As the first cases of AIDS were reported in 1981 in the US, India stood by and watched the epidemic unfold. When AIDS was first detected in Chennai and Mumbai in 1986, some observers instantly played the blame game shifting the burden of the epidemic to Sri Lankan militants, ‘promiscuous’ African students and the west for trying to conspire selling condoms to India. For another five years people watched the epidemic grow, this time blaming prostitutes, injecting drug users and homosexuals for spreading the virus. Still many continue to scapegoat these so-called ‘high risk groups’ and the ‘vectors of the disease’ with a rhetoric of middle class moral code, patriarchy and closely controlled female sexuality.

The epidemic is now completing more than two decades of its existence in India, with an estimated 2.5 million persons living with HIV/AIDS. However there is a disagreement over exact number of people currently living with HIV/AIDS in India. UNAIDS estimates that there were 5.7 million people in India living with HIV by the end of 2005, suggesting that India has a higher number of PLHAs, than any other country in the world.¹ On the other hand National Aids Control Organization² is still grappling with the HIV/AIDS statistics. NACO has officially established an estimate of 2.5 million people, which indicates that there are less infected people in India than in South Africa.³ According to NACO the national prevalence level is 0.8 percent. While this may seem a low rate, but considering India’s vast population, the actual number of PLHAs is remarkably high. While focusing on population of India, a mere 0.1 percent increase in the HIV prevalence would increase the estimated number of PLHA’s by over half a million. As per the official estimates of 2008, nearly 2.310 million people are living with HIV infection in India. About 600,000 new cases occur every year (1,660 cases/day). The magnitude of the infection is second only to that of South Africa though the overall prevalence is still low. Of the 1,14000 reported

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2. Hereinafter to be referred as NACO.
AIDS cases since the beginning, the male/female ratio is 71.25% and 28.75%. The major modes of transmission of infection in these reported AIDS cases are through sexual route (85.83%), parentally (3.5%), through blood and blood products (2.03%), injecting drug use (2.58%) and 5.98% through other routes. According to UNAIDS, India’s HIV/AIDS figure is likely to be trebled in the next decade. Recent reports however, clearly indicate that the infection has been spreading from the major metropolitan cities to the rural areas. Satara and Sangli, two districts in the state of Maharashtra, for instance have seen more than a threefold increase in the rate of new infection since August 1988.

As a consequence of the deep inequalities that exist in Indian society, the spread of HIV infection has revealed an epidemic of multiple dimensions undergoing extensive epidemiological transformations. Initially restricted to large urban centers and markedly masculine, the HIV/AIDS epidemic is currently characterized by heterosexualization, feminization, interiorization and pauperization. The evolution of the profile of HIV/AIDS in India is above all due to the geographical diffusion of the disease to medium and small municipalities in the interiors, to the increase in heterosexual transmission and the persistent growth of cases among injecting drug users. The reported cases reveal that HIV infection is spreading rapidly from the traditionally marginalized groups to the mainstream population. The increase in transmission through heterosexual contact has resulted in substantial growth of cases among women, which has been pointed out as the most important characteristic of the epidemic’s current dynamic in India. The recent rise in HIV infection among pregnant housewives is a significant indicator of this trend as it manifest from the figures of HIV infection rate to antenatal cases. This is responsible for the spread of virus through reproductive tract infection from the affected mother to the child at birth.

The NGOs, media, doctors and activists generally regard the figure of 2.5 million people HIV positive to be an under estimate. Jain gives a detailed account of the ineffective surveillance system that consistently fails to adhere...
to scientific survey techniques and laboratory protocols. For example, the designated centres in Bihar, failed to collect the requisite number of samples to estimate HIV prevalence levels in 2002. Little wonder that Bihar is reported to have low prevalence rates. In many parts of the country, the numbers from individual laboratories, doctors and NGOs point in radically opposite direction. Siddharth Dubey, in his riveting book “Sex, Lies and AIDS”, estimates that 1400 people are infected every day.\(^7\) This would be half a million new infections every year.

A report by the United States, “National Intelligence Council” states that India will have as many as 20 million HIV infected people by 2012.\(^8\) This is five times the current levels. The Indian Ministry of Health and NACO officials have hotly contested these projections by pandering to the discourse that over-projected numbers cause AIDS “scare” – the surest way to arrest the virus is to dismiss the projections as mere panic buttons. Accurate statistics are important because they represent aspects of human realities, shape public perceptions and form a scientific basis for government policies keeping in mind the rights of PLHAs as well as people affected by the virus. A reliable surveillance system and realistic estimates allow us to understand the prevalence magnitude, distribution and mode of spread of a disease. These data are critical pre–requisites for designing effective preventive support and care and mitigation strategies. They also stem the current culture of denial, discrimination and scapegoating and encourage politicians, legislators and the Indian public to accept that there is a problem, which requires their serious attention.

**Constitutional and Legislative Perspectives on HIV/AIDS**

Much has been written about legal rights and duties of PLHAs and the importance of an appropriate legal response. The ongoing reports of serious and unjustified encroachments on the civil liberties of HIV/AIDS victims and people associated with them have established beyond doubt that the law has a central role to play in HIV/AIDS epidemic. It is well known that the legal response to HIV/AIDS epidemic is important, but what should the legal

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response actually be. Can legislation, HIV/AIDS specific or otherwise, assist in strategies for the care and treatment of people with HIV and help to reduce the spread of HIV/AIDS because the epidemic is very much related to personal behaviours of individuals i.e sexuality. Therefore it can be argued that whether legal remedies can respond effectively and appropriately to HIV/AIDS related human rights violations. Institutional responses to HIV/AIDS at individual, familial and community level have tended to mirror personal responses including stigma and discrimination and a varied level, degree and composition of acceptance with infection and overcoming stigma and discrimination. It is a complex and variable impeding factor in the recognition of infection, it arouses stigma and discrimination towards persons infected as well as affected by HIV/AIDS.

At present there is no comprehensive law in India to respond to the demands and needs of HIV/AIDS victims. India has yet to take steps to fulfill its obligations under the UNGASS Declaration on Commitment on HIV/AIDS. The rights of PLHAs are presently protected under the Indian constitution. The dignity of the individuals finds a special mention in the preamble of Constitution of India. Furthermore in Part III of Constitution the Fundamental Rights protects the dignity of individual at large. The constitutional courts have developed the decisional jurisprudence regarding dignity. In the recent case of Naz Foundation,9 the Delhi High Court observed that: "At its least, it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals as members of our society. It recognizes a person as a free being who develops his or her body and mind as he or she sees fit. At the root of dignity is the autonomy of private will, and a person's freedom of choice and of action. Human dignity rests on recognition of the physical and spiritual integrity of human being, his or her humanity, and his value as a person, irrespective of the utility he can provide to others."

Earlier in case of Prem Chandar Shukla v/s Delhi Administration10, the SC observed that dignity forms part of our constitutional culture and in Francis

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10. 1980 1 SCC 529
Coralie Mullin v/s Administration, U.T. of Delhi and others\textsuperscript{11}, the SC through Bhagwati, J observed that: "We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessaries of life such as adequate nutrition, clothing and shelter and facilities for reading, writing, and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings. Every act which offends against or impairs human dignity would constitute deprivation pro tanto of his right to live and it would have to be in accordance with reasonable, fair and just procedure established by law which stands the test of other fundamental rights. Hence one could observe from the above cases that Indian judiciary has accepted that human dignity implies expressing oneself in diverse forms and acknowledges the value and worth of all the individuals in the society including HIV/AIDS victims.

The first decision given to interpret the scope and meaning of life and personal liberty under article 21 of the Indian Constitution was the A.K. Gopalan v/s State of Madras\textsuperscript{12} the apex court interpreted the words "procedure established by law" in Article 21 are to be given a wide and fluid meaning of the expression "due process of law" as given under the U.S. constitution but if it refers to only state made statues laws. If any statutory law prescribed procedure for depriving a person of his rights or personal liberty it should meet the requirements of Article 21.

However, after two decades this was over ruled in the case of R.C. Cooper v/s Union of India\textsuperscript{13} after this there where a series of decisions by the apex court including that of Maneka Gandhi v/s. Union of India\textsuperscript{14} where it was held that any law that deprives the life and liberty must be just and fair. Krishna Iyer J. rightly said that "procedure in Article 21 means fair, not formal procedure law is reasonable law not any enacted pieces" Now it is settled that Article 21 confers positive rights to life and liberty. The word life in Article 21 means a life of dignity and not just mere animal survival.

In the 1978, by 44th amendment, Article 359 was amended and it provided that Article 20 and 21 could not be suspended even during

\textsuperscript{11} 1993 1 SCC 645.  
\textsuperscript{12} AIR 1950 SC 27.  
\textsuperscript{13} AIR 1970 SC 564.  
\textsuperscript{14} AIR 1978 SC 597.
declaration of an emergency. In the case of P.Rathinam\textsuperscript{15}, court held that physical as well as mental health both are treated as integral part of right to live upholding that without good health, neither civil or political rights which Constitution confers cant be enjoyed. Judiciary has played a vital role in the interpretation and correct use of article 21.

In case of C.Masilamani Mudaliar v/s. Idol of Sri Swami Nathaswami\textsuperscript{16} the SC observed that equity, dignity of a person and the right to development are the inherent rights of every human being. Life in its expanded horizon includes everything that gives meaning to a person's life including culture, heritage and tradition with dignity of a person. In Unni Krishan v/s. State of Andhra Pradesh the apex court widened the scope of article 21 and has provided with the rights article 21 embraces within itself. They are right to go abroad, right to privacy, right against solitary confinement, right against delayed execution, right to shelter, right against custodial death, right against public hearing and doctor's assistance. Alongwith all these rights mentioned above, it was also observed that the right to education would also be included as a part of right to life.

Recently in Naz Foundation Case\textsuperscript{17}, which is leading case in context of HIV/AIDS and MSMs it was submitted that Section 377 IPC violates the constitutional protections embodied in Articles 14, 19 and 21. The judgment in this case is a milestone in the jurisprudence on diversity and pluralism in India. Importantly, it inaugurates intersectional jurisprudence that examines questions of constitutionalism in relational terms that underscore inclusiveness. By this token then, it is not merely a judgement that bears significance for the rights of lesbian, gay, bisexual and transgender people (LGBT). It makes the articulation of LGBT rights a torchbearer for a more general understanding of discrimination, oppression, social exclusion and the denial of liberty, on the one hand, and the meaning of freedom and dignity, on the other. "Constitutional morality is not a natural sentiment. It has to be cultivated. We must realise that our people have yet to learn it."\textsuperscript{18} Drawing on Dr. Ambedkar, the court rejected the argument that homosexuality was

\textsuperscript{15} P Rathinam v/s UOI 1994 3SCC 394.
\textsuperscript{16} 1996, 8 SCC 525, Paragraph 22.
\textsuperscript{17} See Naz Foundation v/s Govt of NCT Delhi and others, Writ Petition no.7455/2001.
\textsuperscript{18} Dr B R Ambedkar quoted in paragraph 79 of the Naz Foundation Case.
contrary to public and popular morality in India, upholding constitutional
morality instead, the diffusion of which was contingent on Dr. Ambedkar's
ideas of national change, as evident in the lines quoted above. The judgment
stated: "The Constitution of India recognises, protects and celebrates diversity.
To stigmatise or to criminalise homosexuals only on account of their sexual
orientation would be against the constitutional morality". Linked to this is
the observation of the Court on the question of the horizontal application of
rights, with specific reference to Article 15(2), a barely remembered but
critical part of Article 15: No citizen shall obstruct another from access to
public places on grounds of caste, sex and other specified grounds. This
purposive and intersectional reading of Article 15(2), hitherto restricted
largely to practices of untouchability vis-a-vis dalits, opens out an important
strategy in constitutional interpretation.

