CHAPTER-2
CONCEPTUALIZATION AND MAGNITUDE OF HIV/AIDS PANDEMIC

“It is clear before God & Man that entire war on HIV & AIDS has not been waged with any degree of piety, responsibility & care”
Mangosuthu Buthelezi,WHO Director, 2006

Nature of HIV/AIDS Pandemic

The term AIDS came into existence only in 1981 and HIV, the virus that causes AIDS, was not discovered until 1983. Although the discovery of both the virus and the disease is part of recent history, its impact has been inordinately widespread. There is an entire industry today thriving on this, and HIV/AIDS has developed its own vocabulary and discourse. There is a school of thought that looks upon HIV/AIDS as solely a biomedical reality. There are others, however, who think of it as purely a product of social construction. In the latter group are those who have developed cultural taxonomies in trying to analyse the risk factor. It is now being realized that both these extreme typologies have led to victimization of certain groups. Today there is an effort to look at HIV/AIDS from a more holistic perspective and analyse how and where such victimization has occurred which gave rise to a range of human rights violations of people infected and affected with the virus.

The known history of HIV/AIDS began with the American crisis where a number of gay men were discovered with a rare type of pneumonia.1 The first reports of this appeared in the medical bulletin and then there was silence. Between 1981 and 1982 even national newspapers such as The New York Times carried only three reports of the scourge that was overtaking New York. Because of the homosexual connections the impact of HIV/AIDS was underplayed in these first years. The disease came to be known as the ‘Gay Plague’. As one analyst remarks, for most Americans ‘HIV/AIDS was not primarily a public health emergency. It was the Wages of Sin’. And hence, the

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1. AIDS was first reported on June 5, 1981, when the US Center for Disease Control and Prevention recorded a cluster of Pneumocystis carinii pneumonia (PCP) in five homosexual men in Los Angeles. In general press, the term GRID which stood for gay-related immune deficiency was coined. However, after determining that AIDS was not isolated to the homosexual community, the term GRID became misleading and thereafter AIDS was introduced in a meeting in July 1982.
urge for this secrecy. Soon the heterosexual nature of HIV/AIDS became known and the witch-hunt soon widened to include other marginalized “bad people” such as intravenous drug users and sex workers etc.

When ‘normal’ heterosexual people began to be affected in large numbers scientists turned their attention elsewhere. Many among them began to explore the similarity of HIV with Simian Immunodeficiency Virus (SIV) that causes AIDS-like symptoms in some monkeys. Further research confirmed that the common chimpanzee was the main reservoir of HIV-1. It was told that this species of chimpanzee was native of Africa and so HIV/AIDS was marked as an African disease. Soon, scientists started looking for evidence of the African connection of AIDS. They found this in two sailors, one from England and another from Norway.3 The case of the Manchester sailor could not conclusively prove this connection but the sailor from Norway seemed to have contracted a virus very similar to HIV that proved fatal for him, his wife and their child. The sailor died in 1976 and although he visited Africa, he never traveled to the United States. By the time this correlation was established, fear of HIV/AIDS and anyone connected to it became entrenched in peoples mind. This was caused by the infectious nature of the disease and the rising number of fatalities. Anyone connected to the disease was assumed to have led a bad or immoral life. Many blamed the lax sexual practices of African communities as the root cause for the infection.

By the late 1980s, Africa became the centre of attention because of the HIV/AIDS devastations. The presence of HIV/AIDS virus was dated to the last phase of colonial rule in Africa. By 1975, this had reached epidemic proportions but little was known about this because African disasters hardly ever attracted international attention. The first HIV/AIDS project began in Kinshasa where 6 to 7 percent of women in antenatal clinics were found to be infected. From West Africa attention was turned to East Africa. In Uganda the disease was known as ‘slimming disease’ as it led to massive weight loss. What was interesting about the rapid spread of the disease in Uganda was the largely Christian orientation of the country and its strict sexual practices. Thus the infection was no longer a case of Christian or un-Christian lifestyle.

3. HIV was found in tissue samples from Avid Noe, a Norwegian Sailor who died in 1976, See Hooper, E. “Sailors and star bursts and the arrival of HIV”, 1997.
In these initial days, there were a number of trends that became apparent. It showed that blood transfusions in hospitals led to incredible spread of disease. It also portrayed that multiple use of disposable syringe might have helped to spread the virus. But international media highlighted more the role of migrants and their sexual orientations as the primary cause for the spread of the virus. There was little discussion on a few findings that held the colonial masters and their experimentation in different types of vaccines as a probable cause for HIV/AIDS spread. It was much less traumatic to blame the migrants and their practice of visiting sex workers. Although sex workers received a lot of negative attention, women in general remained outside the focus of general analysis for quite some time and their vulnerability continued to be ignored, especially in the official discourses. Attention turned to other countries particularly in Asia much later but when it did the number of positive cases rocked the world. First it was Thailand and then attention was turned to India. India was seen as a country where potential for damage was extremely high because of its sheer numbers. It is now a pandemic, with an estimated 33.3 million people living with the disease worldwide. UNAIDS and the WHO estimate that AIDS has killed more than 28 million people since it was first recognized, making it one of the most destructive epidemics in recorded history retarding economic growth and destroying human capital.

The three main transmission routes of HIV are sexual contact, exposure to infected body fluids or tissues, and mother to fetus or child transmission during prenatal period. It is possible to find HIV virus in the saliva, tears, and urine of infected individuals, but there are no recorded cases of infection by these secretions, and the risk of infection is negligible. Heterosexual intercourse is the primary mode of HIV infection worldwide. Approximately 30 percent of women in ten countries representing diverse cultural, geographical and urban/rural settings report that their first sexual experience was forced or coerced, making sexual violence a key driver of the

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4. India’s first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu in 1986. It was noted that contact with foreign visitors had played a vital role in initial infections among sex workers.
5. UNAIDS (20 November 2007). Global HIV prevalence has leveled off; AIDS is among the leading causes of death globally and remains the primary cause of death in Africa. Press release. (Retrieved on November 22, 2009).
HIV/AIDS pandemic. Sexual assault greatly increases the risk of HIV transmission as protection is rarely employed and physical trauma to the vaginal cavity frequently occurs which results in the transmission of HIV. Women are more susceptible of HIV-1 infection due to hormonal change, vaginal microbial etiology and physiology, and a higher prevalence of sexually transmitted diseases.

Exposure to infected body fluids is another transmission route which is particularly relevant to intravenous drug users, hemophiliacs and recipients of blood transfusions and blood products. Sharing and reusing syringes contaminated with HIV-infected blood represents a major risk for infection with not only HIV, but also hepatitis B and hepatitis C. Needle sharing is the cause of one third of all new HIV infections. This route also affects people who give and receive tattoos and piercing. Universal precautions are frequently not followed due to shortage of supplies and inadequate training. The risk of transmitting HIV to blood transfusion recipients is extremely low in developed countries where improved donor selection and HIV screening is performed. However, according to the WHO, the overwhelming majority of the world's population does not have access to safe blood and between 5 percent and 10 percent of HIV infections worldwide are transmitted through the transfusion of infected blood and blood products.

The transmission of the virus from the mother to the child can occur in uterus during the last weeks of pregnancy and at the time of childbirth. In the absence of treatment, the transmission rate between the mother to the child during pregnancy, labor and delivery is 25 percent. However, when the mother has access to antiretroviral therapy and gives birth by caesarean section, the rate of HIV transmission is just 1 percent. Studies have shown that antiretroviral drugs, caesarean delivery and formula feeding reduce the chance of transmission of HIV from mother to child. In 2007, around 700,000 children contracted HIV, mainly through MTCT, with 630,000 of these infections occurring in Africa.

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7. Breastfeeding increases the risk of transmission by 10-15 percent. This risk depends on clinical factors and may vary according to the pattern and duration of breastfeeding.
There is currently no vaccine or cure for HIV/AIDS. The only known methods of prevention are based on avoiding exposure to the virus. Current treatment for HIV infection consists of highly active antiretroviral therapy, which allows the stabilization of the patient's symptoms and viremia, but it neither cures the patient of HIV, nor alleviates the symptoms, and high levels of HIV-1, often HAART resistant, return once if treatment is stopped. Despite this, many HIV-infected individuals have experienced remarkable improvements in their general health and quality of life, which has led to the plummeting of HIV associated morbidity and mortality. Ironically antiretroviral drugs are expensive, and the majority of the world's infected individuals do not have access to medications and treatments for HIV/AIDS. It has been postulated that only a vaccine can halt the pandemic because a vaccine would possibly cost less, thus being affordable for developing countries, and would not require daily treatments. Unfortunately, as in many poorer countries, access to this treatment is severely limited in India. The large scale of India's epidemic, the diversity of its spread, and the country's lack of finances and resources all present barriers to HIV/AIDS prevention programmes.

