, but only prevention can be said to be sustainable. My delegation therefore makes an appeal to donor agencies for more funding towards prevention research.

Furthermore, I wish to emphasize the issue of orphans and vulnerable children. While it gives some level of comfort to note that the number of children orphaned by HIV appears to have peaked in 2009, at 17 million, caution should be exercised, since vulnerability is a key determinant for HIV acquisition, as well as for gender and sexual violence. That compounds the scenario for HIV acquisition among orphans and vulnerable children. In that regard, no efforts should be spared in providing adequate provision of social protection services to cushion the impact of abject poverty likely to be experienced in such households.

In conclusion, Zambia remains committed to the 2011 Declaration and will continue to work with all partners and stakeholders to achieve a successful outcome.

Mr. Le Hoai Trung (Viet Nam): First of all, I would like to thank His Excellency Secretary-General Ban Ki-moon for his comprehensive report (A/66/757) on the implementation of the Declaration of the Commitments on HIV/AIDS (resolution S-26/2, annex) and the Political Declaration on HIV/AIDS (resolution 65/277, annex).

Viet Nam aligns itself with the statement made by the representative of Cambodia on behalf of the Association of Southeast Asian Nations.

AIDS remains one of the great challenges of our time, with 34 million people currently living with HIV around the world. During the High-level Meeting on HIV/AIDS that was held in New York in June 2011, the international community reaffirmed HIV and AIDS as "a global emergency and one of the most formidable challenges to the development, progress and stability of our societies and the world at large", thereby embracing the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. We share the view expressed by the Secretary-General in his report that the international community has cause for hope and optimism owing to increased access to essential treatment and prevention services, as well as the fact that there has been a decline in new infections and AIDS-related deaths. However, the world is still far from meeting the targets set out in the Political Declaration on HIV/AIDS. Substantial access gaps still persist for key services, with especially difficult obstacles experienced by populations at higher risk. Therefore, we join the efforts and share the responsibility of each and every member of the international community to scaling up their response towards the goal of universal access to comprehensive prevention programmes, treatment, care and support, and towards halting and reversing the spread of the pandemic by 2015. We therefore call upon all stakeholders, especially developed countries, to fulfil their commitments to support national efforts to strengthen the response.

At the High-level Meeting on HIV/AIDS held here in New York last June, the Government of Viet Nam renewed its determination to combat HIV/AIDS and adopted new targets by supporting the Political Declaration on HIV/AIDS. Viet Nam takes those commitments seriously and has adopted concrete measures to realize them. Just recently, Viet Nam finalized its national strategy on HIV/AIDS prevention and control from 2020, with a vision towards 2030. The strategy contains ambitious targets that echo those of the Political Declaration on HIV/AIDS. The National Assembly also passed a national targeted programme on HIV covering the period 2011 to 2015. Among other things, that programme ensures a higher State budget for HIV activities. Another major development was the passing of decree No. 69/2011, of 8 August 2011, on handling administrative violations in health prevention, the medical environment and HIV/AIDS prevention and control.

As the result of those policies and programmes, Viet Nam was initially able to contain the rise of HIV infection, with HI- infected people currently accounting for about 0.26 per cent of the population. In concrete terms, the prevalence among injecting drug users declined from 30 per cent in 2001 and 2002 to 17 per cent in 2010, while the number of HIV/AIDS-related deaths has dropped from more than 6,000 a year to some 2,500 a year for the past two years. In 2011, 49 of 63 provinces had carried out community outreach activities for people who inject drugs and for female sex workers;

60 provinces had implemented some kind of needle and syringe programme; and 57 provinces distributed condoms free of charge. In addition, the national methadone maintenance treatment programme has been expanded to a total of 11 provinces, treating more than 6,900 people in 41 clinics, with an adherence rate of approximately 96 per cent. It is planned to continue to expand the service to 245 clinics in 30 provinces and to 80,000 patients by 2015.