Applying the U.N. Human Rights framework to an understanding of
sexual orientation and gender identity, the judgment sets out three categories:
non-discrimination; protection of private rights; the ensuring of special general
human rights protection to all, regardless of sexual orientation or gender
identity. Perhaps the most important issue the judgment addresses is the
meaning of "sex" in Article 15(1) of the Constitution of India: "The state shall
not discriminate against any citizen on grounds only of religion, race, caste,
sex, place of birth or any of them." Does the term "sex" in this context refer to
attribute or performance? Is sex to be applied in a restricted fashion to gender
or can the multiple resonance of its common usage be taken into account, so
that sex is both gender (attribute) and sexual orientation (performance)? This
is particularly significant because, as the judgment demonstrates through an
extensive review of case law and principles from different parts of the world,
gender and sexual orientation are an intrinsic and inalienable part of every
human being; they are constituents of a person's identity. In the words of
Justice Sachs of South Africa, the Constitution "acknowledges that people live
in their bodies, their communities, their cultures, their places and their
times". It is this composite identity of every person that is affirmed through a
nuanced reading of "sex" in Article 15(1): "We hold that sexual orientation is

19. Paragraph 80 of the Judgement.
Court of South Africa, 457,1998.
a ground analogous to sex and that discrimination on the basis of sexual orientation is not permitted by Article 15.21

Justice P.N. Bhagwati's delineation of the right to dignity in case of Francis Coralie Mullins, provides the starting point for the discussion on the importance of self-respect, self-worth and privacy to human social life, recognized nationally and internationally. And privacy is particularly important in the area of sexual relationship where the thumb rule is that "If, in expressing our sexuality, we act consensually and without harming one another, invasion of that of precinct will be a breach of our privacy."22

Regarding the criminalisation of homosexuality, the judgment says, by condemning in perpetuity an entire class of people, forcing them to "live their lives in the shadow of harassment, exploitation, humiliation, cruel and degrading treatment at the hands of the law enforcement machinery" denies them moral full citizenship. Because Section 377 is aimed at criminalising private conduct of consenting adults, the court held that it comes within the meaning of discrimination, which "severely affects the rights and interests of homosexuals and deeply impairs their dignity. It is "unfair and unreasonable and, therefore, in breach of Article 14 of the Constitution of India."

The right to public health is another aspect of human right that is seriously undermined through the criminalization of same sex behaviour. There are two parts to this right, both of which lead back to the fundamental right to life under Article 21. The first is the right to be healthy; in this context, the concerns of the National AIDS Control Organization are pertinent. Fear of the law enforcement agencies obstructs disclosure, which in turn impedes HIV/AIDS prevention programmes and increases the risk of infection in high-risk groups.

The second part of the right to health is more expansive and includes the right to control one's health and body, the right to sexual and reproductive freedom, the right against forced medical treatment and the right to a system of health that offers equality of opportunity in attaining the highest standard of health. While several documented testimonies of LGBT persons speak of the treatment of their sexual orientation as a psychiatric/mental disorder, the

21. It was quoted in paragraph 104 of the Naz Foundation Case Judgement.
22. Paris Adult Theatre I v/s.Slaton, 413 US 49 (1973), page 63
judgment importantly affirms the findings worldwide that sexual orientation is an expression of human sexuality—whether homosexual, heterosexual or bisexual. "Compelling state interest," instead of focusing on public mortality, the judgment says, "demands that public health measures are strengthened by de-criminalization of such activity, so that they can be identified and better focused upon.

The judgment holds that Section 377 fails the test of "strict scrutiny" which would require proportionality between the means used and the aim pursued. And when it is a question of "matters of high constitutional importance" like the rights of LGBT persons, the courts are obliged to discharge their sovereign jurisdiction, in this case, reading Section 377 down to apply only to child sexual abuse.23

In principle, discrimination is antithetical to equality. Article-14 of the Constitution of India guarantees equality before law and equal protection of the laws to all persons without any discrimination. So, the state cannot make arbitrary discrimination among citizens including PLHAs. If any classification of PLHAs is made it must be rational otherwise it would be unfair and unjust and violative of their fundamental rights. This freedom from arbitrary discrimination is enforceable against the state and its agencies. But at present this article does not offer any protection against private parties. According to the report of the National Commission to Review the Working of the constitution24 the definition of ‘State’ under Article-12 of the Constitution can be amended to include any private person or entities engaged in functions which are of a public nature. Currently employment in the private sector is covered to a limited extent by law;25 discrimination in employment or private health care settings remains unregulated. The rampant private discrimination evident particularly in the context of HIV/AIDS epidemic calls for immediate legal interventions.

Historically, anti-discrimination standards based on constitutional protections of equality, similar to India’s constitutional provisions, addressed only state entities. In many countries this lacuna has been filled through anti-

23. It is pertinent to point out here that the Andhra Pradesh (Telangana Areas) Eunuchs Act specifically targets Eunuchs and Hijras in far more direct ways than Section 377 does.
discrimination laws that specifically address discrimination by private actors. If the goal of these laws is to achieve equality for PLHAs, then the mechanisms through which this goal is realized is equal opportunity provisions. Article 15 of the Constitution of India elaborates on the principle of equality enunciated in Article 14 by prohibiting discrimination on the grounds of religion, race, caste, sex or place of birth. Similarly Article 16 provides for equality of opportunity in public employment. Article 19 guarantees certain fundamental freedoms. There are other freedoms also that are enforceable through not listed under Article 21 like right to travel, right to privacy, right to development, right to human dignity, right to speedy trial, right to information, right to treatment without discrimination. The obligation of the state to ensure the creation and the sustaining of conditions congenial to good health is classified by the constitutional directives contained in Articles 38, 39(e) (f), 42, 47, and 48A in the part IV of the constitution of India. Further Article-21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. “Failure on the part of a government hospital to provide timely medical treatment to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21,” said the Supreme Court in case of Paschal Banga Khet Mazdoor Samiti v/s State of West Bengal.26 Aside from these provisions in the Constitution, both the Equal Remuneration Act and the Persons with Disabilities Act27 give effect to the mandate of Article 14. The Equal Remuneration Act is a limited instrument as it rectifies gender-based discrimination in the work place. These laws are essentially affirmative action laws that achieve equality of opportunity, but not necessarily, equality of results. Disability law in India has been a recent development that attempts to alleviate the position of people with disabilities, rather than actively protect their equality. The PDA is limited in its scope and application. It addresses the needs of very few categories of

27. The Persons with Disability (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Hereinafter to be referred as PDA.
disability and protects only against discrimination in the public sector. The PDA does not cover the private sector in any of its schemes or provisions. It only mandates that government provides incentives to employers, both private and public, to ensure that at least 5% of their workforce is persons with disabilities, but this does not address marginalization. It does not refer to health care and its categorization of disability is limited, excluding PLHAs from the legislation’s purview. The main weakness of such legal instruments is that it neglects the social context within which stigma and discrimination occur and eradicates the differences between and among marginalized people. The inclusion of PLHAs as persons with disability within the purview of the PDA is of great importance. Although the physical impairment of HIV/AIDS victims is not visible, the discrimination suffered by PLHAs is considerably higher as compared to persons with disabilities. It is the stigma that creates disability. The most effective way to protect the rights of PLHAs is to enact a comprehensive anti-discrimination legislation which includes HIV status as one of the prohibitive grounds for discrimination. This will address the many social, economic and political dimensions of discrimination on the basis of actual or perceived HIV status and provide a means of redress for PLHAs and those associated with them as well. Measures to promote the equality of PLHAs must also move beyond the reservation system and toward a more comprehensive equal opportunity approach to ensure not just equal access but equal rights. It is important to remember that one of the most critical aspects of a successful rights based HIV/AIDS legislation has been the involvement of an informed civil society committed to a broad based community mobilization.29 As such, incorporating the perspectives and experiences of people working in the fields of HIV/AIDS will be essential in creating an anti-discrimination legislation which is in accordance with India’s socio-economic scenario and which meets the varied needs of PLHAs, and others affected by the HIV/AIDS epidemic.

In social and legal context, two diametrically opposed responses to the HIV/AIDS epidemic have arisen. These responses can be conveniently termed

28. The definition of ‘disability’ under PDA is very narrow covering only persons with visual impairment, hearing impairment, hearing impairment, leprosy cured, locomotor disability, mental retardation and mental illness. See Section 2(i) of PDA.

29. The development of the American Disability Act is an excellent example of this.
as the isolationist and the integrationist response. The isolationist response allows for mandatory testing for HIV, isolation of the HIV positive person, non-maintainability of confidentiality and discrimination against the HIV positive persons. In the integrationist response, voluntary testing for HIV is encouraged, not isolation but integration of the HIV positive person is focussed, confidentiality is maintained and there is no discrimination against persons. In India thus far the isolationist strategy has been pursued in the sectoral and formal levels. The existing legal framework has proved inadequate to effectively safeguard the rights of PLHAs despite the constitutional guarantee of equality. Discrimination is antithetical to equality, which is a right protected by Articles 14\(^{30}\), 15\(^{31}\) and 16\(^{32}\) of the Constitution. Equality implies an essential sameness or likeness, on the basis of which people possess the same privileges and are granted equal rights. Acts of discrimination are therefore a violation of one’s right to equality. Case law on discrimination and HIV/AIDS tends to be concerned with a few key issues. The first is discrimination on the basis of one’s HIV status in the fields of employment, health care, education, and housing, which usually involves the denial of or restrictions on access to these services or institutions. The second is the concept of ‘reasonable accommodation’ (which means any modification or adjustment made to a job or to the workplace in order to facilitate access or participation of PLHAs) and the conditions under which such mechanism should be set up. And the third is the discriminatory impact of mandatory testing in the health care system and employment, particularly in the armed forces.

**Legal Issues in Context of HIV/AIDS Victims**

The discrimination and stigma inherent in HIV/AIDS epidemic raise many potential issues from the angle of HIV/AIDS victims. These issues increase the vulnerability of HIV/AIDS victims to various human rights violations. The issues of consent and testing, confidentiality and criminalization of HIV transmission are discussed below.

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30. Article-14, The State shall not deny to any person equality before law or equal protection of laws within the territory of India.
31. Article-15 elaborates on the principle of equality enunciated in Article 14 by prohibiting discrimination on the grounds of religion, race, caste, sex or place of birth.
32. Article-16 provides for equality of opportunity in public employment.
Consent and Testing

The principle of consent is based on the fundamental principle of the autonomy of an individual, and is recognized within the framework of the right to life and personal liberty in Article 21 of the Indian Constitution. Legal issues related to consent in the HIV/AIDS context arise primarily with regard to HIV testing and treatment. The most important reason for taking consent from a person before testing and treatment is respect for human dignity and bodily integrity. Not obtaining consent could result in a criminal charge of assault or battery or a civil claim for damages or trespass to a person. The concept of consent has three important aspects: first, consent is valid only if the person giving it is competent to do so, second, consent must be properly informed, third, consent must be voluntarily given. The patient has a right to all information relevant to the decision of whether or not to consent to a particular diagnostic test, a test to determine the line of treatment or the line of treatment itself. Informed consent implies informing the patient of the implications of the tests and treatment and risks involved in the treatment prior to taking consent from the patient.

Though the common law on consent is not fully developed in India, references to these principles exist in the Indian Contract Act, 1872 and the Indian Penal Code, 1860. The concept of consent is elaborated in Section 10 of the Indian Contract Act. All agreements are contracts made by the free consent of parties competent to contract.\footnote{Section-11 of Indian contract Act, 1872.} Consent is when two or more persons agree upon the same thing in the same sense.\footnote{Section-13 of Indian contract act, 1872.} Consent is free when it is not obtained by coercion, undue influence, fraud, misrepresentation and mistake.\footnote{Sections 14, 15, 16, 17, 18, 20, 21 and 22, Indian Contract Act 1872.} Even though consent in India is recognised in terms of contracts rather than as a principle of tort, the principles of consent may be utilized for medical testing and treatment. The Medical Council of India had laid down guidelines that are now issued as regulations in which consent is required to be taken in writing before performing an operation. Similarly the rules under the Drugs and Cosmetics Act, 1940 speak of consent for research.

Mandatory testing that is not based on informed consent is a violation of the right to autonomy, has had negative public health consequences and has

\footnotesize{33. Section-11 of Indian contract Act, 1872.\\ 34. Section-13 of Indian contract act, 1872.\\ 35. Sections 14, 15, 16, 17, 18, 20, 21 and 22, Indian Contract Act 1872.}
proven to be detrimental to HIV prevention efforts. Testing for HIV is unlike any other diagnostic or therapeutic test because of the profound consequences—social, financial, medical and emotional—of a positive diagnosis. There is still an overwhelming fear of the disease, concomitant with the fear, of stigma and discrimination. Without a doubt, a positive diagnosis changes a person’s life irrevocably, and so public health strategies across the world struggle to determine whether consent should be taken prior to testing, whether testing should be voluntary or mandatory, whether consent should be informed, how much information is required for consent to be truly informed, when testing can be done without consent, and so on.

In India, mandatory HIV testing policies were, as in the case of other countries, mooted at the beginning of the epidemic. The National AIDS Prevention and Control Policy recognizes the counter-productive nature of mandatory testing and notes that the State “feels that there is no public health rationale for mandatory testing of a person for HIV/AIDS.\(^ {36}\) In 1995, the National HIV Testing Policy was formulated to lay down protocols for testing to monitor the trend of HIV infection, to test blood or organs or tissues for ensuring safety to the recipient to identify individuals with HIV infection for diagnosis and voluntary testing purposes and for research.\(^ {37}\) Mandatory screening for HIV is recommended only for blood transfusion safety and for screening donors of semen, organs, or tissues to prevent transmission to the recipient of the biological products.\(^ {38}\) In these circumstances, the tests cannot be linked to the identity of the individual. As seen above, the Indian private sector remains virtually uncontrolled while adopting discriminatory practices such as mandatory testing for employment and access to services, particularly health care. Mandatory testing is also being considered by the forces. In relation to immigration, the Minister for Health and Family Welfare, in September 2002, declared that foreigners in India, including students, no longer had to undergo mandatory HIV testing as it contravenes the testing policy of the World Health Organization as well as the National HIV Testing Policy.