Extent of HIV/AIDS Pandemic

Globally, between 33.4 and 46 million people currently live with HIV. In 2008, between 3.4 and 6.2 million people were newly infected and between 2.4 and 4.4 million people with AIDS died. Sub-Saharan Africa remains by far the worst affected region, with an estimated 21.6 to 27.4 million people currently living with HIV. Two million [1.5-3.0 million] of them are children younger than 15 years of age. South Asia is second worst affected with 15 percent of HIV/AIDS infected persons. AIDS accounts for the deaths of

8. Hereinafter to be referred as HAART.
11. “It is a sad irony that India is one of the biggest producers of the drugs that have transformed the lives of people with AIDS in wealthy countries. But for millions of Indians, access to these medicines is a distant dream”.
Jonnae Csete, Director of the HIV/AIDS programme at Human Rights Watch.
500,000 children in this region. Two-thirds of HIV/AIDS infections in Asia occur in India. Earlier it was estimated that India has 5.7 million infections (estimated 3.4-9.4 million) (0.9% of population), surpassing South Africa’s estimated 5.5 million (11.9% of population) infections, making it the country with the highest number of HIV infections in the world. The 2009 report on the epidemic suggests that there are around 2.5 million infections in India. The estimated number of adults and children living with HIV /AIDS in Eastern Europe and Central Asia was 1.6 million at the end of 2008. Some 2.70,000 people were newly infected with HIV in 2008. AIDS related deaths claimed an estimated 62,000 lives in 2008 alone as compared to 36,000 AIDS related deaths in 2005. Likewise in Asia about 8.3 million people were living with HIV in 2008, bringing to an estimated 1.1 million of people newly infected with the virus. A further 520,000 people are estimated to have died due to AIDS-related diseases in 2008.

About 1.8 million people are now living with HIV in Latin America and about 300,000 in Caribbean. At least 24000 people died of AIDS-related diseases in Caribbean and about 66,000 died in Latin America. The Caribbean's status shows the second-most affected region in the world which marks substantial differences in extent and intensity of the epidemic. Estimated national adult HIV prevalence surpasses 1 percent in Barbados, Dominican-Republic, Jamaica and Suriname, 2 percent in the Bahamas, Guyana, Trinidad and Tobago, and exceeds 3 percent in Haiti. The number of people living with HIV in North America, Western and Central Europe rose to 1.9 million in 2007, with approximately 65000 people having acquired HIV in the past year. Wide availability of antiretroviral therapy has helped keep AIDS deaths comparatively low, at about 30,000. There were an estimated 1.04 million-1.2 million HIV cases in the USA at the end of 2008.
Global Summary of the HIV/AIDS Epidemic, December 2010

<table>
<thead>
<tr>
<th>Number of people living with HIV in 2009</th>
<th>Total</th>
<th>33.3 million [31.4 - 35.3 million]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>30.8 million [29.2 - 32.6 million]</td>
<td></td>
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<tr>
<td>Children under 15 years</td>
<td>2.5 million [1.6 - 3.4 million]</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>People newly infected with HIV in 2009</th>
<th>Total</th>
<th>2.6 million [2.3 - 2.8 million]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>2.2 million [2 - 2.5 million]</td>
<td></td>
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<tr>
<td>Children under 15 years</td>
<td>370 000 [230 000 - 510 000]</td>
<td></td>
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</tbody>
</table>

<table>
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<tr>
<th>AIDS deaths in 2009</th>
<th>Total</th>
<th>1.8 million [1.6 - 2.1 million]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>1.6 million [1.4 - 1.8 million]</td>
<td></td>
</tr>
<tr>
<td>Children under 15 years</td>
<td>260 000 [150 000 - 360 000]</td>
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</tbody>
</table>

Source: AIDS epidemic update 2010 (UNAIDS, WHO)

A Global View of HIV Infection in 2009: 33.3 million People living with HIV

Adult prevalence (%)
- 15.0% - 28.0%
- 5.0% - <15.0%
- 1.0% - <5.0%
- 0.5% - <1.0%
- 0.1% - <0.5%
- <0.1%
- No data available
HIV/AIDS Scenario in India

The vast size of India makes it difficult to examine the effects of HIV/AIDS on the country as a whole. The majority of states within India have a higher population than most African countries, so a more detailed picture of the crisis can be gained by looking at each state individually. The HIV prevalence data for each state is established through antenatal clinics, where pregnant women are tested. While this means that the data is only directly relevant to sexually active women, they still provide a reasonable indication as to the overall HIV prevalence in each area.\(^\text{13}\)

In Andhra Pradesh in the year 2006-07 the HIV prevalence at antenatal clinics was around 2%, higher than in any other state. The HIV prevalence among MSMs was highest at 17 percent followed by 9.7 percent among female sex workers and 3.7 among IDUs. HIV prevalence at STD clinics was 17 percent in 2007. In Goa the HIV prevalence at antenatal clinics was found to be above 1 percent in both 2005 and 2006, but was 0.18 percent in year

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2007, Goa State AIDS Control Society reported that in 2008 a record number of 26,737 persons were tested for HIV, of which 1018 (3.81%) were tested positive. In Karnataka the average HIV prevalence at antenatal clinics has exceeded 1 percent in last five years. Districts with the highest prevalence tend to be located in and around Bangalore in the southern part of the state, or in northern Karnataka's 'devadasi belt'. The average HIV prevalence among female sex workers in Karnataka was just over 5 percent in 2007 and 17.6 percent of MSMs were found infected. Likewise the HIV prevalence at antenatal clinics in Maharashtra was 0.5 percent in 2007 and surveys of female sex workers have reported highest rates of infection i.e above 20 percent. Similarly prevalence among injecting drug users was 24 percent and 12 percent among MSMs. The HIV prevalence at antenatal clinics in Tamil Nadu was 0.25 percent in 2007. Prevalence among injecting drug users was 16.8 percent, 6.6 percent in MSMs and 4.68 percent among FSWs.

Taking about Manipur, the nearness of Manipur to Myanmar and therefore to the Golden Triangle drug trail, has made it a major transit route for drug smuggling. NACO has reported that HIV prevalence among injecting drug users is 17.9 percent but various studies from different areas of the state find prevalence above 32 percent. However the virus is no longer confined to this group, but has spread further to the female sexual partners of drug users and their children. The estimated adult HIV prevalence at antenatal clinics is 1.57 percent. Similarly in Mizoram in 1998, HIV epidemic took off quickly among the state's male injecting drug users, with some drug clinics registering HIV rates of more than 70 percent among their patients. In recent years the average prevalence among this group has been much lower, at around 3-7 percent. HIV prevalence at antenatal clinics was 0.75 percent in 2007.

In Nagaland injecting drug use has again been the driving force behind the spread of HIV. In 2003, the HIV prevalence at antenatal clinics was 8.63 percent but has since declined to 1.91 percent in 2007. The rate at STD clinics was 0.60 percent.

14. Devadasi women are a group of women who have historically been dedicated to the service of gods.
16. See World Bank 'South Asia Region (SAR) – India' Regional Updates, 2005.
14 Districts with HIV Prevalence > 3% among ANC clinic attendees

**ANDHRA PRADESH**
- West Godavari
- Mahabubnagar
- Prakasam
- Narasampet

**KARNATAKA**
- Hassan
- Belgum

**MAHARASHTRA**
- Chandrapur
- Sangli

**MANIPUR**
- Ukhrul

**NAGALAND**
- Tura

**ORISSA**
- Cuttack

**RAJASTHAN**
- Chittorgarh

**TAMIL NADU**
- Namakkal
- Salem

- ANC HIV prevalence 3%
- ANC HIV prevalence 2.5-3%
- ANC HIV prevalence 2-2.5%
- ANC HIV prevalence 1.5-2%
- ANC HIV prevalence 1-1.5%
- ANC HIV prevalence <1%
- No data available

In 2006, HIV Sentinel Surveillance was conducted at 628 ANC sites (470 urban + 158 rural).

- 150 ANC sites showed >1% positivity in ANC clinic attendees 124 of these are in six high prevalence states and the rest 26 are in Gujarat (6), MP (4), Orissa (4), UP (3), Mizoram (2), West Bengal (2) Arunachal Pradesh (1), Bihar (1), Chhatisgarh (1), Haryana (1) & Rajasthan (1).