Despite such efforts to address HIV, challenges, such as overlapping policies and sets of measures, the lack of personnel, health facilities, equipment and laboratories, and limited resources for sustainable programmes, still remain and hinder the implementation of HIV intervention. To address those challenges, among other things, Viet Nam will continue to strengthen its political commitment on HIV, to improve the legal framework and regulations, and to scale up efforts to ensure universal access to HIV prevention, treatment, care and support services for all in need. We would like to ensure that HIV prevention and control are mainstreamed into the current system of health service provision, as well as into other sectors and national socio-economic development programmes.

I would like to end my remarks by expressing my sincere appreciation to all United Nations organizations and other development partners for their important ongoing work for the national response in Viet Nam. Through our collective efforts, we are moving closer towards our shared goal of universal access to HIV prevention, treatment and care.

Mr. Tarar (Pakistan): Despite considerable gains in different parts of the world, we are not likely to achieve our shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths in the near future.

The overall thrust of the Secretary-General's latest report (A/66/757) is positive with regard to the number of newly infected persons, including children and adolescents, as well as AIDS-related deaths. Unfortunately, however, that progress varies considerably among countries and regions, and HIV remains the leading cause of death among women of reproductive age at the global level. The current level of international response is unlikely to suffice to meet the 2015 targets reaffirmed in last year's Political Declaration on HIV and AIDS (resolution 65/277, annex). That is a worrisome situation. On the positive side, after four decades of struggle against HIV and AIDS, the international community is better informed and equipped to deal with the threat.

Until recently a low-prevalence country, Pakistan now finds itself in a concentrated phase of the epidemic. Among the key affected populations, people who inject drugs exhibited the highest HIV prevalence, at 27.2 per cent, in 2011. According to the latest national estimates, there are approximately 98,000 cases of HIV/AIDS in Pakistan. The geographic trend of the epidemic is expanding from major urban centres to smaller cities and towns. However, the latest prevalence estimation models indicate that, fortunately, the HIV prevalence among the general adult population is still below 0.1 per cent. That stands us in good stead to contain the epidemic.

The response to the HIV epidemic in Pakistan has been a coordinated effort of the Government, along with bilateral and multilateral donors, the United Nations system and civil society. The national AIDS control programme has come a long way since 1986 to develop into a comprehensive and effective response to the threat of an HIV and AIDS epidemic in Pakistan.

The Government's response was in three five-year phases between 1987 and 2010. However, following the devolution of health care to the provinces in 2011, each province is developing its own provincial AIDS strategy tailored to specific needs. The final document Pakistan AIDS Strategy 2012-2016 will consolidate provincial strategies in line with national health and development priorities and international development goals, including the Millennium Development Goals.

The main goal of the Pakistan AIDS Strategy is to prevent new infections and to improve the health and quality of life of people living with HIV. The programme provides a strategic direction, and its operationalization involves all stakeholders, including non-governmental and community-based organizations.

The majority of AIDS victims live in developing countries. The problem of HIV/AIDS cannot be addressed as a health or human rights issue alone. It has a strong development side. Poverty directly contributes to situations that are conducive to the spread of HIV/AIDS. It also exacerbates lack of access to the medical treatment and social facilities required by victims of HIV/AIDS. Therefore, combating HIV/AIDS and eradicating poverty must go hand in hand. That

cannot be achieved without the active and determined cooperation of the international community.

Less emphasis on profits, new research and information-sharing are necessary to ensuring low-cost drugs. We support the Secretary-General's call for increased global cooperation in order to meet the agreed commitments to universalize access to HIV prevention, treatment, care and support. In that regard, the public good should trump corporate interest.

Mr. Rahman (Bangladesh): Let me begin by thanking the Secretary-General for his comprehensive report on the implementation of the Declaration of Commitment on HIV/AIDS (A/66/757), presented this morning. The High-level Meeting held last year provided us with a unique opportunity to review our progress and to make fresh commitments towards achieving a world with zero new HIV infections and zero discrimination and zero AIDS-related deaths (see A/65/PV.95).

It is heartening that access to essential medication for the treatment and prevention of HIV/AIDS has shown a significant increase. In a single decade, the number of people in developing countries receiving antiretroviral therapy has increased by more than twentyfold. The number of people newly infected by that deadly disease is also on the decrease. However, the rate of decrease is still too low to meet the HIV-related Millennium Development Goal target. As the report notes, more than 34 million people are still living with AIDS. Moreover, the achievements are disproportionate among different regions of the world. While some regions witness considerable progress in reducing AIDS-related deaths, some still have much to achieve.