\(^{36}\) See Paragraph 5.6.1 NAPCP: “HIV Testing”.


\(^{38}\) Ibid
Mandatory Testing, HIV/AIDS and Marriage

Recent developments in legal attitude in context of HIV/AIDS, have revived the debate around mandatory HIV testing. The NAPCP states that testing for HIV infection should be voluntary, only to be done if decided by an individual after pre – test counseling. But there are instances in which the government at the state or national level, has either subjected or has proposed to subject certain groups based on their origin or their occupation, to mandatory testing of HIV infection39. These are classified as:

Students from foreign countries coming to India: Foreign students intending to study at any institution in India for a period of one year or more had to undergo mandatory HIV testing, at least till 2002. The present status of this policy is unclear as different sources give different views. The National AIDS Prevention and Control Policy states that this testing is voluntary and other sources state that mandatory testing for students existed only till 2002. But information on the website of the Indian and the United States governments suggest that such a policy may still in a place.

Military recruits and soldiers: The intent of subjecting individuals either being drafted into or already in the military and paramilitary forces to mandatory HIV testing has been announced from time to time, though not implemented40.

Other groups: The government of Maharashtra ordered mandatory HIV testing for all girls of 12 years and older living in designated “destitute homes”

An addition to the controversy surrounding mandatory HIV testing in the recent years has been the announcements by different states government, including those of Goa, Karnataka, Kerala and Andhra Pradesh, of their intention to introduce pre marital HIV testing. The National Commission for Women also recommended the adoption of a similar policy at the national level by amending the Special Marriage Act 1954 and the Hindu Marriage Act 1955. The government of India announced at the World AIDS Conference in 2005 its intention to introduce premarital testing for HIV at the national level, a statement that was subsequently retracted after the reaction of the international community. Therefore, though the “thought” of mandatory

premarital HIV testing has not yet translated in to action, it would be interesting to examine various aspects associated with the implementation of such a policy in the country. Such a policy should not be implemented in any state of India or in India as a whole. The various arguments and scenarios in support of this opinion are presented below:

**Limited beneficiaries of a policy of mandatory premarital HIV testing:**
The average age of marriage in India is 20 years. In most South Asian countries nearly 60 percent girls are married by 18, with one-fourth marrying by the age of 15. Thus, even if one believes that such a policy would prevent individuals from indulging in risky behaviours before marriage, only a minor percentage of the susceptible population, mainly in the adolescent age group, would be targeted. The policy of mandatory premarital HIV testing might work if the couple planning to get married have not had prior sexual relations. In that case if one of the two tests HIV-positive and they do not get married, then one could say that the policy has been successful in preventing transmission of infection to an unsuspecting partner. But if the couple already have a sexual relationship, this premise would not hold true. This scenario is very possible, as research shows that young unmarried individuals, from both rural and urban areas, do indulge in premarital sexual relationships, and a majority of them plan to marry their partners.

**Issues with implementation and marriage registration:** If an individual indulges in risky behavior, but does not want to undergo the HIV test, then he or she may opt for marrying outside the state where the policy of testing does not apply. This occurred in the state of Illinois in the USA when mandatory premarital testing was introduced in the late 1980s. In India it is not compulsory to get married in the state of one’s residence, and therefore, this situation may very well arise. Also, if such a policy does come into effect, then it would be enforceable only in those marriages that are officially registered, the proportion of which is quite low in India. The Supreme Court of India ruled in February 2006 that all states should bring about legislation to make the registration of marriages mandatory, a ruling that it reiterated in October 2007. But compliance with the ruling has been slow, and certain

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41. See The Compulsory Registration of Marriages Bill. Rajya Sabha XXI of 2006

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religious communities have objected to the promulgation of such legislation. Thus, the percentage of marriages coming under the ambit of a mandatory premarital testing policy is likely to be low.

**Potential for societal stigma and discrimination**: There may be a situation in which a couple, being regular residents of the state that has adopted the policy but get married outside the state for personal reasons. It is possible that society at large may conclude that they got married outside the state as one or both have indulged in risky behaviours or are HIV positive, and did not want to undergo testing. This may lead to bias, stigma and discrimination. Usually, weddings in India are social events, with the involvement of families and friends of both sides. In other words, a wedding occurs under “social scrutiny”. If a potential marriage breaks up after either one or both partners test positive, the chance of breach of confidentiality becomes more imminent. Also, if a proposed marriages does not materialize for any other reason, it may be thought that it was a result of one or both prospective partners testing positive for HIV. This may lead to stigma and discrimination as well.

**Defining the responsibility of the state**: If one or both individuals planning to get married test positive, what should be the recourse of the state? Should it allow the marriage to be solemnized if both partners consent? If the state does not allow the marriage, does it have a right to do so? Is it not impinging on the rights of the individual? Further, if one or both test positive, not because they themselves wanted to get tested but because of state policy, should the state also take responsibility of providing them with further medical and social support? These are issues that have to be considered before implementing a mandatory testing policy. At present HIV testing at the individual level is meant to be done after pre-test counseling, thereby addressing the issue of informed consent. An individual has the “right” to refuse an HIV test. The test result is meant to be communicated to the concerned individual only, and it is left to his or her discretion to communicate the result with family members or others concerned. If mandatory HIV premarital testing is enforced, then in effect it take away the “right” of refusal from individuals who are about to married. Also, if a positive result surfaces, can the state share the information with the other uninfected partner in an effort to protect him or her without consent of the infected individual? At this time the two individuals in question
are not yet legally bound to each other. Does the state have the prerogative of informing the HIV status of a person to somebody who is at present not in a legal relation with the infected person? Also, even if the state accepts its responsibility to inform the prospective uninformed partner and the marriage does not materialize, does the state also have responsibility of informing any sexual partners that the infected person may have had in the past or will be having in the future? Should the state’s responsibility be only limited to protecting the partner in case of an impending wedding, or should it extend to each partner that the infected person may have had in the past or will have in the future? If one argues that mandatory premarital testing for HIV should be implemented, then it could be questioned whether the same should be put in place for all infection having similar transmission dynamics. This would not only include diseases for which affordable treatment is easily available, such as syphilis or gonorrhea, but also diseases like hepatitis B, for which there are limited and expensive treatment options. The prevalence of these infections is higher than that of HIV in India.

Or, for that matter, should the state screen for all diseases potentially transmissible from one partner to another?

Issues related to the test itself: The “window period” in the context of HIV refers to the duration after infection in which a test is not able to detect the presence of the infection although the individual is infected. It is possible that an infected person is in the window period at the time a premarital mandatory test is conducted. This may give a false sense of security to the infected and non-infected partners, as well as to the state. Later on, depending on the sexual practices of the partners, the uninfected partner may acquire an HIV infection from the apparently infected partner. In such a case if the couple wants to separate and the “blame” has to put on one of the two for divorce proceedings or alimony matters, it may be contended that the premarital test was negative for both. If, in order to cover the window period, the state decides to conduct two tests as far apart as the maximum length of the window period, does it have the right to stop two willing and consenting adults from getting married at the time they wish to? The positive predictive value of a screening test, being applied to detect the higher to asymptomatic cases of a particular

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disease, gives the probability of the disease being present in an individual who
gets a positive result. It increases with the prevalence of a disease in the
community. It is very likely that the persons entering a nuptial bond belong to
a group in the population that has a low HIV prevalence. In such a condition,
mandatory premarital HIV testing would have a low positive predictive value.
It would result in a large number of false positive tests for the disease as
compared to, say, when it is applied to a high-risk population. Thus, a person
may be labeled positive even when he or she is not, and that too when he or
she did not voluntarily give consent to be tested and to be put in that situation.
A positive test result, true or false, is associated with negative psychological
effects such as anxiety, depression and even suicide, and negative social
effects like stigma and discrimination. Subjecting any individual to these
negative consequences cannot be justified. If a repeat test is conducted after
some time to reduce false position, is it justified to make an individual who
been falsely labeled as HIV-positive undergo the negative consequences for
the period till he or she is proven to be actually negative.

**High and low risk group:** Certain groups within the population have a higher
vulnerability to HIV infection. These include those attending sexually-
transmitted disease clinics, commercial sex workers, men having sex with men
and intravenous drug users. Among these high-risk or vulnerable groups, with
the possible exception of STD clinic attendees, only a minor proportion are
likely to be marrying and coming under the ambit of a mandatory premarital
HIV testing policy. If the premise of the government is that mandatory
premarital testing could control the HIV epidemic, then it may not be
successful as it would be missing out to a large extent in “capturing” the HIV
infection in these high-risk groups. The majority of HIV infections that would
come to light would likely to be in the general population, which already has a
“low” risk of HIV infection. The ratio of the number of persons who would be
screened out as positive to the total persons screened would be quite low when
one screens for a disease in a low-risk population. Such a case is likely to
occur if mandatory premarital screening is adopted as it did in the state of
Illinois. The cost associated with identifying a single case of HIV-positive
infection when mandatory premarital testing for HIV was adopted in Illinois in
the late 1980s was nearly $500,000 for each HIV infection detected. From a utilitarian perspective, such an approach is not justified: if the same amount of money is spent in implementing targeted interventions among the high-risk groups, the outcome in terms of the number of infections diagnosed as well in terms of the number that would be potentially prevented is likely to be higher.

**Would such a policy change behaviour:** One argument for mandatory testing is that it would make more and more positive individuals aware of their HIV-positive status, thereby making them adopt safer behaviours and practices. Studies show a reduction in risky behaviour after HIV counseling and testing. But it is not clear whether this can be attributed to testing and counseling or to psychological or environmental factors. The change in the behaviour of an individual, although influenced by external forces, finally rests upon his or her decision to make the change and adopt it. It seems plausible that if one has voluntary opted for an HIV test, then one has already thought it out in a rational manner and would be more inclined to adopt safer behaviours and practices if the test comes up positive, than if one has been coerced or forced into a test.

In a mandatory testing scenario, if neither the prospective husband nor wife tests positive and the two get married, would it prevent either or both from indulging in risky behaviours after marriage? With the policy enforcing mandatory HIV testing, as we stated before, it may to some extent influence the behaviour of individuals before marriage, but not after. In fact, among HIV-infected married women, the only exposure is often single-partner heterosexual sex with their husbands. The onus of the responsibility of not indulging in risky behaviours is at the level of each individual who has entered into the contract of marriage, based on mutual trust and understanding. Therefore, individual responsibility plays a far greater role in adoption of safe behavioral practices.

Implementing a policy of mandatory premarital HIV testing should also be considered from the human rights perspective. The International Covenant on Civil and Political Rights states that no one “shall be subjected to

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arbitrary or unlawful interference with his privacy”, and goes on to say that:” This right to privacy includes an obligation to seek informed consent for HIV testing, and an obligation to maintain the privacy and confidentiality of all HIV related information”. In the context of mandatory premarital HIV testing, where it would be mandatory to undergo a HIV test, and given that the information would be shared between the two prospective partners and may even be shared between their immediate families, directly or indirectly, there would be definite chances of the breach of the right to privacy. The decision of marriage is meant to be a personal one that is taken by two consenting adults with mutual understanding. As per Article 16 of UDHR, the right to marry and to found a family encompasses the right of “men and women of full age, without any limitation due to race, nationality or religion…..to marry and found a family”, to be “entitled to equal rights as to marriage, during marriage and at its dissolution”, and to protection by society and the state of the family as “the natural and fundamental group unit of society”. The interpretation of this right in the International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, states:

“Therefore, it is clear that the rights of PLHAs is infringed by mandatory premarital testing and/or the requirement of “AIDS-free certificates” as a precondition for the grant of marriage licenses under the State laws…..PLHAs should be able to marry and engage in sexual relations whose nature does not impose a risk of infection on their partners. PLHAs, like all people who know or suspect that they are HIV- positive, have a responsibility to practice abstinence or safer sex in order not to expose others to infection”.

IMPLICATIONS OF MANDATORY TESTING FOR INDIAN WOMEN
In patriarchal and gender inequitable societies such as ours, women’s vulnerability to HIV/AIDS within the marital context is apparent. Inability to exercise their right to consent and autonomy in the context of marriage coupled with the lack of information about their spouse’s HIV status has been the reality for many women living with HIV/AIDS in India. In this respect, the introduction of mandatory premarital testing could garner support from

women’s groups and organizations working with women. The underlying assumption behind NCW’s recommendation is that it will protect young women, who get infected by their husbands after marriage. Some argue that a mandatory premarital HIV testing policy would empower women, as often they are not aware of any risky behaviours on part of their prospective spouses. And having such a test would empower them to refuse marriage and save them from a troubled life in the future.