<table>
<thead>
<tr>
<th>HIV Prevalence among ANC Clinic Attendees</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
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<tbody>
<tr>
<td>ANC</td>
<td>0.80</td>
<td>0.95</td>
<td>0.90</td>
<td>0.60</td>
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</table>
Implications of HIV / AIDS Epidemic

It goes without saying that HIV/AIDS epidemic is as much about social phenomena as it is about biological and medical care. Thus from a public health issue HIV/AIDS has now become a human rights issue. PLHAs are stigmatized worldwide in a variety of ways, including ostracism, rejection, discrimination, compulsory HIV testing without prior consent or protection of confidentiality and violence against HIV/AIDS infected individuals. The stigma is turning what could be a manageable chronic illness into a death sentence and perpetuating the spread of HIV/AIDS.

The harassing of individuals suspected of being infected with HIV/AIDS has been reported number of times worldwide. HIV/AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand. There have been instances where PLHAs are publicly censured, abused or abandoned by their families and even in some reported cases, denied last rites when they die. The impact of HIV/AIDS on women is particularly acute. In many developing countries like India, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In majority of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases. The women are the primary caregivers to sick members of the family, when it comes to HIV/AIDS, the husbands, who carry the deadly HIV virus to their wives abandon and blame them for causing infection. Stigmatised without any fault of theirs, women become more vulnerable to abuse, exploitation and ravaged by the malady.

When AIDS enters the household, the adult male/female infected with AIDS are generally unlikely to live beyond the age of 47, thereby devastating economies and crippling health sectors. In this context, it is easy to see how AIDS is responsible for creating a missing generation across the world. A study in 15 villages in Uganda found that number of households had a ‘missing generation’ of family members; where men and women who

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17. In December 1998, Gugu Dhalamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status. Similarly a family affected with AIDS at Chak Holgarh village near Anandpur Sahib, Punjab has been facing social boycott from neighbours as well as relatives. (Family faces social boycott-AIDS hit, The Tribune, 10th Nov 2006.


19. Hereinafter to be referred as STDs.
succeeded to AIDS and died at the age when they were prime income earners. This loss of members of generation has robbed communities not only of financial support but also, farming techniques, culture, traditions and wisdom which are passed from one generation to other. The devastation is most evident in African and Asian countries where the burden of care-giving is on the elderly population. As the parents die of AIDS at much younger age, the trend of grandparents raising HIV+ grandchildren has become so prevalent that as many as 40 percent of these orphans live with their grandparents. Taking into consideration the missing generation scenario many NGOs and other organisations have started “Granny Clubs”. These are social and educational networks of women (and some men) who are caring for HIV/AIDS infected grandchildren.

It has been realized that where elders have become the head of households with burden of care-giving responsibilities, they sink deeper into poverty which disproportionally affects the households. Their old age limits their ability to contribute to work and earn an income. The burden is enormous, as caring for an AIDS patient can increase the workload of a family caretaker by one-third. The average monthly expenditure increases and in many cases, this gap is met by loans or sale of assets, cattle and also land, leading to an increase of indebtedness. While medical costs varied in accordance with the stage of the illness. Ironically, older women and men are pushed into labour force for raising minimal supplies to care for their grandchildren and adult children with AIDS and also paying for funerals. Another worrying phenomenon is emergence of child-headed households. The escalating AIDS crisis is leaving an unprecedented number of children orphaned with little or no adult protection and care. The proportion of orphaned children is expected to double in the next five years and remain exceptionally high until 2020. India today is home to the largest number of AIDS orphans in the world. The odds against AIDS orphans and children in HIV/AIDS affected households are staggering. Children begin to suffer even

20. VMM (Vasayya Mahila Mandali) Bangeluru an NGO reported on Infochangeindia.org “The Missing Face of AIDS”.
21. UN estimates children orphaned by AIDS as those under the age of 18 who have lost one or both parents to the disease, 2006. Available at www.un.org. Though there are no official figures in the country for the number of children affected by AIDS, World Bank estimates suggested that the number of children in India orphaned by AIDS is approaching 2 million.
before a parent or caregiver has died. Household income plummets, schooling is interrupted and many children are forced to drop out either to care for a sick parent or to earn money. The threats and challenges these children face are compounded by the emotional trauma of losing parents and other family members and the stigma associated with disease, marks them out as a new class of untouchables. HIV/AIDS affects individuals in prime-working age groups, it is typically expensive to treat and results in retarding economic growth by destroying human capital. UNAIDS has predicted outcomes for Sub-Saharan Africa for the year 2025. These range from a plateau and eventual decline in deaths beginning around 2012 to a catastrophic continual growth in the death rate with potentially 90 million cases of infection.\textsuperscript{22}

The increased mortality rate will result in a smaller skilled population and labour force. This smaller labour force will be predominantly young people with reduced knowledge and work experience leading to reduced productivity. An increase in worker’s time off to look after sick family members or for sick leave will also lower productivity. Increased mortality will also weaken the mechanism that generate human capital and investment in people, through loss of income and the death of parents. By killing the mainly young adults, AIDS seriously weakens the taxable population, reducing the resources available for public expenditures that results in increasing pressure on the state’s finances and slower growth of the economy.

The lost lifetime earnings due to an AIDS death were estimated to be more than ten times the annual treatment costs of AIDS\textsuperscript{23}. Moreover, income and earnings losses also occur due to the loss of a job from stigma associated with HIV infection, even if the HIV-positive individual is not sick with opportunistic infections associated with HIV/AIDS. An ILO study\textsuperscript{24} confirms that stigma and discrimination at the workplace complicate matters, with many PLHAs not disclosing their status to employers for fear of losing their jobs.

There are few studies on the sector level impact of HIV/AIDS. The UNAIDS, WHO and the UNDP have documented a correlation between the decreasing

\textsuperscript{23} See Bloom D, Mahal A; Economic Implications of AIDS in Asia. Draft. New York, Columbia University, Department of Economics, 1996.
\textsuperscript{24} International Labour Organization Research Study; Assessing the socio-economic impact of HIV/AIDS on People Living with HIV/AIDS (PLHAs) and their families in India. New Delhi, ILO Publications, 2004.
life expectancies and the lowering of gross national product, in many African and Asian countries with prevalence rates of 10 percent or more. Existing empirical analyses do not predict huge adverse aggregate economic impacts for India in the near future. Even the most pessimistic scenarios project HIV prevalence rates among Indian adults to be no more than 5 per cent by the year 2025. These projected prevalence rates are considerably smaller than, South Africa and Botswana, whose economic consequences have attracted much attention from economists. The consequences of high prevalence rates of the pandemic in future are progressively cumulative and so will become apparent only after few generations. The UNAIDS and the World Bank forecasts for South Africa have cleared that, if nothing is done to combat the epidemic, a complete economic collapse will occur, within three generations.

Concept and Types of HIV/AIDS Victims

Defining victim is not an easy task as the term victim carries various connotations which depend upon the social and legal context in which it is used. The word "victim" is not one generally to be found in law. The legal terminology includes such terms as "the complainant", "the injured party" or "complaining witness." The definition of victim status is profoundly influenced by social divisions including class, race, ethnicity, gender, age and sexuality and as such, remains a point of contention and debate.

Today, the word victim is used in many different contexts and is broadly interpreted. It is not unusual to hear the word "victim" paired with a wide range of human experiences: accident victims, crime victims, cancer victims, HIV/AIDS victims, hurricane victims and others. Each of these conjures up visual images of suffering and devastation. However when it comes to HIV/AIDS victims, it is no wonder that society acts in a confused state about how positively or negatively to regard them as victims. PLHAs themselves are not only the ideal victims of various human rights abuses against them but people associated with PLHAs, i.e. people affected by HIV/AIDS are also victims practically. They are the innocent victims who are

25. Hereinafter referred as GDP
worthy of protection. They individually or collectively suffer harm including physical harm, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts of stigma and discrimination against them as well. They are sufferers of collective victimization because social, economic, cultural and legal factors and circumstances make them the object of victimization. Such persons include spouse of a PLHA, children, parents, relatives, friends, human rights defenders etc.