Bangladesh is one of the countries with the lowest prevalence of HIV/AIDS. Since the detection of the first HIV infection in 1989, statistics show that the prevalence of HIV/AIDS in Bangladesh is less than 0.1 per cent. So, in that sense, it is still below the level of an epidemic. That has been possible due to the pragmatic action undertaken by the Government from the very onset.

The Government has taken an evidence-based approach towards HIV and sexually transmitted disease (STD) programming. The National AIDS/STD Programme is the focal point for the coordination, implementation and monitoring of HIV/AIDS programmes in Bangladesh. With the support of development partners, non-governmental organizations and United Nations agencies, the Programme has been undertaking awareness-raising programmes. We have included HIV/AIDS education in the national school curriculums. A number of well-developed strategies/guidelines have been adopted. Last year, the National Strategic Plan for HIV and AIDS 2011-2015 was adopted, providing the framework for a national response to prevent an HIV epidemic.

However, we cannot afford to be complacent. Although it is still considered to be a low-prevalence country, Bangladesh remains vulnerable to an HIV epidemic, given its abject poverty, overpopulation, the high mobility of its population, emigration and so on. Migrant workers remain at risk for HIV infection and thus can be a source of AIDS in our country. Moreover, HIV infection sometimes remains unreported due to the social stigma attached to the disease.

It is rightly pointed out in the Secretary-General's report that achieving a world with zero new infections demands the concerted efforts of all countries, developed and developing alike. It will be impossible to achieve global targets without sufficient financial resources. It is a matter of concern that, just as the international community has committed to intensifying its efforts to eliminate HIV/AIDS, the funding is falling short. We urge our development partners, philanthropic organizations and the corporate sector to come up with more financial and technical support to combat the menace in developing countries.

The Global Fund to Fight AIDS, Tuberculosis and Malaria needs further strengthening. Barriers like intellectual property rights should be eliminated in order to make life-saving medicines affordable. In that connection, we would also like to emphasize the role of faith-based organizations and their leaders in raising awareness of and empathy with those who have been infected with HIV/AIDS. We believe that strong family bonds and social and religious values and ethics should play an important role in fighting the global menace of HIV/AIDS. Thus, through a concerted effort on the part of all stakeholders, the rhetoric of zero new AIDS infections will become a reality.

Mrs. Chikava (Zimbabwe): Zimbabwe aligns itself with the statements made by the representative of Botswana on behalf of the African Group and by the representative of Angola on behalf of the Southern African Development Community. Both statements accurately described the status quo of our regional and subregional efforts to combat the scourge of HIV/AIDS.

I wish to make a few additional remarks on behalf of my country.

Zimbabwe has made progress in pursuing universal access commitments. Over the past few years, we have scaled up our national response to HIV/AIDS, using the specific targets and indicators contained in the universal access declaration for guidance. Accordingly, Zimbabwe's HIV prevalence has continued to decline from a high of over 29 per cent in 1999 to the current 18 per cent. That decline has also been consistent with the decline of the general incidence of HIV. The declines in both areas have been underpinned by expansion of access to HIV prevention services, including, inter alia, prevention of mother-to-child transmission, provision of male and female condoms, HIV testing and counselling, and awareness campaigns. We have recently added male circumcision to our HIV-prevention programmes, based on compelling evidence that, if offered to men and carried out appropriately, the practice has potential HIV-prevention benefits.

Following the adoption of the Political Declaration on HIV/AIDS in 2006 (resolution 60/262), Zimbabwe was one of the first countries in the world to develop and implement an evidence-based behaviour change strategy whose primary result has been the reduction of new cases of HIV. Evidence shows that the behaviour change strategy has contributed to increased demand for and use of HIV-prevention services. To enhance the use of testing and counselling services as a gateway to treatment and care, Zimbabwe has introduced provider-initiated testing and counselling services in all health institutions. That proactive service has made our testing and counselling services user-friendly and robust by enhancing services already provided in the context of voluntary testing and counselling services.