On further examination, it becomes clear that this is a myopic and restricted view, which actually has negative implications on women’s rights and empowerment in the long term. An HIV-certificate for a spouse would give a woman a false sense of security foreclosing possibilities of safer practices. Women will be at increased risk after marriage as safer sex will be more difficult to negotiate. That premarital mandatory testing and subsequent HIV negative certificates will be a safeguard for women against HIV infection comes from a narrow and limited perspective what is oblivious to the realities of sex outside the marital context and pluralities of sexual behaviour that cut across class, caste, community and gender lines. An example of this scenario is the case of male migrant workers who acquire HIV infections through unsafe sexual contact in urban areas and then infect their unsuspecting partners on return to their villages.46

Existing socio-cultural factors in India already put a woman at a disadvantage with regard to negotiating condom use within heterosexual married relationships.47 If a couple has tested negative during mandatory premarital testing, and the woman wants the husband to indulge in safer sex practice, the husband might very well argue that he is “officially” HIV-negative and does not need to. So, a mandatory testing policy cannot really empower a woman in this regard. The mandatory prenuptial HIV test would be of no use in preventing the partner from indulging in risky behaviours after marriage. Hence, instead of putting a check on the propensity of an individual in risky behaviours, it might on the contrary encourage his or her propensity to do so, as “officially” to the unsuspecting partner he or she is free of infection.

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46. See Chatterjee P. HIV/AIDS infection carries on in rural India, Lancet Infectious Diseases, 2004; 4 (7) 386.
This is likely to push marriage underground which will result in making women, particularly those from socially and economically disempowered backgrounds, more vulnerable to infection. The need of the hour is to create conditions where women are equipped with information, education and are in a position to make choices for themselves about marriage, sex, sexual relations and practices, procreation etc. At the same time it is imperative to question mainstream norms that maintain the universality of marriage and put premium on monogamy, procreation and motherhood, particularly for women. Further, in the context of legislative action, affirmative provisions may be introduced that strengthen women’s ability to insist on safe sex and provide access to a range of remedies in case of coercive and unprotected sex both within and outside marriage. The ultimate responsibility of changing one’s behavior to a nature that does not put one’s prospective partner at risk of HIV infection rests with an individual. The responsibility of the state is more towards creation of an atmosphere that enables the individual to obtain correct and complete information about HIV/AIDS, one that is conducive to voluntary counseling and testing, and supports behavior change in a voluntary manner, rather than through coercive mandatory testing strategies.

**Confidentiality**

Although India does not have a specific law on confidentiality, courts have construed Article 21 of the Constitution – the fundamental right to life and liberty – to include the right to privacy, from which is derived the right to confidentiality. This implies that every person has the right to a sphere of activity and personal information that is exclusive to them and that they have the right to disclose as they please. In legal terms, confidentiality exists within the parameters of a special relationship (doctor-patient, attorney-client, for instance) that is dependent on factors such as mutual trust, or to impart services. Legislatures and courts around the world have gone to some length to protect confidentiality on the grounds of privacy and public interest. In HIV/AIDS context, protecting privacy is often seen as being in the public interest. The maintenance of confidentiality of an individual’s health status is one of the cornerstones of a rights based legal and public health response to HIV/AIDS. Given existing prejudices, the disclosure of an individual’s HIV
positive status indisputably leads to them being ostracized and discriminated against. People avoid a health care system that violates their confidentiality and leads to their stigmatization, which ultimately drives the epidemic underground making attempts to control it ineffectively. The right to confidentiality has thus been viewed as a crucial component to encourage those most at risk to come forward for HIV testing, counseling and treatment. However the principle of confidentiality is not absolute and has been circumscribed in law with specific provisions. This has been done by drawing a fine balance between the importance of maintaining confidentiality and that disclosure in exceptional circumstances.

Accordingly, two divergent interests are balanced in legal approaches to this issue, i.e. the public interest of maintaining the confidentiality of an individual vis a vis the public interest in disclosure of the information. The principle of disclosure states that it can be made with the consent of the person concerned. However the law also lays down situations where it may be necessary to disclose the HIV status of an individual irrespective of consent being obtained. These situations arises where:

- notification to public authorities is required by law
- disclosure is necessary in the public interest, or for the administration of justice (in a court proceeding where HIV status is a material fact) or for the benefit and treatment of the patient (to a healthcare worker directly involved in the treatment).
- disclosure is necessary to protect an identifiable person who is in foreseeable danger (partner notification).

Courts also maintain that the potential negative impact of disclosure must be mitigated through detailed protocols that provide mechanisms by which HIV status is to be revealed to a third party. Indian law has not addressed confidentiality in a substantial manner and there have not been many legal development in the sphere of confidentiality and HIV / AIDS. The Supreme Court has issued a judgement though, that impact partner notification, and allows for disclosure of a person’s HIV status to their partner. It is unfortunate, however that in its judgement the court gave no direction regarding the protocols and methods by which this disclosure was to take
place. This emerged from the Supreme Court case of Mr. X v/s Hospital Z which raised other critical issues (the right of PLHAs to marry), in addition to the right to confidentiality. Mr. X donated blood for his uncle’s surgery at Hospital Z. Months later, Hospital Z informed the uncle that Mr X’s blood had tested positive for HIV. Meanwhile Mr. X was to be married to Ms Y, but he himself called off the wedding when he heard about his HIV status. However, several people including members of Mr X’s family and the large community had been made aware of his HIV positive status because of the public nature of the wedding being arranged and then cancelled, and he was completely ostracized by the community and finally had to leave the state. Mr. X approached the National Disputes Redressal Commission for damages against Hospital Z, on the ground that they disclosed confidential information. The Commission dismissed the petition on the grounds that Mr. X could seek remedy in the civil court. Mr. X therefore approached the Supreme Court. The question of law before the court was whether the NDRC had the jurisdiction to rule on a case in which a plaintiff’s HIV positive status was disclosed by the hospital to third parties.

The Supreme Court however, ignored the limited question before it and chose to pass a judgement on the merits of the case and held that at HIV positive patient who may transmit the disease to his or her prospective spouse is not entitled to the maintenance of confidentiality, since the life of the spouse has to be saved. Therefore, a hospital can disclose a patient’s HIV status to the prospective spouse (partner) and a fact since acts that are likely to spread communicable diseases are a crime under the Indian Penal Code, the failure of the hospital to inform the spouse of the disease would make them participant criminals. The court also ruled that since being infected with a venereal disease is ground for divorce under Indian matrimonial laws a person suffering from such a disease has no right to get married until they are cured.

In this judgment, the Supreme Court only upheld the breach of Mr X’s confidentiality, it also circumscribed the rights of PLHA to marry. An appeal was filed, seeking clarification, and challenging the judgment of the Supreme Court decision to suspend the right of PLHA to marry when that was not even

48. (1998) 8 SCC 296
an issue before it. In the appeal Mr X v Hospital Z\(^{49}\) also known as the right to marry judgment, while the Supreme court rescinded its earlier observations regarding marriage and restored the right to marry for PLHA, it upheld its previous decision about partner notification maintaining that this disclosure was permissible.

Many countries permit partner notification by healthcare workers, even while maintaining strict codes of confidentiality. They do this by adopting a uniform set of protocols to regulate the process of notification. Some of the conditions of these protocols include that there is a significant risk of transmission to the partner; that the HIV positive person is counseled about modes of transmission, the importance and methods of prevention of transmission, and the need to tell their partners their status; the healthcare worker’s reasonable certainty that the positive person will not tell their partner themselves; that the healthcare worker informs the HIV positive person that they intend to make the disclosure and that counseling services are available to the partner when the information is disclosed.

**Criminal Liability for the Transmission of HIV**

Liability for transmission of HIV virus looks at two separate issues. The first arises from the transmission of the virus through blood, blood products and organ transplants, or in other words, transmission of the virus in medical environments due to negligence or a lack of proper quality checks. The other is when an HIV-positive person is held liable for the transmission of the HIV virus and is criminally charged for acts that transmit or risk transmitting HIV. As such individual knowingly, intentionally or negligently had sexual intercourse with other individual, shared a needle or donated blood.\(^{50}\) This could be due either to the negligence or malignant intention of the HIV-positive person. Secondly, a PLHA who is not aware of her/his serostatus may unknowingly infect her/his sexual partner. Thirdly, the transmission or the risk of transmission could be consensual i.e. if an HIV-positive person discloses her/his serostatus to her/his sexual partner, and such partner consents to

\(^{49}\) AIR 2003 SC 664

\(^{50}\) “The situation with respect to perinatal transmission is peculiar. There are some commentators who suggest that an HIV-positive women getting pregnant even after the knowledge of the fact that she is HIV-positive and she might give birth to an HIV-positive child should be included in the ambit of the offence of criminal transmission.” Shah, A.P., AIDS spreading Disease and Criminal Liability, 1995.
protected or unprotected sexual intercourse and contracts HIV. While in the first situation a person is said to have committed criminal transmission of HIV, the law is unclear as to criminal liability in the latter two situations. When and under what circumstances PLAHs can be prosecuted for transmission or risking transmission to others requires a fresh rendition and review of criminal laws in the HIV context.

Criminal sanctions are used as tools to deter people from behaving in any manner that unjustifiably and inexcusably inflicts or threatens substantial harm to an individual or to public interest. However, whether or not criminal sanctions deter risk behaviour and help in preventing the spread of HIV is a complex question. As also, whether imposing criminal sanctions on certain acts done by a PLHA is justified in the first place is a debatable one. For the transmission of HIV to be deemed criminal, certain criteria such as the presence of intention or the absence of consent must exist. Given the social stigma that attaches to HIV/AIDS, the peculiar nature of the epidemic, misconceptions about modes of transmission and the consequent fear attached to it, it is necessary to determine the exact circumstances under which the transmission or risk of transmission of HIV should be criminalized.

Several countries have specific statutes recognizing the intentional or negligent transmission of HIV as a specific offence. In Australia, some jurisdictions have offences in their public health legislation that apply specifically to the transmission of HIV, while others have public health legislation which cover infectious diseases generally. In jurisdictions that deal with criminal transmission non-specifically, i.e. within the existing criminal or public health laws, transmission of HIV is ascribed different levels of gravity, ranging from murder to attempted murder to assault with a deadly weapon. In Canada, where a HIV positive person donates blood or transmits the virus to several people through unprotected sexual intercourse,
the offence committed is of ‘common nuisance’. However charges of common
nuisance do not apply when the conduct of the accused does not endanger the
safety or health of the ‘public’ in general. In a later case in Newfoundland,
the court rejected this conclusion saying that specific individuals are members
of the public and it does not matter whether or not deliberate sex is had with
one person, one thousand persons or one million persons. In the U.S., a
Court of Appeal confirmed the conviction of a physician who was charged
with attempted second-degree murder for infecting a patient with HIV. The
Court held that the fact that the victim tested negative for HIV was irrelevant
to the issue of whether the defendant committed sexual assault or any other
offence. HIV-positive defendants have, in some cases been convicted for the
aggravated offence of ‘sexual assault using deadly weapons’ where her/his
sexual organ, body fluids and even saliva were considered to be deadly
weapons. In one case, a military service member’s conviction was affirmed
on the basis that even though he had used a condom in compliance with a safe
sex order, he was aware that the condom might not prevent HIV transmission
totally. An individual who knows s/he is HIV-positive and has unprotected
sexual intercourse without disclosing the condition to her/his partner may thus
be found guilty of aggravated assault.

The Indian Scenario

In India, criminal transmission related to HIV/AIDS may fall under Sections
304-A, 319, 320, 321, and 322 of the Indian Penal Code, 1860

58. R v/s. Syenyonga 73 CCC (3d) 216 (Ontario City Provincial Division)
60. State v. Schmidt 669 So. 2d 448 (Los Angeles City, App. 1997).
63. Section 304-A, IPC penalises the causing of death by any rash or negligent act not amounting
culpable homicide.
64. Section 319, IPC defines “hurt” as whoever causes bodily pain, disease or infirmity to any person is
said to cause hurt.
65. Section 320, IPC defines “grievous hurt” as “...eighty, any hurt which endangers life or which causes
the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his
ordinary pursuits.”
66. Section 321, IPC defines “voluntarily causing hurt” as whoever does any act with the intention of
thereby causing hurt to any person, or with the knowledge that he is likely thereby to cause hurt by
any person and does thereby cause hurt to any person is said “...voluntarily to cause hurt.” Section
323, IPC prescribes imprisonment or a fine or both for voluntary causing hurt. Section 324, IPC
enhances the punishment if the hurt is cause by dangerous weapons or means.
67. Section 322. IPC defines “voluntary causing grievous hurt” as whoever voluntarily cause hurt, if the
hurt which he intends to cause or knows himself to be likely to cause grievous hurt, and if the hurt
which he causes is grievous hurt, is said “...voluntarily to cause grievous hurt.” Section 325, IPC
prescribes imprisonment and fine for voluntary causing grievous hurt. Section 364, IPC
enhances the punishment if the hurt is cause by dangerous weapons or means.
generally and under sections 269\textsuperscript{68} and 270\textsuperscript{69} specifically. Under Section 320 of the IPC, the injury caused must endanger the life of the victim or must cause severe bodily pain or inability to follow her/his ordinary pursuits for at least twenty days. Under Section 321, intention or knowledge is the main ingredient of the offence.\textsuperscript{70} Therefore, under this section it is important to prove that the accused either intended to transmit HIV to the victim or knew of her/his HIV-positive status while committing the act that transmitted or risked transmission of HIV. The explanation to Section 322 of the IPC clarifies that if a person intended or knew himself to be likely to cause grievous hurt and actually does an act which causes grievous hurt of another kind, then such action could be an offence under this section.