At the international level, the Basic Principles and Guidelines27 have developed the definition of 'victim' of human rights and humanitarian law violation to include dependants, members of family and persons who have suffered physical, mental or economic harm in assisting the victim or preventing the occurrence of further violation of their rights. The various agencies like European Court of Human Rights, Inter-American Court of Human Rights and the Human Rights Committee have supported the adoption of a broad definition of victims. The term victim not only include direct victim but also any person who would have a valid personal interest in securing the cessation of such victimization. Such an approach can act as a torch bearer for determination of rights of people infected as well as affected by HIV/AIDS, as such people are largely suffering from invisible victimization. Invisible victimization refers not only to victimization that cannot be seen but also to an inability or omission in measuring different types, experiences and aspects of victimization of such groups. The extent of these groups is approximately ten times the number of PLHAs which are generally excluded from being part of policies or surveys. This situation signifies deficiencies in theoretical and policy development programmes.

The most effective way to assist a victim is by preventing him from becoming a victim. However in most of the proclamations, declarations and resolutions, the comments on the importance of HIV/AIDS prevention remains on the level of a mere platitude. Many policy makers assume that HIV/AIDS prevention measures are good per se that potential victims are quite willing to change their behaviour, purchase the necessary paraphernalia, and assist the authorities in order to prevent the spread of the disease.

Besides this, the State’s role cannot be disregarded. The state drafts, passes and enforces the law, and establishes the various organs of the justice system. Similarly, it is the State that takes policy goals into consideration in the different sectors of social welfare, health care, educational policy, employment policy and so on. It is the cohesive response of the community, in turn, that is most important in determining whether or not the law will be enforced—and how it will be enforced or adopted to avoid victimization of PLHAs as well as people associated with them.

Despite the fact that the major responsibility for the prevention of HIV/AIDS personally lies with the individuals and the communities, still victims assume that the state, public health and primarily law enforcement machinery, are responsible for the spread and the prevention of HIV/AIDS. State authorities give an impression that for the spread of the epidemic the victims are at fault. The victim-blaming process in case of HIV/AIDS epidemic is the result of risky/immoral behaviours in which individuals like CSWs and IDUs etc indulge. At the same time, there are victims like women who despite of their conscientious efforts to avoid infection become the target of a deliberate or unintentional transmission of HIV. Even structural factors like economic and gender disparity are conducive for the spread of infection. A study of types of victims could be of great help in determination of prevention strategies.

**The Conscientious Victim:** Such a person behave in accordance with the traditional standard of care expected of a reasonable and prudent person. He takes the conventional precautions against infection. No blame or reproach can be attached to his actions or omissions; he is the ideal "totally innocent victim". In context of HIV/AIDS, such victims may include medical practitioners or health care workers etc.

**The Facilitating Victim:** Such a victim fails to take reasonable precautions against infection, for example when a person indulges in unprotected sexual activity with a commercial sex worker. The victim himself facilitates the transmission of HIV. This facilitation is usually refers to those situations in which a victim unknowingly, carelessly, negligently, foolishly and unwittingly put itself into risk of catching HIV/AIDS infection.
The Inviting Victim: An inviting victim knowingly enters into a dangerous situation. For example, a person who engages in illegal/immoral activity that carries with it an appreciable risk of victimization like in the case of injecting drug use. The victim invites himself the harm that would not have been caused without the deliberate and unnecessary assumption of risk on the part of the victim. The difference between a facilitating and an inviting victim lies in the awareness of the situation. A facilitating victim is careless but he is not aware of any particular risk of an infection. An inviting victim is aware that his actions could result in transmission of infection and he could adopt greater caution to prevent the infection.

The Consenting Victim: In this case the victim, although may not deliberately set out to engage in risky behaviour, may willingly permit the other person to carry out his intention. For example, involvement of a person in homosexual activities or injectionable drug use.

In relation to HIV/AIDS epidemic, which depends on personal behaviour of individual, dealing with victimization outside of the legal justice system is an encouraging step to protect PLHAs and others affected by the disease. The role of informal mechanisms arises from two limitations of the legal justice system. First of all the legal justice system may inappropriately respond to protect people infected as well as affected by the virus. Secondly the legal justice system may be too restricted in its response because victimization is mainly a social, cultural and medical phenomena.

The lack of resources makes it impossible for the legal justice system to deal comprehensively with HIV/AIDS situation and its implications. As a result, most of the cases of victimization which is relatively a serious social problem remains unreported or unresolved. Such a situation is itself a cause for alarm for legal systems. Moreover the law enforcement agencies are assigned the functions of preventing crime, ascertaining the responsibility for offences, and deciding on the proper sanctions. Victimization leads to many needs that cannot be met within such a framework. Such needs can best be met by family, friends, professional social service workers, health care workers, counselors and NGOs. The HIV/AIDS victims at many occasions are denied basic human rights like shelter, food, treatment, employment, education etc.
There is a need to design both formal and informal programmes in order to prevent further victimizations of PLHAs and people associated with them.

The Victimized/Marginalized Groups

HIV/AIDS affect all segments of world’s population. From children to adults, rich businessman to homeless people, female sex workers to housewives and homosexuals to heterosexual individuals. There is no single ‘group’ which cannot be affected by HIV/AIDS. Nonetheless, HIV/AIDS is known to impact certain communities more than others due to behaviours patterns, which are stigmatized by norms and looked on unfavourably by social and legal institutions. Some of the marginalized groups who face acute vulnerability to HIV/AIDS are women, children, sex workers, MSM, IDUs, prisoners, refugees, migrants and victims of human trafficking. These communities are identified as member of high risk groups.

Women: Feminization of HIV/AIDS

"The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV/AIDS"


Initially constrained to large urban hubs and a masculine epidemic, because of gender inequality HIV/AIDS is increasingly becoming a heterosexual phenomenon associated with women, poverty and common households. In recent years, the burden of the HIV/AIDS endemic on women has increased notably, with women now representing half of all people living with HIV. More than one in five pregnant women are HIV infected in most countries in southern Africa, and in some countries like Gaborone, Botswana, Manzini, Mozambique and Swaziland the prevalence among pregnant women is up to 40 per cent. In India, too the pandemic is increasingly feminizing as the male-female ratio of infected people shifted from 55 per 100 males in 2001

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28. CHG Commission on HIV/AIDS and Governance in Africa, "Gender and HIV/AIDS Discussion Outcomes" ECA World Bank Gender in Africa: the issues, the facts, an pocket− reference publication in collaboration with the World Bank, 2004 P3 "See report of the Fourth World Conference on Women, Beijing, 4-15 September 1995, United Nations publication, Chapter 1, Resolution I, Annex 11, para 112 and 117
to 63 per 100 males in 2005\textsuperscript{29}. Social marginalization, inability to haggle options and lack of access to information leads to increased susceptibility of females to HIV/AIDS.\textsuperscript{30} Such dynamics generates multiple mechanisms and factors that exacerbate the vulnerability of women both for contracting the disease, coping with the infection and caring for others affected by the endemic. The gender dimensions of HIV/AIDS penetrate numerous aspects of society including the economic, legal, cultural, religious, political, biological and sexual status of women.

The biological vulnerability to infection is higher in women. Male-to-female transmission is estimated to be twice as likely as than female to male due to the higher viral concentration in semen compared to vaginal fluids, larger exposed surface and longer viral contact among women. HIV and other sexually transmitted infections also show "biological sexism" and make women more susceptible to the viral and bacterial agents because of hormonal changes, vaginal microbial ecology and physiology.\textsuperscript{31} The average age of infection for women is much lower than for men due to variety of reasons. Sexual activity tends to start earlier for women even before her reproductive system is fully developed. This simple biological fact makes her more vulnerable to STDs including HIV/AIDS. Pushy myths like that sex with a virgin will cure a man of HIV/AIDS and the chances of infection for young girls are minimal and the damaging practices like rape, female genital mutilation and trafficking of women and girls operate as strong stimulants to the feminization of HIV/AIDS.

The low social status and lack of information and education increase women’s vulnerability to HIV/AIDS. In most of the developing states, because of social pressures and cultural norms, the women and girls have limited access to information and education about HIV/AIDS, gender roles, sexuality

\textsuperscript{29} The 2009 NACO report says that for every 100 PLHAs, 61 are men and 39 are women.