Despite perennial funding challenges, Zimbabwe has recorded significant progress in the provision of treatment and care services. By the end of 2010, Zimbabwe had achieved 77 per cent coverage towards our universal access target, whereby 350,000 of an estimated 593,000 persons requiring antiretroviral therapy were receiving antiretroviral medications. Although there has been progress, it is disheartening and untenable that some people in need of treatment have to delay starting the treatment because the demand for antiretroviral medicine is greater than the supply.

Nevertheless, in pursuit of universal access targets, Zimbabwe has expanded and decentralized treatment services to all districts, including to various rural health centres, opening new antiretroviral therapy sites at all those levels. Regular outreach campaigns penetrating into villages, farming and mining establishments have resulted in an increased use of treatment services, as well as the reduction of stigma and discrimination. In addition, my country has also strengthened coordinated tuberculosis and HIV interventions, whose impact has already been immense in the scaling up of treatment and care services. As part of our commitment to and pursuit of universal access, Zimbabwe has now switched to the use of more efficacious regimens and is slowly phasing out the triple dose regimens whose efficacy have been shown to be comparatively lower.

Zimbabwe salutes all our partners for their assistance in the area of treatment and care. The Global Fund to Fight AIDS, Tuberculosis and Malaria, the Expanded Support Programme, the United States President's Emergency Plan for AIDS Relief, the Children's Investment Fund, the Clinton Health Access Initiative, the Bill & Melinda Gates Foundation and many others have played central roles in enabling Zimbabwe to expand access to treatment and care services.

My country's progress in combating HIV/AIDS is being threatened by the withdrawal of funds by some donors. As we speak today, there is apprehension in my country because at least 66,000 people on antiretroviral drugs risk losing their drug allocations if no steps are taken to redress the funding gap. The gap is also widening because of the introduction of a new treatment regimen. It is known that Zimbabwe devised an innovative national mechanism, the AIDS levy drawn from workers' salaries, to augment the financing of prevention, treatment and care. Even with the national mechanism in place, my country still requires additional financial assistance. We appeal to donors to have a change of heart and continue to fund our HIV/AIDS programme. The consequences of withdrawing funding for treatment will surely be measured in untold suffering of people living with HIV. Most of them have already been made vulnerable by illness and lack of income, and they end up unable to fend for themselves and their families during the course of the illness. Patients might also end up rationing their drugs in an effort to make them last longer, which can result in drug resistance and other complications.

We therefore hope that those partners who have been working with us in combating HIV and AIDS will reconsider their decision to withdraw funding.

The Acting President: We have heard the last speaker in the debate on agenda item 10.

We shall now proceed to consider draft decision A/66/L.49.

The Assembly will now take action on draft decision A/66/L.49 entitled "Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS".

May I take it that the Assembly wishes to adopt draft decision A/66/L.49?

The draft decision was adopted.

The Acting President: Before giving the floor to speakers in explanation of position, I would remind delegations that explanations of vote or position are limited to 10 minutes and should be made by delegations from their seats.

Mr. Hassani Nejad Pirkouhi (Islamic Republic of Iran): The Government of the Islamic Republic of Iran remains fully committed to providing the widest possible access without stigma and discrimination to care, treatment and support for people living with HIV/AIDS and their families. However, I would like to put on the record my country's reservation on the decision just adopted and the report of the Secretary-General (A/66/757) and the recommendations contained therein, in particular, paragraph 76 (c).

National laws and regulations have to reflect the ethical, cultural and religious values of a society. Otherwise, they would lose their acceptability and applicability. Furthermore, we have yet to be convinced of the direct link between the revision or elimination of such national laws and regulations that the report asks for and the realization of the goals of the 2011 Political Declaration on HIV/AIDS (resolution 65/277).

The Government of the Islamic Republic of Iran requests that its explanation of position be duly recorded.

The Acting President: May I take it that it is the wish of the General Assembly to conclude its consideration of agenda item 10?

It was so decided.

The meeting rose at 3.55 p.m.