Sections 269 and 270 of the IPC are the most obvious provisions that may be attracted in case of the criminal transmission of HIV in India. These provisions have in the past had been used to address the spread of diseases like cholera, plague, syphilis, gonorrhea and other sexually transmissible diseases. These sections provide penalties for actions that unlawfully, malignantly or negligently spread the infection of any disease dangerous to life. To establish an offence under Section 269, two main elements must be established. First, the action of the accused must be unlawful and/or negligent. An action must be contrary to Indian law to be unlawful. A negligent act is an omission to do something that a reasonable person, guided upon those consideration which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable person would not do.\textsuperscript{71} Second, it is necessary that the accused knew or had reason to believe that her/his action could cause harm. The element of malignancy is essential in the commission of an offence under Section 270. Malignant transmission is a deliberate intention to harm. The use of the word ‘malignantly’ denotes that the

\textsuperscript{68} Section 269, IPC: “Whoever unlawfully or negligently does any act which is and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.”

\textsuperscript{69} Section 270, IPC. “Whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.”

\textsuperscript{70} In re Nataraja Goundan AIR 1939 Mad 507.

\textsuperscript{71} See Rattanlal and Dhirajlal, Indian Penal Code, Wadhwa and Company Law Publishers, 28\textsuperscript{th} Edn. 1997, p-322.
spreading of infection should be actuated by malice. In the HIV/AIDS context, not using condoms and/or adopting safer sex practices, could, depending on the circumstances, be negligent or malignant. A man who uses a condom improperly and consequently transmits HIV, may have committed a negligent act under Section 269. Similarly, a person who discovers that s/he is HIV positive, and subsequently had unprotected sex without disclosing her/his HIV status thereby infecting another person, would have committed a malignant act i.e. Section 270. The expression ‘dangerous to life’ used in both sections is not restricted to diseases that are immediately dangerous to life.

The concept of mens rea is contained in almost all sections of the IPC; in Sections 269 and 270 mens rea implies ‘negligently’ and ‘malignantly’ respectively. For an act to be done or be believed to be done with good faith, it must be done with due care and attention. When the question arises as to whether a person acted in good faith then s/he must show not only that s/he had a good intention, but that s/he exercised such care and skill as the duty reasonably demanded for its due discharge. Thus if a person, who is aware of her/his HIV positive status, does not use a condom or uses it improperly and as a result transmits HIV to her/his partner, s/he will said to not have acted in good faith.

Sections 269 and 270 are silent on the issue of the consent of the victim. It is therefore debatable if a person’s consent to protected/unprotected sexual intercourse with a partner who they know is HIV-positive would be a defence against an offence under these sections. Section 87 of the IPC makes consent of a victim/sufferer, a defence available to the person accused of committing a crime under the IPC. In the HIV context, consent would be not only to sexual intercourse, but also specifically to intercourse with an HIV-positive person. However, in order that Section 87 may apply, the accused must have acted without any intention of causing death or any grievous hurt, or without knowing that his act was likely to cause death or grievous hurt. Consent is also not valid if given under fear of injury or misconception of facts. The general principle is that consent of the victim cannot legalise a

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72. Ibid.
73. State v/s Sakharam Jairam AIR 1955 NUC (Bom) 4834.
74. Section 52, IPC. States that nothing is said to be done or believed in ‘good faith’ which is done or believed without due care and attention.
75. (1878)14 Cox CrPC 226,227,228.
crime except when it is otherwise provided by statute, or the absence of consent for the act in question is a constituent element of the offence as in the case of rape.\textsuperscript{76} At common law, although consent may be a defence to ordinary or common assault, it is not a defence to any serious assault involving the infliction of bodily harm.\textsuperscript{77}

In Rakma\textsuperscript{78} a prostitute was charged with having communicated syphilis to the complainant. The Bombay High Court held that the accused was not guilty of an offence under Section 269 because the complainant himself was a responsible person and an accomplice.\textsuperscript{79} It has been contended that this decision is not sound, as the complainant cannot be deemed to be an accomplice, being unaware of the disease. R.v.Clarence\textsuperscript{80} in England followed the judgment in Rakma. In Clarence, a husband failed to disclose to his wife that he had gonorrhea before engaging in sexual intercourse with her. The court held that the husband’s failure did not vitiate his wife’s permanent consent to sexual intercourse because there was no fraud as to the ‘identity of the person’ or the ‘nature of the act’. On the contentions raised by the prosecution viz. “that had the wife known that her husband was diseased she would not have consented, that the husband was guilty of a fraud in concealing the fact of his illness; that her consent was therefore obtained by fraud, and was, therefore, no consent at all.” The judge noted, ‘This reasoning seems to me eminently unsatisfactory.” This was affirmed in another case, where a person suffering from a venereal disease had sexual intercourse with his wife. He could not be said to be doing an ‘unlawful’ act even though his wife might have been ignorant of the fact that he was suffering from a venereal disease. In Cuerrier,\textsuperscript{81} which differed from Clarence, the Supreme Court of Canada has articulated circumstances when consent for sexual intercourse is vitiated. The accused was charged with two counts of aggravated assault pursuant to Section 268 of the Criminal Code of Canada. Both complainants had consented to unprotected sexual intercourse with the accused not knowing

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\textsuperscript{76} See Section 375, IPC.
\textsuperscript{77} R.v. Brown (1994) 1 AC 212.
\textsuperscript{78} The Queen-Empress v. Rakma Kom, Sadhu B.S. Vol. XI 59, 1886.
\textsuperscript{79} “Assuming that there was a dangerous disease and culpable negligence, still the accused’s act of sexual intercourse would not spread infection without the intervention of the complaining party, himself a responsible person and himself generally an accomplice.” Ibid.
\textsuperscript{80} (1888) 22 Q.B.D. 23
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that he was HIV-positive. They testified at trial that if they knew of his HIV-positive status they would never have engaged in unprotected sexual intercourse with him. At the time of the trial neither of the complainants had tested positive for HIV. The trial court acquitted the accused. On appeal, the court of Appeals held that the failure of the accused to disclose his HIV-positive status, as a type of fraud. This fraud was committed by the failure of the accused to disclose her/his infection to the victim vitiates consent. The Supreme Court held that, “the failure to disclose HIV-positive status can lead to a devastating illness with fatal consequences and, in those circumstances, there exists a positive duty to disclose.” The consent cannot be only to have sexual intercourse; rather it must be to have intercourse with a partner who is HIV-positive. The HIV-positive status of one of the partners in a sexual act is a material fact, which must be disclosed.

For criminalizing an act of HIV transmission, two layers of consent must be determined. First, if the HIV-negative victim consented to sexual intercourse and second, if s/he consented to sexual intercourse with an HIV-positive person, knowing the possible risks of transmission. Ultimately, Sections 269 and 270 of the IPC will be attracted when one or both of the following circumstances exist. First, where the victim has not consented to the risk of the transmission of HIV e.g. the victim consented to unprotected sexual intercourse, but not to unprotected sexual intercourse with a person who is HIV-positive. Second, where the person with HIV intended to cause harm to the victim. For criminal sanctions to be an effective mechanism in preventing the spread of HIV there is a strong argument to make lack of consent to transmission or the risk of transmission an element of the crime, or alternatively, to make consent a defence to transmission offences. Sections 87, 88, 89 and 92 of the IPC recognise certain exceptions whereby acts

83. Section 23 of Singapore’s Infections Disease Act, 1976 states: “A person who knows that he has AIDS or HIV infection shall not have sexual intercourse with another person unless, before the sexual intercourse takes place, the other person-(a) has been informed of the risk of contracting AIDS or HIV infection from him and (b) has voluntarily agreed to accept this risk.”
84. Section 87, IPC lays down consent as a defence where the act is not intended and not known to be likely to cause death or grievous hurt.
85. Section 88, IPC lays down consent as a defence where an act not intended to cause death is done in good faith for a person's benefit.
86. Section 89, IPC lays down consent by the guardian as a defence for an act done in good faith for the benefit of a child or an insane person.
87. Section 92, IPC excludes the requirement of consent for an act done in good faith for benefit of a person.
that may constitute an offence, are not punishable. Consent of the alleged victim is one such exception. Thus acts done with the express or implied consent of the person at risk of harm or that are done unintentionally or in good faith or for the benefit of a child or an insane person are not punishable, even though they may constitute an offence under the IPC. However Section 90 of the IPC stipulates that consent must be ‘free’ and according to Section 91, an act would in certain cases amount to an offence even if consent were given.

However, Section 87 of the IPC does not permit a person to give her/his consent to any act intended or known to be likely to cause her/his death or grievous hurt. This is based on the notion that it is not in public interest that a person would cause actual bodily harm to another for no good reason. This means that the consent of the victim would not be construed as a defence under Sections 269 and 270 of the IPC since the HIV infection would be likely to cause the death of the victim, albeit not immediately. Therefore a distinction needs to be drawn between the principle that one cannot consent to actual bodily harm or to one’s own homicide, and situations entailing the risk of such harm. There is ample precedent where law permits consent to the risk of very serious harm; situations such as surgery and competitive activities such as boxing, wrestling and other sports involving physical contact. These consensual activities are allowed despite the risk of death or serious bodily injury, which in some instances in much higher than certain types of conduct involving HIV infection that are criminalized.

Section 91 states that consent, as a defence is not available in cases of acts, which are offences independent of any harm that they may cause. Since Sections 269 and 270 are applicable in cases where there has been an unlawful, negligent or malignant act but no actual transmission of HIV, and since they are considered offences against public safety. Section 91 would be

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88. Section 90, IPC specifies that consent given under fear of injury or misconception of fact will not be a defence if the accused knows or has reason to believe that the consent was given under such fear or misconception.

89. Section 91, IPC limits the exceptions contained in Sections 87 and 89, IPC. These exceptions do not extend to acts which are offences independently of any harm which they may cause, or be intended to cause, or be known to be likely to cause, to the person giving the consent, or on whose behalf the consent is given.

applicable and the defence of consent would not be available. This means that a PLHA may be liable to criminal sanctions even though s/he had sexual intercourse with an HIV-negative person with such person’s express consent to sexual intercourse with the HIV-positive person, and even where HIV was not transmitted to the HIV-negative partner. The implications of such harsh application of laws that were not designed to deal with the HIV epidemic is that they criminalize sexual intercourse for all HIV-positive persons, since protected sexual intercourse only reduces the risk of transmission and does not guarantee complete protection from infection. Therefore, there is a need to amend the IPC in making Section 91 specifically inapplicable to Sections 269 and 270 in relation to the transmission or risk of transmission of HIV. The protection of Section 90 i.e. that the consent must be free, should form an essential component for such consent to be considered a valid defence. Absent such amendments, Indian criminal laws may have the effect of criminalizing consensual sexual activity.

In a vast majority of cases, HIV is not transmitted due to malicious or calculated acts by PLHAs. Internationally, there have been very few cases involving the deliberate transmission of HIV since the early 1980s. Most involved some form of violence, such as rape, forced or threatened exposure to bodily fluids or, in a negligible number of cases, biting. Despite their rarity, these cases received enormous publicity and contributed to a sharp increase in fears and misconceptions about HIV/AIDS and PLHAs. In India, concerns regarding the intentional or negligent transmission of HIV have arisen due to the increasing rate of HIV transmission among married couples. Anecdotal evidence suggests that there have been several instances where one of the spouses was aware of her/his HIV positive before marriage and failed to inform the other of this status, consequently transmitting the virus to the spouse. Similarly there have been instances where one contracts the virus after marriage, knows of her/his HIV-positive status and fails to disclose this to her/his spouse, thereby exposing him/her to the risk of transmission. Increasing reports of such incidents have promoted proposals for enhanced punishments who knowingly, negligently and/or malignantly infect others

91. “By reason of Section 91, it would seem that the offences created by Sections 269 and 270 are committed irrespective of any consent that might have been given by the person at risk of infection.”