\textsuperscript{30} Societal barriers such as sexism, racism, heterosexism and ableism affect the conditions of women’s lives and may increase their risk of violence and HIV by: decreasing access to education and employment and increasing poverty among women; increasing women’s social and economic dependency on men; reducing women’s power and choice in their relationships and in other aspects of their lives; reducing the availability of and access to gender-specific information and services for all women; reducing the availability of and access to culturally sensitive information and services for immigrant women, women from ethno-cultural, aboriginal and rural communities, women involved in the sex trade, lesbians and women with disabilities."

and reproductive health including safe sex. Considerable gender fissures in school enrolment and retention and equally in pulling out of girls from school in order to tend the ailing relatives, run the household, or support the family further weaken their chances to acquire the skills to avoid HIV infection and ease the brunt of infection and its adverse implications, if infected. The discrimination and stigma becomes horrendous against HIV+ women as they are branded as 'promiscuous' and vectors of the epidemic. It leads to their further marginalization as they are denied access to facilities like testing, counseling, treatment and care, education, accommodation, employment and other supportive rights. Sometimes they are publicly censured, abused, abandoned or even killed by their families.

Also the weaker economic status of women and perpetuation of poverty along with HIV/AIDS eats up all the resources and thus jeopardizes the survival chances of the family. The women become highly vulnerable, both in terms of infection and impact, because of unequal access to economic resources, inequality in the field of work, burden of care, resort to sex work in order to survive and spousal separation in migration. The breakdown of social services such as health care, education and social welfare, further intensify the crisis for women. In addition, anemia, repeated pregnancies and childbirth, coupled with the lack of dietary supplements lead to rapid depletion of their immunity system and make them excessively susceptible to HIV/AIDS and other opportunistic infections.

Due to lack of female friendly laws and programmes the basic rights of women like reproductive rights and property rights are denied. The absence of the political will and lack of commitment to form effective policies and laws to address gender inequality in the context of HIV/AIDS increases the vulnerability of the female population to the epidemic. The efforts to curtail the feminization of the pandemic demand strong commitment to respect and protect human rights and active participation of civil society particularly the PLHAs at all levels of rule making, programme execution and evaluation.

HIV/AIDS have drastically increased the burden of care for many women. Poverty and poor public services have converted the care burden for women

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into a trap with far-reaching social, health and economic consequences. It exhausts their energy and diverts them from their usual economic and social activities. This leads to loss of productivity and livelihood by families. Where the caregiver is herself infected with HIV, her health worsens quickly under the burden of care giving. In many cases, young girls drop out from school to tend the sick family members or younger siblings. Due to lack of information about proper protection measures to be adopted, many women get infection during the caring process. Biologically women are twice as likely as men to contract HIV from a single act of unprotected sex, but they continue to depend on male cooperation to protect them from infection. As it is men who initiate sex, control it, coerce into it due to their power status and pay for it with economic worth. The conventional prevention strategies based exclusively on the 'ABC' approach -- "abstain, be faithful and use a condom" is thus quite untenable for women. The epidemic is further fuelled by under investment in research and development of inexpensive female controlled methods of protection such as microbicides, female condoms and vaccine.

Women are frequently denied their right to refuse unwanted sex or to determine when and with whom they engage in sexual activity, they are routinely exposed to the risk of contracting STIs and HIV/AIDS. Girls are especially vulnerable to sexual abuse, incest, rape and trafficking, and are often targets of systematic rape and other forms of sexual abuse in times of war and emergency situations — directly exposing them to HIV. Thus the State obligations to protect human rights in the context of HIV/AIDS arise at two stages. Firstly, States have a duty under international law to take positive measures to prevent and prohibit sexual violence, in all its forms. Where States do not recognise different forms of sexual violence, and laws and procedures fail to address sexual violence, vulnerability to HIV/AIDS increases. Secondly, States are mandated to fulfil the right to health and


34. See Guidelines 5 and 6, International Guidelines on HIV/AIDS and Human Rights. These guidelines call on States to ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV / AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, and to among other things empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.
provide appropriate health care to survivors of sexual violence. The lack of services provided to survivors of sexual violence affects their health in psychological and physical terms, and in the context of HIV/AIDS represents a direct violation of the right to life.

Perinatal transmission of HIV is also a cause for concern as one in every three infected persons is a woman. Perinatal transmission accounts for 2.74 percent of all HIV infections in India.³⁵ Like the epidemic itself, which is heterogeneous in its spread within and among States, infection rates among pregnant women also show considerable variation ranging from 0 to 4.9 percent.³⁶ Before the effect of antiretroviral therapy in reducing the risk of vertical transmission was known, termination of pregnancy among HIV-positive women was the only means to curtail the spread of the HIV epidemic. This often involved subjecting HIV-positive women to forcible abortion and sterilizations, therapy controlling their decisions about pregnancy, child birth and fertility. This constituted a violation of women’s fundamental rights including reproductive rights recognized in various international human rights instruments including the ICCPR, CEDAW and national laws like the Medical Termination of Pregnancy Act, 1971³⁷, Section 313 of IPC,³⁸ and principles laid down in the National AIDS Prevention and Control Policy³⁹. In the international arena, States have signed the UNGASS Declaration of Commitment in which they have resolved to reduce the proportion of HIV infected infants by ensuring access to information, counseling, testing and treatment options, especially antiretroviral therapy, breast milk substitutes and continuum of care.⁴⁰ To this end, NACO in collaboration with UNICEF, conducted feasibility trials for Nevirapine in 11 sites across 6 high prevalence

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³⁵ For details see the HIV/AIDS Surveillance in India (as reported to NACO), as on 31 May 2008, NACO. Available at http://www.naco.nic.in
³⁶ “HIV/AIDS Profile: India”. Available at www.usaid.gov
³⁷ “No pregnancy shall be terminated except with the consent of the pregnant woman”. Section 3 (4) (b) Medical Termination of Pregnancy Act, 1971.
³⁸ “Whoever causes a woman to miscarry without the consent of the woman, shall be punished with imprisonment and fine”, Section 313, Indian Penal Code, 1860.
³⁹ See Paragraph 5.1.4, NAPCP.
⁴⁰ The UNGASS Declaration of Commitment to which India is signatory requires vide “Paragraph 54.-By 2005, reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010, by ensuring that 80% of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counseling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care.”
states in India. The government announced that proper dosage of Zidovudine and Nevirapine would be provided to HIV-positive pregnant women free of cost from January 2002. A comprehensive response to MTCT must address shortcomings in the larger health system that impair a person’s access to information, education, treatment and long-term care. In addition, the discrimination that HIV positive pregnant women face in the health system contributes extensively to their lack of access to appropriate and adequate prenatal services. Effective dissemination of the essential ‘information package’, particularly to women and girls, from an early age would be a critical element in curtailing MTCT. The most persuasive argument in favour of a comprehensive MTCT programme, which includes routine counseling, provision of voluntary testing and antiretrovirals to the mother and to the child after birth and during post natal care, is purely economic; it would cost the state considerably less to implement a MTCT program than the lifetime medical costs by failing to implement such a programme. Countries like Brazil and the U.S. have been excellent examples of the fact that it makes economic sense to implement MTCT programmes.

Children: Victimized Innocence

“No discrimination should be suffered by children on any grounds, including in education, leisure, recreational, sports, and cultural activities because of their HIV/AIDS status. Children have a right to access health and social services on an equitable basis, irrespective of their HIV/AIDS status or that of members of their families.”


India today is home to the largest number of AIDS orphans in the world. While India’s AIDS orphan crisis is not as dire as Africa’s, it is on the African

41. It stands for Mother to child transmission of HIV.
44. The UN estimates children orphaned by AIDS as those under the age of 18 who have lost one or both parents to the disease. Though there are no official figures in the country for the number of children affected by AIDS, WHO estimates suggest that the number of children in India orphaned by AIDS is approaching 2 million.
trajectory. Other than MTCT, sexual abuse, blood transfusion and unsterilised syringes (including injectionable drug use) are also sources of HIV/AIDS infection among children. UNICEF experts have stated that HIV/AIDS situation among Indian children is becoming acute because the country has no national policy to specifically address the impact of HIV/AIDS on the rights of the children. The plight of AIDS orphans goes virtually unnoticed as most of them are being left to fend for themselves. Intervention options for providing care and support to orphans in the country are limited. The number of shelter homes, health care centres and orphanages providing short-term care for HIV/AIDS children are insufficient.