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with HIV. Enhancing punishment to deter crimes has been a questionable strategy in several settings other than HIV. Firstly, convictions are only on proof of guilt beyond reasonable doubt. Any doubt on an issue confers the benefit of doubt to the accused person. Secondly, persons are presumed innocent until proven guilty, there is difficulty in establishing criminality in cases relating to the transmission HIV. The criminal legal system is premised on the principle that it is better to let a hundred guilty persons go free than for one innocent person to be wrongly convicted. In this context if punishment were enhanced, conviction of an accused would be less likely than under the existing provisions.

The existing provisions of Indian criminal law can be applied to HIV-positive individuals who act in an irresponsible manner and malignantly transmit the virus to another person. Laws relating to criminal transmission must be used judiciously and should only criminalise the ‘the willful transmission of HIV’ and not the HIV positive status of the person. The enactment of an HIV/AIDS specific criminal law to cover acts that are already criminalized, with the misguided intention of stemming the spread of the epidemic, is likely to increase the hysteria and stigma related to HIV/AIDS. Such attempts to introduce HIV/AIDS specific criminal law in other parts of the world have accordingly been abandoned. HIV/AIDS specific criminal legislation or coercive public health measures could also send a misleading message that people need not protect themselves against the risk of HIV infection as the State’s law will serve the function. This would seriously undermine HIV education campaigns which stress that it is the responsibility of everyone, people who are HIV-positive as well as people who are HIV negative, to take precautions. It would give credence to the notion that PLHAs are “criminals” and their sexual partners are “innocent victims”. Such a law would simply target PLHAs, leading to further marginalization -an impact that will seriously hamper the innumerable prevention, treatment, care and support efforts that are already functioning to prevent and control the HIV epidemic and promote the rights of PLHAs.
Approach of Indian Judiciary Towards HIV/AIDS Victims

A landmark anti-discrimination case in the Bombay High Court that affirmed the rights of PLHAs in the workplace was MX v. ZY where MX, a casual labourer, was tested for HIV by his employer, ZY, a public sector corporation, prior to being regularized into a permanent position. MX tested positive for HIV, and though otherwise fit, was rejected from being regularised, and his contract was terminated. MX filed a writ petition in the Bombay High Court, arguing that the company’s rules (mandatory HIV testing and denial of employment to positive people) and actions violated Articles 14, 16 and 21 of the Indian Constitution. The court ruled that, a government/public sector employer cannot deny employment or terminate the service of an HIV-positive employee solely because of their HIV positive status is a violation of Fundamental Rights. Secondly the services of HIV positive employees can only be terminated if they pose a substantial risk of transmission to their co-employees or are unfit or unable to perform the essential functions of their job. Determining whether a person is unfit or incapable of performing their job must be made on the facts of each specific case by conducting an individual enquiry (beyond a mere diagnostic test). This case set a very positive precedent in Indian law for the right of people living with HIV and equality in the employment, and is consistent with widely accepted international human rights norms. Although the High Court did not refer expressly in its ruling to any international human rights instruments addressing discrimination, it did refer at length to a number of policy statements from outside India on the issue of HIV and employment-including the WHO resolution passed by the Member States, the ILO and the Southern African Code on HIV/AIDS and Employment. It also cited the National HIV Testing Policy published in 1995 by the NACO. All of these provided clear guidance that mandatory HIV testing in the employment context is irrational and unjustified, and amounts to an infringement of human rights.

Unfortunately, while the decision overall was very positive, the High Court did not explicitly prohibit pre-employment HIV testing, a point which was made in several of the sources cited. In fact, the High Court's judgement

92. AIR 1997 Bom 406
left the door open to such testing. In stating that the petitioner may have to resubmit to medical tests to establish current fitness for the position, the Court made reference to such tests "including for HIV", even though it had declared his HIV status irrelevant to the employment decision. In this regard, the question of whether pre-employment HIV testing (or even demand for testing during employment) infringes human rights was left to be challenged in another case.

As a side matter, in this case, the High Court also considered the petitioner's request for an order suppressing his identity. The Court considered jurisprudence from the Supreme Court of India and from Australian courts in concluding that such an order was appropriate and "in the interests of the administration of justice", in light of the widespread societal stigma still attached to the disease and the ostracism and discrimination still experienced by PLHAs. This was also a welcome development in Indian law, since it addressed one barrier, among many, to people with HIV using the law and the court system to protect and promote their human rights.

In RR v. Superintendent of Police & others, RR, was tested for HIV as a requirement for entry into the police force. On being found to be HIV-positive his job application was rejected. RR approached the Karnataka Administrative Tribunal challenging the constitutionality of a circular issued by the Director General of Police mandating that applicants testing HIV-positive would not be inducted into the Karnataka Police. The Tribunal declared that a person who was fit, otherwise qualified, and posed no substantial risk to others cannot be denied employment in a public sector entity. It also found that the policy circular that denied employment on grounds of an HIV-positive diagnosis alone was a violation of Articles 14 and 16 of the Constitution of India, and prohibited the government from denying employment on these grounds in future.

In 1988, Goa became the first state in India to introduce a specific law on HIV/AIDS. The Act called for mandatory testing of anyone suspected of being HIV positive. Upon a positive result, the person was mandatorily isolated, with no concern for her/his rights. HIV status was not be kept

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93. Unreported [2005] Karnataka Administrative Tribunal
confidential, and discrimination was not only condoned but also expected. In essence, being HIV positive became a ground for depriving a person of her/his liberty. The provision of mandatory isolation has since been amended and left to the discretion of the authorities and though it is rarely invoked, it remains the law. Lucy D’Souza, mother of the late HIV/AIDS activist Dominic D’Souza, challenged Act on behalf of her son. When Dominic D’Souza was found to be HIV positive, he was put in jail under the Goa Public Health Amendment Act. This case was fought on constitutional grounds. It was argued that the deprivation of a person’s liberty under the Act was arbitrary, unreasonable and discriminatory, because there was no rational basis for concluding that the isolation of PLHAs could prevent spread of HIV infection. Secondly, it was argued that the act constituted a breach of the principles of natural justice because it allowed a PLHA to be isolated without giving the person an opportunity to be heard on the issue. Therefore, it was contented that the Goa Public Health Amendment Act was violative of Article 14 and Article 21 of the Indian Constitution. The challenge was repelled by the Bombay High Court. The court concluded that isolation on medical grounds, as decided by medically trained persons, could not be deemed arbitrary or unreasonable.

After the Lucy D’Souza decision, which clearly indicated that the law in India was heading down the path of ensuring discrimination on the basis of HIV infection by pursuing the isolationist strategy, the Government of India sought to introduce a National AIDS Bill along the lines of the Goa Public Health Amendment Act. Due to the campaign efforts of voluntary groups as well as pressure from international organizations like the WHO, AIDS Bill was never enacted into law. It has become clear that an HIV/AIDS control policy and strategies including legal strategy need to be developed as an integrated programme. Since the Lucy D’Souza case, the Goa Public Health Amendment Act has not been applied to any other person living with HIV/AIDS. The isolationist strategy is not strictly practiced and an adhoc response has followed. Another notable case in HIV/AIDS context is Mr. X.

v/s Hospital Z\textsuperscript{96} where in its initial decision the SC denied the right to marry for people living with HIV/AIDS, then resiled from this conclusion.

The application of this justification to absolve the hospital physician on the facts of this particular case was most troubling. First, it should be noted that the hospital physician did not notify Mr. X himself of his HIV positive test result, even though he was the first and, arguably the only, person to whom this information should have been conveyed. Rather, the hospital physician notified the minister to whose relative Mr. X had been willing to donate blood (although ultimately it was not used in the surgery). Through a circuitous route, the information made its way to Mr. X's fiancéé, the person whom the Court considered at risk of infection and whose well-being it invoked in order to justify the physician's egregious breach of confidentiality. It was illogical to absolve the physician and hospital of liability for breaching Mr. X's confidentiality on this basis. Only after taking the basic step of first informing Mr. X of his test result would it have been permissible to consider whether it was necessary or justifiable to disclose his HIV-status to his fiancéé. There was nothing in the judgement suggesting any plausible reason as to why the hospital doctor should have given this confidential health information about Mr. X to the minister.

Second, the Supreme Court seems to have ignored the explicit language of the Code of Medical Ethics adopted by the Indian Council. The Code expressly says that patient secrets may be disclosed "only" in a court under a judge's order. There was no such court order in this case. Rather, the Supreme Court simply noted that there was a similar exception in English law, and then went on to say that English law also permits disclosure, "in very limited circumstances, where the public interest so requires. Circumstances in which the public interest would override the duty of confidentiality could, for example, where there is an immediate or future (but not a past and remote) health risk to others." It also noted that the guidelines provided by the General Medical Council of Great Britain on HIV disclosure allowed for disclosure "when there is a serious and identifiable risk to a specific person, who, if not so informed would be exposed to infection." On this basis, the Supreme Court

\textsuperscript{96} Mr. X v/s Hospital Z, 1998, 8SCC 296, varied 2002 SCCL 701, Civil Appeal No. 4641, SC 1998 & 2002. Also see A, C & others v/s Union of India & others, High Court of Judicature at Bombay (Mumbai), Writ Petition No1322 of 1999.
concluded that the Code of Medical Ethics "also carves out an exception to the rule of confidentiality and permits the disclosure in the circumstances enumerated above under which public interest would override the duty of confidentiality, particularly where there is an immediate or future health risk to others." Yet, the Indian Code of Medical Ethics does not, in fact, refer to such an exception, and says clearly on its face that disclosure is only permitted under judicial order. The Supreme Court apparently chose to create such a new exception in the common law of India, but it was incorrect to say that it flows from the existing Code of Medical Ethics.

The Supreme Court also appeared to endorse the view that the law denies people living with HIV the right to marry. In ruling so, the Court went beyond addressing any issue also breach of confidentiality that was squarely before it on the facts, and created a new discriminatory provision in Indian law. Whatever legitimate concerns the Court may have had regarding the potential for transmission from one spouse to another, it was not necessary to adopt such a position, in which the outright denial of a basic right, based on HIV-positive status, was at odds not only with the basic international human rights principles but also India's own jurisprudence on equality.

The case highlighted a tension between different human rights concerns. The Court offered little justifications for its far-reaching declaration flatly denying the right to marry to people living with HIV, even though the right to marry is recognized as a basic human right. Yet a number of women's organizations in India, concerned about the widespread and entrenched gender inequality that leaves many Indian women with little autonomy when it comes to marriage decisions or engaging in sexual relations with their husbands, welcomed the decision as a measure that would protect women from HIV/AIDS.

Following the Supreme Court's decision, advocates initiated further legal proceedings [A, C & Others v. Union of India & Others] to challenge the court's statement that PLHAs do not enjoy the right to marry. Represented by the Lawyers Collective HIV/AIDS Unit, four people (two of them living with HIV) filed a petition in the High Court of Judicature at Bombay asking the court to declare that a PLHA has the right to marry and this right is not lost or suspended on account of the person's HIV status. Further it was also
contended that a person with HIV who enters into marriage with a willing partner after disclosing this fact does not commit an offence under Indian Penal Code; and the overriding duty of physicians is to preserve the confidentiality of information about their patients, save for very limited, exceptional cases in which the law may require them to disclose certain information, such as when a third party appears to be in imminent danger or harm.

The petitioners argued that the right to marry is a basic human right recognized in various international instruments (e.g. the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights), in the Indian Constitution and in various judgments of the Supreme Court itself, and can only be abridged by a valid law enacted by the competent legislature. They argued that there was no justification for the state to deny PLHAs the right to marry or to subject them to criminal prosecution, if their spouse is aware of their status. Furthermore, they argued that suspended fundamental rights of people with HIV/AIDS will drive people underground and away from testing, thereby ultimately contributing to the spread of HIV/AIDS. Finally, they pointed out that HIV transmission can be prevented by adopting safer sex practices, and that the risk of mother-to-child transmission can be significantly reduced through appropriate interventions.

In response, the federal Solicitor General sought to uphold the original Supreme Court decision. In addition to repeating the reasoning set out previously by the Court, the Solicitor General also argued that a complete prohibition on the right of persons with HIV to marry was justified in order to protect women's human rights.