The Convention on the Rights of the Child advocates the right of every child to complete and wholesome development and opportunities along with specific rights such as the right to family, education, health services, participation in decision making, freedom of expression, freedom of association and the right against exploitation, trafficking and torture. Article 19 guarantees protection to all children against “all forms of physical or mental violence, injury or abuse.” In the context of HIV/AIDS interventions and prevention strategies, the Indian legal system does not, as such provide any direct solutions. Children’s issues are mostly discussed in the context of child labour, juvenile delinquency and child marriages. This limited understanding disempowers children and prevents them from accessing sexual health information and services. However recently, The Protection of Children Against Sexual Offences Bill, 2011 was passed which exclusively deals with sexual offences against children. In India, children between the age of 10 to

45. Sex between an HIV-positive adult and a child is particularly likely to transmit HIV as a child is not physically fully developed and, therefore, is more easily torn or damaged by penetrative sex (both vaginal and anal), making it easier for the virus to pass into the child’s body. Thus, children run a greater biological risk than adults of becoming infected with HIV or other STIs. Article 34 of the CRC mandates member states to protect children from all forms of sexual exploitation and sexual abuse. The first periodic report of the Government of India to the Committee on the Rights of the Child in 2001 quotes a news report stating that, “the GOI is contemplating the introduction of a separate legislation on child rape and sexual abuse, which accounts for 27% of the total cases of rape reported in the country. The National Crime Records Bureau Data shows that there has been a significant increase in cases of sexual offences against children from 2265 in 2001 to 5749 in 2008.

46. Other important documents include The Paris Declaration on Women and Children and the Acquired Immunodeficiency Syndrome (AIDS), November 1989; The Agenda item 19 of the Forty-Third World Health Assembly, Vienna, May 1990; UNGASS Declaration of Commitment and International Guidelines on HIV/AIDS and Human Rights.

47. This Bill was passed by the Cabinet on 3 March 2011. It aims to protect children against offences of sexual assault, sexual harassment as well as pornography.
19 years account for 21.4 percent of the population.\textsuperscript{48} Sexual health education and information, therefore, can play an important role in providing information to young people about the nature of the HIV/AIDS epidemic and precautions they can take to protect themselves from contracting the virus.

Denial of sexual health information or the abstinence-only approach to sex education interferes with fundamental rights, including the right to “seek, receive and impart information and ideas of all kinds” and the right to the highest attainable standards of health, which can have dire consequences on the right to life.\textsuperscript{49} A 1997 report of the UNAIDS found that sexual health education for children and young people promoted safer sexual practices and did not increase their sexual activity. Further, HIV/AIDS and sex education that addresses the sensitivities of lesbian, gay and bisexual youth has been associated with a reduction in high-risk sexual behaviour.\textsuperscript{50}

Sexual health information is key to the right to life.\textsuperscript{51} The failure to provide accurate information about prevention of HIV transmission puts children at risk of HIV/AIDS. However this important right is restricted by obscenity and censorship laws in India.\textsuperscript{52} 


\textsuperscript{49} All persons enjoy an inherent right to life, which is guaranteed in Article 6, ICCPR. Noting that the right to life ‘should not be interpreted narrowly’ the Human Rights Committee, which monitors compliance with the ICCPR has observed: ‘the expression inherent right to life cannot properly be understood in a restrictive manner and the rotation of this right requires that states adopt positive measures. In this connection, the Committee considers that it would be desirable for states parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.’ Human Rights Committee, General Comment 6, 16\textsuperscript{th} session, 1982, paragraphs 185.

\textsuperscript{50} One study found that lesbian, gay and bisexual youth who received gay-sensitive instruction had fewer sexual partners, were likely to have had sex in the previous three months, or use drugs or alcohol prior to sexual activity. The study noted that effective prevention programs for lesbian, gay and bisexual students are characterized by ‘inclusive instruction, adequate support services, Acknowledgement of diversity, and a non discrimination school climate.’ See: Blake, S., et al., ‘Prevention Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-sensitive HIV Instruction in Schools,’ American Journal of Public Health, Vol.91, No. 6, June 2001, pp. 940-946; Most sexual health programs in India either avoid any discussion of homosexuality or raise it as a negative issue, thereby discriminating against homosexuals. Article 26 of the ICCP Provides that, “states may not discriminate in securing the fundamental rights and liberties guaranteed in the convention,” The UN Human Rights Committee, which monitors compliance with the ICCPR determined in a 1984 case that an Australian law banning sexual context between consenting adult men was a violation of Australia’s obligation as a party to the ICCPR. This decision concluded that discrimination provision of the ICCPR should be prohibit discrimination on the basis of sexual orientation. See: Torren v. Australia, UN Human Rights Committee, CCPR/C/50/D/488/1994.

\textsuperscript{51} In this context according to the Committee on Economic, Social and Cultural Rights, the right to the enjoyment of the highest attainable standard of health includes the right to information and education concerning prevailing health problems, their prevention and their control. In addition, the committee advises that states have a legal obligation to refrain from “censoring, withholding or intentionally misrepresenting health-related information, including sexual education information.” Paragraph 12 (b), 16, and 34, General Comment No. 14.

\textsuperscript{52} See Sections 292, 293 and 294, IPC. These sections criminalise the sale of obscene books/objects and performance of obscene acts. ‘Obscenity’ is again widely defined and has been interpreted with moral overtones by the courts in the past.
the Constitution on grounds of preserving public decency and morality. Courts in other countries have recognised the pressing need of adolescents for sexual health information and have affirmed their right to receive accurate information to prevent the spread of HIV/AIDS. The State must ensure that working children and street children have adequate access to education, health, safe working conditions and social security. Working children also miss the messages from school-based sexual health and HIV/AIDS prevention programmes. State education programmes should be flexible so as to reach children who work whether through night schools or schooling at work places with the obligation on the employer to ensure education. For children living on the streets vulnerability to HIV infection increases due to exposure to hazardous labour, sex work, sexual abuse, lack of consistent food, shelter and social security. Prevalence of sexual activity amongst children living on the street, whether amongst peers or with adults and whether consensual or coerced is a widely observed reality. Injecting drug use is also common amongst adolescents on the streets in many parts of the county. Apart from behaviour that could put them at a risk of HIV transmission, the nutritional levels and health status of street children makes the impact of infection more severe. The lack of access to primary or specialized health care, information and power to keep oneself safe from contracting HIV are other factors that compound vulnerability.

Apart from the lacunae in criminal laws, the role of education and information in encouraging healthy sexuality and keeping children safe from sexual abuse cannot be underestimated. Young children need accurate, friendly and easily understood information about sexuality and sexual abuse. Denying a sexual information to the child is putting the child in potential

53. See AIDS Action Committee of Massachusetts, Inc. v/s Massachusetts Bay Transportation Authority, 849 F. 1st Cir. 1994,US, p 74.

54. Article 21-A of the Constitution of India obliges the State to provide education to all Indian children between the ages of 6 and 14.

danger of both mental trauma and STIs including HIV/AIDS. The main weakness of the existing mechanisms designed to meet children's needs is that they do not conceptualise children as persons who have inherent, independent rights and are capable of exercising them. The focus of legislation related to children and HIV/AIDS related issues requires a shift to enabling children and adolescents to exercise their rights in situations where they have, hitherto, been considered not in a position to do. It is only after this re-conceptualisation that effective strategies can be put in place to change the circumstances, which leave children and young people vulnerable to HIV/AIDS.

Commercial Sex Workers: Victims of Occupational Hazards

Current information on the spread of HIV/AIDS tends to emphasize the role of sex workers as vectors of the epidemic. As such, HIV/AIDS intervention programmes have been undertaken among sex workers for the purpose of protecting others rather than sex workers themselves. This approach has serious human rights implications and has failed in raising awareness about HIV/AIDS and reducing the rate of HIV transmission among people selling sexual services. The most effective interventions have been those, which seek to reduce the vulnerability to HIV of sex workers themselves. These interventions have recognised that the relationship between the HIV/AIDS epidemic and sex workers hinges on the socio-economic scenario and is seriously impacted by the criminalisation of activities associated with sex work.

It is a widespread belief that sex workers are a 'high risk group' serving as a 'pool' of infection that is propelling the epidemic into the general population. While epidemiologically it is true that sex workers are a source of HIV transmission, to reduce them primarily to vectors of disease is to obscure their own vulnerability to HIV. Various measures that directly violate the

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56. Child sexual abuse survivors in India have reported that half of the abuse took place when they were under 12 years of age. In a study of 150 minor girls surveyed, 58 of them had been sexually abused before the age of 10. Regarding societal factors that have made child sexual abuse possible, studies have identified the 'child' ignorance about sex and sexual matters'. Ganesh, Anita Ratnam, et al., Childhood Sexual Abuse of Girls: Report of a Workshop Series and Survey, Paragraph 1.4, A Samvada Publication, Bangalore, 1994.

rights of sex workers have been proposed, and in some cases implemented ostensibly to control the spread of the epidemic. One such measure is mandatory HIV testing for sex workers. There is considerable evidence that punitive measures such as mandatory health examinations drive vulnerable populations underground and further erode their ability to access information and health services including prophylactic services, voluntary counseling and testing, treatment and support. This strategy absolves clients of all responsibility for practising safer sex, making sex worker vulnerable to coercive and unsafe sexual practices. While harassment and exploitation is a reality for sex workers almost everywhere, the problem is acute in regimes where the police are granted special powers under criminal laws. In such settings the risk of HIV/AIDS is heightened due to the inability of CSWs to access legal and social protection.