According to the learned Additional Solicitor General for India, the proposition urged on behalf of the petitioners that an HIV positive individual would have the right to marry subject only to disclosure of the HIV status to a prospective spouse, would be too broad to merit acceptance. According to him, such a consent as an attribute may have relevance to a society with high levels of literacy, education and one that is individualistic. He has submitted that in Indian society the Court has to be mindful of that position of women in society and the peculiar disabilities faced by women, and that the regard will have to be had to the impact of such social circumstances like poverty,
illiteracy and socio-economic pressures which operate as barriers upon human rights of women. According to him the mere requirement of consent is not sufficient to protect against the exploitation of women as a class extremely vulnerable to the transmission of HIV infection.\textsuperscript{97}

A similar argument was advanced by an intervener Majlis Manch, a NGO providing legal aid and advocacy to women in distress. The intervener argued that the denial of the right to marriage to PLHAs was a reasonable restriction in order to protect the rights of women who are vulnerable to infection from their male partners. It is rather optimistic to presume that an order from this court marriage of HIV positive persons is likely to benefit women, and men will willingly marry ailing and afflicted women. On the other hand, it is likely to adversely affect a large number of women who might be forced into marriage with afflicted men. They contended that the right of PLHAs to marry, even with consent, needs to be contextualized within this social reality, where the terms like 'disclosure' and 'consent' lose their significance for a vast number of women. In the Indian setting, rarely the bride is provided with an opportunity of giving informed and valid consent. According to them any judgement of Hon'ble Court which gives a right to marry for HIV positive persons can only be construed as a death trap for the vast majority of women.

India is one of the few countries which has still not granted legal recognition to marital rape. So in the Indian context a consent to marriage in effect implies a consent to daily and recurrent sexual intercourse. While the parents may have given their consent to marry off their daughter to an HIV-positive man, or the girl herself may have done so, within the existing legal scheme, this consent automatically gets translated into a consent to repeated sexual intercourse endangering her life. A consent to marriage cannot be construed as a consent to a virtual suicide.\textsuperscript{98}

The intervener therefore argued that the Court should declare that all agencies providing counselling and health care to HIV/AIDS patients had a

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legal obligation to reveal their client's HIV status to the spouse and counsel the couple together regarding unprotected sex. It also urged the Court that, if it were to allow an HIV-positive person to marry an HIV-negative person, this should be permitted only after application to the Court, and after the Court has had the chance to determine the consent of the HIV-negative spouse to the marriage.

While the case was before the Bombay High Court, Mr. X initiated further proceeding before the Supreme Court seeking a clarification on these very points challenging the Court's ruling. Consequently, the Bombay High Court dismissed the petition by "A", "C" and the others, on the ground that it was more appropriate that the matter be dealt with directly by the Supreme Court. Consequently, the matter was brought on before that Court, where the same basic arguments were presented. In its decision, the Supreme Court reiterated the correctness of its original decision on the issue of justifying the doctor's actions in revealing Mr. X's HIV diagnosis "to persons related to the girl whom he intended to marry". However, it admitted that since this disposed of the claim before it, there was no need for this Court to go further and declare in general as to what rights and obligations arise in such context as to right to privacy or confidentiality or whether such persons are entitled to be married or not or in the event such persons marry they would commit an offence under law or whether such right is suspended during the period of illness. Therefore, all those observations made by this Court in the aforesaid matter were unnecessary, particularly when there was no consideration of the matter after notice to all the parties concerned. In that view of the matter, the observations made by this Court, except to the extent of holding as stated earlier that the appellant's right [to privacy] was not affected in any manner in revealing his HIV-positive status to the relatives of his financee, are uncalled for.99

In the result, the Supreme Court distanced itself from the statements in its earlier ruling that appeared to deny marriage rights to all people living with HIV. It did not, however, explicitly disavow or correct them, which would have been preferable. Furthermore, the initial judgement with its overly

99. See Mr. X v Hospital Z, 2002 SCCL.COM 701 at para 6.
permissive approach to excusing doctors' breaches of confidentiality remained intact\(^\text{100}\). There are innumerable cases of HIV/AIDS related discrimination in the workplace that have been adjudicated.\(^\text{101}\)

Though these cases are specific to discrimination in the workplaces, the constitutional guarantee of equality also extends to other areas like healthcare, education, travel etc.\(^\text{102}\) At present the Supreme Court in Sankalp Rehabilitation Trust and others v/s Union of India\(^\text{103}\) is hearing a case about HIV-related discrimination in health care settings. In the present case, the Writ Petition was filed under Articles 14, 21, 32, 41, 42 and 47 of the Constitution of India, as there were a large number of PLHAs who were denied medical treatment in public hospitals. Closely associated with discrimination in health care is the issue of health care workers denying treatment on account of fear of occupational exposure to HIV while treating HIV-positive patients. Further, the petition also raised the issue that certain provisions of the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 were violative of the right to self-autonomy and confidentiality of PLHAs.

The petition sought from the Supreme Court a declaration that the denial to treat or discrimination in treating a person on the ground that s/he is or is suspected to be HIV-positive is violative of Articles 14 and 21 read with Articles 37, 41, 42 and 47 of the Constitution of India. Also an appropriate writ, order or direction to the Respondent to frame, adopt and follow a formal protocol to ensure non-discriminatory treatment to PLHAs and for providing Universal Precaution and Post Exposure Prophylaxis to all its medial staff. Among other things, the Petitioners sought availability of anti-retroviral

\(^{100}\) The full text of the two Supreme Court rulings in Mr.X v Hospital Z (1998,2002) and the ruling in A,C& Others v. Union of India & Others can be found through website, www.lawyerscollective.org.


\(^{102}\) LX v. Union of India, Delhi High Court (order dated 05 May 2004)
P v. Union of India ( 2001) Kolkata High Court ( Negligence in Blood Transfusion.)
M. Chinnayyan v. Srs. Gokulam Hospital and Queen Mary’s clinical Laboratories ( National Consumer Disputes Redressal Commission, 2006), Case No. 1698/30/2003-04 of National Human Rights Commission Cases : Medical treatment to XXX, an HIV positive denied at LNJP Hospital, New Delhi.

\(^{103}\) Writ Petition No. 512 of 1999. Also see: Sahara House and ors v. Union of India-orrs, Voluntary Health Association of Punjab & ors. v. Union of India and others.
treatment for life time to PLHAs free of cost and universal access to all by 2010; a safe working environment and Post-Exposure Prophylaxis to all health care workers to be made available throughout the country; free Opportunistic Infection (OI) programme to be strengthened; all drugs and tests to be made free; ART Rollout programme needs to be planned better; Government to take immediate steps to remove taxes on ARVs; proper implementation of Country Coordinating Mechanism and accessing the Global Health Fund and source ARVs from Public Sector Companies.

The Government of India then filed a reply to the said directions. Briefly the reply stated that: Efforts shall be made to provide anti-retroviral treatment therapy to PLHA’s who are eligible clinically. The Government is all set to establish 250 ART centres covering the whole country to provide ART to 300,000 patients under National AIDS Control Programme Phase III (2007-2011). The ART should be available in an equitable manner to all groups including marginalized communities. In accordance with National AIDS Policy, testing is carried out with informed consent, confidentiality and in a non-discriminatory manner in all the Integrated Counseling and Testing Centres in the country. NACO has recently updated guidelines for post-exposure prophylaxe to Health Care Workers which are being circulated to all health care facilities. The guidelines for management of opportunistic infections have already been updated by the technical committee. The treatment of O.I.s and ART are provided free in government hospitals including CD4 tests for those on ART. No patient has suffered on account of shortage of drugs and in case of an emergency the centres are also authorized to make local purchases. The Union Government has reduced the customs duty to 5% and the blood testing kits to 5%. All the drugs for treatment are exempted from excise duty and countervailing duty. However no comments were made by the government with reference to proper implementation of Country Coordinating Mechanism and accessing the Global Health Fund.

Need for Human Rights based Law to Protect the Rights of HIV/AIDS Victims

Human rights violations of HIV/AIDS victims assume many shapes and forms and occur within unacceptable frequency and impunity. The epidemic touches
on the most personal behaviours and aspects of people's lives, and its effect is felt in every sphere of a person's life. Combating it therefore demands a socio-legal approach that integrates social, cultural, economic and human rights perspective. Justice Michael Kirley of Australian High Court has perhaps most eloquently articulated this principle: "The most important public health lesson emerging from the HIV/AIDS epidemic is that respecting and protecting the rights of those already exposed to HIV/AIDS and those most at risk is the most effective way to curb the rapid spread of the epidemic. This situation can only be tackled by enacting a special legislation on HIV/AIDS".

Increasing numbers of HIV/AIDS related cases on issues of confidentiality, consent and discrimination are entering the Indian Courts. There is a need to address these cases with sound scientific and rational understanding of HIV/AIDS and its multifarious implications, and an overall love for justice and equality. It is evident from the very numbers of people living with HIV/AIDS seek legal aid, advise and support. HIV/AIDS is an emerging issue in the area that our legislature, executive as well as judiciary must respond to, with sensitivity. The lack of sensitivity on the part of the policy makers was exposed in a “Person-to-Person” survey\(^\text{104}\), conducted amongst the Indian Parliamentarians. It was found that many of them still hold incorrect beliefs about HIV transmission like, 40 percent of the 250 parliamentarians surveyed believe that HIV can spread by working with an HIV-positive person; 56% think sharing food and utensils increases the risk of acquiring the virus; and 22.8 percent believe it is spread by using same toilet seat. This survey brings together some very provocative material on the perceptions and approach of our elected representatives in a vital area of national policy.

The litany of woes related to HIV/AIDS continues unabated in India. In India there is no law or statute that specifically addresses the issues that are raised in the HIV/AIDS context. Both appellants and the judiciary make their complaints, decisions and rulings by extrapolation from a variety of law sources. In the early days of HIV/AIDS, when scientific and medical

\(^{104}\) Survey released by India’s Prime Minister Manmohan Singh and conducted by the Indian Association of Parliamentarians on Population and Development. 24 August 2007 (Rabinourtz, AP/Canada.com). It was concluded that nearly two-thirds of India’s Parliament members incorrectly believe HIV is transmitted by sharing clothing, food, toilets and office spaces.
information about the disease and particularly about the modes of transmission was limited, public health legislation that was enacted to curtail and control other contagious diseases were amended and modified to include HIV/AIDS. For instance, a person living with HIV/AIDS was required to inform the station master of his/her status and faced possible restrictions on travel by trains. To date, for example AIDS is a notifiable disease in Mumbai. In its early days the government's response was to isolate anyone who was HIV positive in an effort to control the epidemic. India's first HIV litigation arose when HIV positive activist Dominic D'Souza was incarcerated in the late 1980's. Since this first case, violations of rights of PLHAs and people affected with HIV/AIDS have increasingly come to light, many legal cases have been fought and won or lost, and many judgements have been pronounced by the courts. The HIV/AIDS epidemic has thrown up myriad legal issues and the responses of the judiciary have been mixed. The framework of legislation is too limited and cannot be transposed to adequately cover HIV/AIDS related issues. This necessitates the creation of a legal environment that protects the dignity and rights of the individuals infected and affected by HIV/AIDS through the enunciation of a statutory law that guarantees such protection. The various reasons why a specific statute is required to govern the HIV/AIDS scenario are mentioned below.

The vagaries of common law: Most legal issues that arise in the context of HIV/AIDS are governed by common law-where law is defined by principles set down in prior case law by judges. This allows for the personal predilections of judges to impact cases of HIV/AIDS, an approach that lends itself to inconsistency and to rulings that are sometimes in opposition to the existing, well thought out policy of the government.

Addressing stigma, discrimination and denial: The guarantee of equality in the Indian Constitution is available only against state entities and there is no restriction on discriminatory practices in the private sector, be it in healthcare, employment, or education. Most countries have enacted anti-discrimination laws applicable to the private sector to ensure a universally applicable legal system, but this is not a case in India.
Insufficiency of policies: As seen earlier, the National AIDS Prevention and Control Policy (NAPCP) through it mandates a rights-based approach, does not have the status of law and is neither binding nor enforceable in court.

Law reform: There are various interventions amongst marginalised populations in India that effectively check the spread of HIV, notably, condom promotion and needle syringe and exchange programmes. Existing legislation could set these initiatives at naught and the interventions have to be legally protected to ensure that they continue providing services and information that empower persons to protect themselves and others from HIV/AIDS.

Fulfilling international obligations and commitments: In 2001, the United Nations General Assembly adopted the Declaration of Commitment on HIV/AIDS. India as a signatory to this Declaration is committed to general obligations such as the prohibition of discrimination and specific obligations such as ensuring that by 2005, at least 90% of young persons aged 15 to 24 have access to information, education and services necessary to reduce their vulnerability to HIV. The Indian government is obligated therefore to enact legislation that will fulfill these and other obligations such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of all forms of Discrimination Against Women.

For all these reasons, a specific statute to address HIV/AIDS- its prevention, its treatment and the manner in which we respond to the people most affected by it is needed. A nationally applicable rights-based statute would serve several purposes, it would provide holistic coverage, consistency, clarity and predictability in order for courts to effectively pass judgments in HIV/AIDS cases, it would provide certainty for people to seek remedy from a strong reliable legal system, and it would enshrine ethical, equitable and just practices that become harbingers for change in the many other contexts and spheres in which people are continuously disempowered, it will ultimately reflect the ideals and principles for a more inclusive and humane society.

While our Constitutional ethos and interpretation thereof delineated above make it clear that the public sector cannot discriminate on the basis of HIV, discrimination in and by the private sector is more difficult to address. While most countries have anti-discrimination legislation to cover discrimination in the private sector, this is not the case in India. One-third of countries
worldwide lack laws protecting PLHAs from discrimination. Even where laws exist, there is no information on how well they are enforced. Only 33% of countries use performance indicators for the reduction of HIV/AIDS related stigma and discrimination. PLHAs in India do not have any statutory protection against discrimination. In India the drafting of HIV/AIDS Bill has gone through various phases since 2002. In 2002 at the International Policy Makers Conference on HIV/AIDS, New Delhi the government supported the creation of an enabling environment for HIV prevention and control. Recognising that HIV/AIDS is not just a medical condition but also has socio-economic and legal consequences, the conference called for an appropriate rights-based law on HIV/AIDS. Subsequently in 2006, the HIV/AIDS draft bill was prepared by the Health Ministry after intensive discussions with concerned NGOs and different stake-holders including PLHAs, sex workers, MSM as well as IDUs. This 2006 version of the Bill was sent to the Ministry of Law and Justice for vetting.


This Bill embodies principles of human rights and seeks to establish a humane and egalitarian legal regime to support India’s prevention, treatment, care and support services for the HIV/AIDS victims.

Prohibition of Discrimination: The HIV/AIDS Bill specifically prohibits discrimination related to HIV/AIDS both in the public and private spheres. Under the Bill, no person could be discriminated against in employment, education, healthcare, travel, insurance, residence and property, etc. based on his/her HIV related (be they infected or affected) status. It covers all acts and omissions that are discriminatory on the basis of HIV status, whether it is actual or perceived and whether the person discriminated against is HIV-positive, a relative, a friend, or is associated with HIV/AIDS similar in the case of groups that are considered in the public imagination as ‘vectors of the epidemic such as sex workers, injecting drug users, men having sex with men, truckers or migrants etc’. Further since discrimination in healthcare

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105. The 2008 Report on the global AIDS epidemic compiled information from 147 countries that reported on their progress towards the 2001 Declaration of Commitment on HIV/AIDS, made at special session of the UNGASS on HIV/AIDS in Geneva.

106. In the Bill, these persons are collectively referred to as ‘protected persons’.
settings is attributed largely to the lack of healthcare workers right to a safe working environment, the Bill imposes an obligation on healthcare institutions to provide universal precautions and training to all healthcare workers. The Bill also addresses the issue of hate and discriminatory speech and make it punishable.

**Informed Consent for Testing, Treatment and Research:** The Bill requires specific, free and informed consent for HIV related testing, treatment and research. HIV testing must be accompanied by pre- and post-test counselling, HIV treatment may commence only after an explanation of risks, benefits and alternatives available while HIV research may take place only after the research subject is informed of aims, methods, sources of funding, possible conflicts of interest, institutional affiliations of the researcher, potential benefits and risks, possible discomfort and the right to withdraw consent. The Bill embodies the recognized standards of informed consent and exceptions to it, while increasing access to healthcare services for children and young persons. The Bill also requires special attention to be given to women and young persons and for specific counselling regulations that will create an atmosphere conductive to individual decision-making. Consent for HIV testing under the Bill is not required when it is ordered by courts as in case of testing blood, organs, semen etc and also for surveillance purposes.

**Disclosure of Information:** The Bill guarantees the confidentiality of HIV related information (including the HIV status of a person) and outlines the exceptions under which disclosure can be made as in cases of partner notification' and the 'duty to prevent transmission.' The Bill specifies the exact protocol for, and circumstances, in which, a healthcare provider can notify the partner of an HIV positive person about his/her status. It recognises the particular vulnerability of women to violence in such situations and specifies that partner notification should not take place if there is an apprehension of violence. The Bill also imposes a duty on all HIV positive persons to prevent transmission through various measures like using safer sexual practices or informing their partners.

**Right to Access Treatment:** The Bill provides for universal and free access to comprehensive HIV related treatment, prevention, care and support. This includes services, information, voluntary testing and counselling services in
every sub-district, counselling, medicines for opportunistic infections, post exposure prophylaxis, anti-retroviral therapy, nutritional supplements, prevention of mother-to-child transmission, diagnostic, etc. Many of these services are already part of the national HIV/AIDS programme including the ARV rollout plan of the Indian government. Under the Bill, access to treatment must be provided in a sustained, accessible and acceptable manner. The Bill also requires the National HIV/AIDS Authority to notify protocols for HIV related treatment and testing.

**Risk Reduction**: Risk reduction strategies minimise a person’s risk of exposure to HIV/AIDS. It includes programmes that promote safer sex, provide clean needles to drug users and provide information to children. Since they are provided to communities and persons often subjected to criminal sanction under various laws (sex workers, injecting drug users, men having sex with men etc.), the Bill specifically protects risk reduction strategies from civil and criminal liability and law enforcement harassment. This does not mean for instance, that injecting drug use is legalised. It simply means that providing clean needles to protect a person from HIV cannot be stopped on grounds that it promotes drug use.

**Information, Education and Communication (IEC)**: Information is the key to any successful prevention programme. The Bill treats the government IEC programme as an essential component in the fight against HIV/AIDS. Communication messages should be positive and evidence based and should speak not just about prevention but also about care, support and rights. The Bill recognises the right of all persons to information and education relating to health and the protection of health from the State, and focuses specific to their needs. The Bill obligates the State to institute IEC programmes that are evidence-based, age-appropriate, gender-sensitive, non-stigmatizing and non-discriminatory.

**Implementation and Grievance Redressal**: The HIV/AIDS Bill creates innovative grievance redressal and implementation mechanisms. The Bill provides for health ombudsmen to be appointed in every district to provide easy and quick access to health services for all persons who may be discriminated against or denied treatment. It also provides for internal complaints mechanisms in institutions. Grievance redressal provisions also
include special procedures in courts like suppression of identity, speedy trials etc. The emphasis is on quick trials and creative redressal. Thus a case related to discrimination could see a court awarding damages and directing the person who discriminated to undergo sensitisation and training and doing community service. In terms of implementation the Bill establishes HIV/AIDS Authority that will take over from the national and state AIDS control societies with an independent and accountable structure and expanded policy and programme base.

Special Provisions of the Bill: The Bill specifically recognises certain rights for women, children and persons in the care and custody of the State who due to social, economic, legal and other factors are more vulnerable to HIV/AIDS and are disproportionately affected by the epidemic. Prisoners and detainees are provided with specific access to risk reduction strategies, counselling and healthcare services. The Bill attempts to recognise and address some underlying causes of the vulnerability of women to HIV/AIDS and suggests the registration of marriages, the provision of maintenance and the right of residence for HIV positive women. The right of HIV positive women who are pregnant to proper counselling and to decide on treatment options is specifically recognised. The Bill also recognises the link between sexual violence and HIV and provides for counselling and treatment of sexual assault survivors and directs the setting up of sexual assault crisis centres. Special provisions for children and young persons include the right against discrimination in education and to access health care services and information in their own right. This is particularly important for street children and those living on their own. It also provides for protection of inheritance and property rights and recognises community-based alternatives to institutionalisation for vulnerable and affected children, provisions that were a direct result of feedback from the consultation with children's groups.

The HIV/AIDS Bill 2006 envisages a detailed and carefully planned strategy to address the HIV epidemic through an extensive prevention, care, treatment and support programme that entails widely disseminated and easily accessible, IEC, an accountable and accessible government response, access to healthcare services and treatment and the protection and promotion of the fundamental human rights of persons living with or affected by HIV/AIDS.
One of the key visions of the Bill is to establish a government initiative on HIV/AIDS that is completely accountable and that is implemented at every stage with consultations. It is worth reiterating that in the HIV/AIDS context, only by protecting the rights of the most vulnerable hope to tackle the epidemic and thereby protect all could be sustained. By providing for a right against discrimination, to informed consent, to confidentiality and to access treatment, people can be encouraged to come forward for testing with the understanding that there will be no adverse consequence to their HIV-positive status and if there are the law will offer protection.

By recognising the rights of women, the Bill empowers them to demand information and safer sexual practices from their partners. By premising the IEC programme on the right to information, Bill empowers all persons to demand IEC in their languages, regions and to suit their specific needs. By protecting needle exchange, condom promotion and sexual health information programmes, The Bill help those most marginalised to protect themselves and others from HIV/AIDS. By recognising the right of all citizens to question their government bodies are also made accountable, consultative and democratic creating a strategy to tackle the HIV epidemic where every person is a stakeholder, every voice is included and no one is left behind. The aim of this bill is to help the epidemic emerge from the underground so that HIV/AIDS is no longer a synonym for fear, neglect, discrimination and violence but become a symbol of empowerment, compassion, united action and triumph.

However much diluted version of the 2006 Bill was sent back by the Law Ministry which was roundly criticized on various grounds. The concerned NGOs submitted that: “The HIV/AIDS Bill 2006 is comprehensive and reflects concerns of all stakeholders. In making changes, the law ministry has ignored people’s views and diluted principles of democratic governance.” In particular, it deletes chapters on prevention and treatment that forms the core of the National AIDS Control Programme. As result of the protests the Law Ministry again sent the draft of the Bill- almost like the last one. The Law Ministry proposed the third draft of the HIV/AIDS Bill after deleting 38 key...
provisions that the Positive People’s Network has demanded. It also deletes chapter on strategies of risk reduction and access to free treatment which the government should be obliged to offer as per the original draft Bill. The new draft also ignores important issues like the special needs of women and children, and the definition of discrimination has also been watered down. Moreover, a new chapter has been added that proposes the isolation of people infected with HIV. This is a step which would take India back to the isolationist attitude towards the disease. Today, as per the National AIDS Policy, and in the world as a whole, an approach for integrating the PLHA population in society is followed. This policy has also been espoused in the International Guidelines on HIV/AIDS and Human Rights, which promotes greater involvement of PLHAs in controlling the epidemic. This isolation policy contradicts it. The revised Bill is also attacked on the ground that it works against creating an “enabling environment” for sex workers, IDUs and MSMs who are considered high-risk groups for HIV infection. Presently the stake-holders are demanding that the deleted provisions should be reinstated in the latest version of the Bill and passed by the Government.

The increasing instances of discrimination against PLHAs and the inadequacy of the existing legal system to address these issues, underscores the need for a law that can effectively protect the basic human rights of PLHAs. Though it may seem paradoxical, the fact is that protection and promotion of the rights of the infected and those most vulnerable to the disease is the most effective public health strategy. This is reflected in experiences from other parts of the world where the spread of the disease has either slowed down or been halted through such a public health strategy. Emphasizing on legal issues like consent, testing, confidentiality and the transmission of HIV etc. would be an appropriate rights-based legal approach on HIV/AIDS.

It is hard reality that legal developments does not automatically translate into human rights development: a link between law and human lives must be created through conscious national policies. The rights based approach needs to be centered around the dicta of distributive justice to redress

107. One of the major provisions that has been deleted in the third draft of the Bill was emergency health services for an HIV/AIDS patient.
the stigma and discrimination by designing ambitious schemes and programmes for protecting the dignity and human rights of HIV/AIDS victims which is one of the major tasks in the new millennium. If we fail here, all talk of human rights movements would only sound a verbal jugglery against large portion of humanity suffering discrimination and indignity.

Thus one key challenge to human rights of HIV/AIDS victims in the new millennium is to ensure distributive justice in the national as well as global context. One of the principles which has been derived from the upheavals of seventeenth and eighteenth centuries is the primacy of democracy, but it is a principle which carries with it a baggage of inchoate assumptions that are capable of subverting the principle itself. Both in enacting rights and in applying them, it is necessary to understand that such principles are not self-implementing and that in their application they can readily be hijacked by those who already possess the greatest power in the society. It is only by being rigorous about a second such ground rule or principle, substantive equality before the law, that it becomes feasible to go about fire-proofing the juridical elements of life in a democracy and be serious about preventing the appropriation of legal rights for private or partial ends. It has been said with some justification that there is potential tension between the principle of democratic government and the principle of equality before the law.

Democracy must mean inclusive democracy, involving all sections including HIV/AIDS victims women, sex workers IDUs or sexual minorities in decision-making and governance. That is why the human rights movement needs to address the stigma and discrimination against HIV/AIDS victims which threaten the values- possibly even the meaning of democracy. In India the judiciary has shown a fair degree of sensitivity to these questions. Through various techniques like Public Interest Litigation, giving expansive interpretation to right to life and liberty, protecting minorities rights, promoting gender justice, creating new kind of compensatory jurisprudence, holding executive responsible for avoiding public duty and requiring transparency and probity in conduct of public affairs, the judiciary in India has attempted to strike the balance. The task remains incomplete and sporadic aberrations need to be firmly curbed. Commitment of the institutions of the
governance to the democratic principles is the real safeguard against the apprehended dangers of the HIV/AIDS epidemic.