In India, the Immoral Trafficking Prevention Act, is the main statute dealing with sex work which is based on the principle that sex work is exploitative and is incompatible with the dignity and worth of human beings. The objective of ITPA is to “inhibit or abolish commercialised vice namely, the traffic in women and girls for the purpose of prostitution as an organised means of living. While the goal of ITPA is to eliminate trafficking, the statute does not even define trafficking as an offence. Further, its implementation has raised questions about whether it actually achieves its goals. ITPA does not criminalise sex work or sex workers per se, but mostly punishes acts by third parties facilitating sex work, even when it is not coerced. The Act punishes anyone maintaining a brothel (which includes owning, managing or allowing premises to be used as a brothel), "living off earnings of prostitution" and "procuring, including, or detaining for the sake of prostitution". The statute provides for detention in a ‘corrective’ institution of a female offender.

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58. The policy of the AIDS and Civil Liberties Project of the American Civil Liberties Union points out that, as a purely practical matter, compulsory testing of sex workers won’t work: “[i]f there is any group which will be driven underground by such a policy, it is prostitutes”. Canadian HIV/AIDS Legal Network and Canadian AIDS Society, “HIV Testing and Confidentiality: Final Report”. Available at www.aidslaw.ca.
59. Hereinafter to be referred as ITPA.
60. Ibid.
62. See Section 4, ITPA.
63. See Sections 5 and 6, ITPA.
suggesting that disapproval and censure of sex work is inherent in the approach adopted. The ITPA was made gender neutral in that it includes trafficking of and sex work by males\(^{65}\), children and adults also as opposed to SITA that applied only to females. However this bias plays out in ITPA as well as it imposes heavier penalties on women as compared to men for the same offence.\(^{66}\)

Besides ITPA, several provisions of the Indian Penal Code 1860\(^{67}\) as well as certain state level Acts on police, begging, public nuisance, and vagrancy are also applied on sex workers. For instance, Section 110B of the Bombay Police Act 1951, which penalises indecent behaviour in public, is used extensively against street-based sex workers. Male and transgendered sex workers can also be punished under the anti-sodomy law.\(^{68}\) Restrictions on practice as well as fear of the police pushes sex workers into ghettoized locations where they are difficult to reach and vulnerable to abuse.\(^{69}\) Peer based interventions are hampered as women carrying condoms are apprehended by the local police on charges of promoting prostitution.\(^{70}\) In the recent past, several organizations implementing peer-based interventions have complained of harassment of peer and outreach workers and disruption of meetings/efforts to sensitize the sex workers. All this makes HIV/AIDS prevention work difficult, if not impossible, in an already marginalised and hidden community.\(^{71}\)

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64. See Section 10, ITPA.

65. The male sex workers are also known as Gigolos. The presence of gigolos has been well established but an alarming fact is that their number is fast increasing. There is no initiative at the national or local level to create awareness among members of this group about the risk of HIV/AIDS and STDs. The NACO and other agencies must include gigolos in the high risk category. For more details see “Gigolos put women clients to high HIV risk.” Naveen S Garewal, The Tribune, 4 January 2010.

66. While the punishment for an offence under Section 8 of ITPA is imprisonment for a term which may extend to six months or with fine which may extend to five hundred rupees or both on first conviction and in the vent for second conviction, with imprisonment for a term which may extend to one year, and also with fine which may extend to five hundred rupees, the proviso to the section provides that where the offence is committed by a man, he shall be punishable with imprisonment for a period of not less than seven days but which may extend to three months.


68. See Section 377 of the IPC which criminalises carnal intercourse against the order of nature with any man, woman or animal.


71. Ibid.
STD/HIV Intervention Programme (“SHIP”) in Songachi in Kolkata stands out as one of the world’s most successful examples of a rights based HIV/AIDS intervention with sex workers. Its approach is based around three R’s: Respect, Reliance and Recognition – Respecting sex workers, relying on them to run the programme and recognizing their professional and human rights. By helping to put sex workers in a position where they can respond to their own needs, the Sonagachi project has achieved impressive results. Between 1992 and 1995, condom use among sex workers rose from 27 percent to 82 percent. By 2001, it was 86 percent. The project continues to have an impact, as HIV prevalence among sex workers in the area has fallen from 11 percent in 2001 to less than 4 percent in 2004. The Songachi Project has become internationally famous for its achievements, and the UN has used the project as a ‘best practice’ model for other sex worker projects around the world.

Successful examples of self regulation by sex workers do exist. Sex workers collectives with a presence in a particular geographical area have been able to regulate the sex trade by enforcing preconditions of age (above 18 years) and informed consent (devoid of factors of coercion, deception and undue influence) and health care schemes for individuals entering sex work. The illegality of sex work and the subsequent disempowerment of sex workers are the main hurdles in the effective implementation of such self-regulatory strategies. A decriminalised environment is imperative to ensure the efficacy and success of self-regulatory models. The need for legislative reform in addressing sex work arises from the recognition that existing legal structures exacerbate the vulnerabilities to HIV infection of persons in sex work settings. This has also been recognised by international bodies including the WHO and the UN.

72. It was started in 1992 in Sonagachi, Kolkata, the red light area in Asia, with the objective of controlling the spread of STD & HIV/AIDS. The collaborating agencies in this initiative include the All India Institute of Hygiene & Public Health, the WHO, NORAD, UNAIDS and NACO.
76. Ibid.
77. “With regard to adult sex work that involves no victimisation, criminal law should be reviewed with the aim of decriminalising, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not
The urgency for reviewing criminal laws imposed on sex work emanates from a human rights perspective on HIV/AIDS. Notwithstanding the complexity of sex work settings and the issues arising therein, there is a strong case for removing penal sanctions against sex workers while instituting controls to address concerns of public health and HIV/AIDS like the entry of minors and unwilling persons as well as rights and safety of persons in sex work contexts. Further, isolationist strategies such as mandatory HIV testing that are violative of human rights and have negative public health outcomes must be rejected outrightly. Instead, there must be an effort to create conditions that enable sex workers to assert their rights and make informed decisions about sex work, safety, health and HIV/AIDS concerns.

Men Who Have Sex With Men: Penalized Minority
In the context of HIV/AIDS, one of the most vulnerable segments among sexual minorities are MSM, a category which itself consists of several sub-segments like gay men, bisexual men, transgendered males (including male to female transsexuals, hijras', kothis etc.) and other homosexually active men who may not relate to any of the preceding terms. The higher vulnerability arises in part from the increased risk of HIV infection present during penetrative anal sex, particularly if it occurs without a condom and/or lubricant, due to the likelihood of membrane rupture and bleeding. But an equal, if not greater, cause for vulnerability is the social stigma and discrimination attached to male-to-male sex that enforces a silence around such sexual behaviour, thereby imposing significant barriers in imparting


78. There is much debate over the definition of the term 'transgender.' The definitions referred to here offer only an idea of what the term refers to and are by no means definitive. "Transgender (sometimes shortened to trans or TG) people are those whose psychological self ("gender identity") differs from the social expectations for the physical sex they were born with. To understand this, one must understand the difference between biological sex, which is one's body (genitals, chromosomes, etc.), and social gender, which refers to levels of masculinity and femininity. Often, society conflates sex and gender, viewing them as the same thing. But, gender and sex are not the same thing. Transgender people are those whose psychological self ("gender identity") differs from the social expectations for the physical sex they were born with. For example, a female with a masculine gender

transgenderists, gender queers, and people who identify as neither female nor male and/or as neither a man or as a woman. Transgender is not a sexual orientation; transgender people may have any sexual orientation. It is important to acknowledge that while some people may fit under this definition of transgender, they may not identify as such." Bolin, Cierra, "GLBT Rights": Available at http://history.crf-usa.org; "A transgender person is one that crosses gender boundaries or a man or woman that adopts the attributes of the opposite sex. The sexual preference of a transgender person often varies." Trannie 101, available at http://gaylife.about.com.

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information on the associated health risks in an objective and scientific manner. The contribution of MSM to the HIV/AIDS epidemic in India was officially set at 1 percent in 2001. But these estimates may seriously underestimate the significance of MSM behaviours to the epidemic in India, especially since global estimates suggest that 5 percent of HIV prevalence is attributable to sexual transmission between men. Truck drivers are a group known to have higher levels of homosexual behaviour than the general public. 24-34 percent of truck drivers in various surveys have reported to engage in homosexuality. In India, as elsewhere, many MSM do not consider themselves homosexual, and a large number of them have female partners. A study in Andhra Pradesh found that 42 percent of MSM truck drivers in the sample were married, that 50 percent has had sexual relations with a woman within the past three months and that just under half had not used a condom.

Unfortunately there is no nation-wide data on the prevalence of HIV/AIDS infection among MSM in India. NACO says, “On HIV situation among MSM groups, little reliable data is available. Only a few studies from Mumbai have reported HIV seroprevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6 month period in 1992 in collaboration with “Bombay Dost.” HIV prevalence was found to be 20.67 percent which was very high given the fact that the studied cohort was of educated middle class and hence had the means and material and were adequately aware of the transmission routes of HIV. It therefore implies that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be much higher. The Government of India, through its NAPCP and its statements at the UNGASS, has recognised that MSM is a

82. See Dandosa L and Dandosa R. et al, Sex behaviour of MSM and risk of HIV in Andhra Pradesh, 2005 India.
83. It is India’s first gay news letter.
population disproportionately vulnerable to HIV/AIDS which should be addressed through targeted interventions that focus on its needs.  

It is imperative, therefore, to introduce law reform, which decriminalizes sexual activity between men and creates a positive legal environment where rights are guaranteed, allowing MSM to lead wholesome and fulfilling lives. Further, this will serve as a measure to assist in controlling the spread of HIV/AIDS among MSM and society in general. By criminalising sodomy, the legal regime also criminalises consensual sex between men. Along with social stigma related to homosexual activity, this criminalisation has driven MSM underground and to the fringes of society, thereby creating an environment of denial and neglect, which pushes MSM to spaces that encourage furtive, unsafe sexual intercourse. This process of marginalisation prevents MSM from expressing their full human potential as emotional and sexual beings and creates a situation that excludes them from social structures, which are necessary to maintain physical and mental health. As such, MSM are denied their fundamental rights to non-discrimination (equality), life, liberty and health.

In June 2003, the U.S. Supreme Court in Lawrence v. Texas,\textsuperscript{85} struck down a sodomy law, which applied exclusively to homosexuals. The Court recognised an expansive privacy right of consenting adults in "their private lives in matters pertaining to sex."\textsuperscript{86} This trend in jurisprudence across the world reflects an understanding of sexual orientation within the context of diverse geographies, cultures and traditions. International human rights documents have also recognised sexual orientation as a basic right and have particularly highlighted the need for rights of MSM in the context of HIV/AIDS.\textsuperscript{87} In India, section 377 of the IPC\textsuperscript{88} criminalises sexual acts, which

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\textsuperscript{84} See Paragraph 5.1.2, NAPCP.
\textsuperscript{86} Ibid.
\textsuperscript{87} The ICCPR guarantees equality without discrimination on the basis of, inter alia, 'other status', which has been interpreted to include sexual orientation. See: Guideline 4, International Guidelines on HIV/AIDS and Human Rights which explicitly requires states to review and reform criminal laws, which adversely impact on vulnerable populations including MSM. See also: Guideline 5, International Guidelines on HIV/AIDS and Human Rights, which provides for the need for anti-discrimination laws that protect vulnerable populations including MSM.
\textsuperscript{88} "Unnatural Offences,-Whoever voluntarily has carnal intercourse against the order of nature, with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine. Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section." Section 377, IPC.
are "against the order of nature". The introduction of Section 377 by the British resulted in a shift in Indian cultural conceptions of sexual relations, including the rejection of homosexuality. Such laws perpetuate negative and discriminatory beliefs towards same-sex relations. Additionally, the perpetuated misinformation about MSM behaviour leads medical establishments to conduct 'aversion therapy' on MSM, which involves inhumane and extreme methods such as electric shock 'treatment'. Several other Indian laws which mostly require a lower degree of evidence and carry lesser punishments, are used very often to harass, blackmail, threaten, extort money and perpetrate violence against MSM. They include local level Police Acts, criminal laws of public nuisance, obscenity, abetment and criminal conspiracy. This oppressive criminal regime is also been used to disrupt the work of NGOs working in the field of HIV/AIDS and wrongfully arrest its outreach workers.

However, this does not mean that law reform alone can alleviate the marginalization suffered by MSM. The greatest emphasis needs to be placed on increasing social understanding of same-sex behaviour and thereby increasing tolerance, acceptance and reducing harassment and hate. Certain

89. The British colonisers introduced this law in India in 1860. Similar laws were also introduced in other colonies in that period. Influenced by Victorian notions of sexual purity, and based upon an essentially anti-pleasure and anti-sex bias, the British sought to rectify Indian marital, familial and sexual arrangements which they viewed as "primitive". See Dhagamwar, Vasudha, Law, Power and Justice, Sage Publications, New Delhi, 1992. for the debates at the time Section 377 was being legislated and the justifications based on Christian morality provided by Lord MacCaulay, its drafter.
92. Sections of The Bombay Police Act, 1951, are such laws e.g. Section 110 provides for 'indecent behaviour in public', Section 111 provides for 'annoying passengers in the street', Section 112 provides for 'misbehaving with intent to breach peace'. All these sections are extremely ambiguous and are widely used against MSM who are highly susceptible to extortion due to social stigma and legal sanction.
93. Section 268, IPC is another highly ambiguous provision. This section provides that any conduct in a public place that causes injury/danger/annoyance to the public is criminal.
94. See Sections 292, 293 and 294, IPC. These sections criminalise the sale of obscene books/objects and performance of obscene acts. ‘Obscenity’ is again widely defined and has been interpreted with moral overtones by the courts in the past.
95. See Section 109. IPC wherein abetting an offence under the IPC is also an offence.
96. See Section 120B, IPC wherein 2 or more persons agreeing to do an illegal act can be convicted for an offence.
97. For instance, in July 2001 the premises of an NGO, Naz Foundation International in Lucknow, which carried out a sexual health awareness programme with the MSM population, was raided and its workers arrested, inter alia, under Section 377, abetment to commit a crime under Section 377 and obscenity laws for publishing safer sex messages, distributing condoms to MSM and explaining the dangers of HIV/AIDS. It was only after 47 days in jail that the workers were granted bail. This instance showed that legitimate attempts to carry out public health services have also been greatly hindered due to Section 377 and the wrongful use of other criminal laws to exploit a marginalised population.
legal measures are essential in order to alleviate the situation of MSM. The first step towards empowerment would be to repeal laws that impede this empowerment process and the repeal of Section 377 (decriminalisation) would be a primary step in the context of MSM. This view has even been espoused by government bodies such as the National Human Rights Commission of India and the Law Commission of India.\(^{98}\) Despite of the Delhi High Court declaration in Naz Foundation case\(^ {99}\) where the court has declared that Section-377 of IPC, insofar as it criminalizes consensual sexual acts of adults in private violates Articles 21, 14 and 15 of the constitution, there is continued stigmatization of MSMs. This case is a leading case in context of MSMs in Indian judiciary. It was submitted that Section 377 IPC violates the constitutional protections embodied in Articles 14, 19 and 21. It suffers from the vice of unreasonable classification and is arbitrary in the way it unfairly targets the homosexuals or gay community. It also unreasonably and unjustly infringes upon the right of privacy, both zonal and decisional. It also conveys the message that homosexuals are of less value than other people, demeans their identity and infringes upon their right to live with dignity. Section 377 also creates structural impediments to the exercise of freedom of speech and expression and other freedoms under Article 19. Furthermore it was contended that morality by itself cannot be a valid ground for restricting the right under Articles 14 and 21. Public disapproval or distrust for a certain class of persons can in no way serve to uphold the constitutionality of a statute. Abundant material was placed on record which showed that the Indian society is vibrant, diverse and democratic and homosexuals have significant support in the population. It was submitted that the courts in other jurisdictions have struck down similar laws that criminalize same-sex sexual conduct on the grounds of violation of right to privacy or dignity or equality or all of them. Keeping in mind that Section 377 is the only law that punishes child sexual abuse and fills a lacuna in rape law, it was prayed that Section 377 may be declared as constitutionally invalid insofar as it affects private sexual acts between consenting adults or be read down to exclude consenting same-sex sexual acts between adults.

However in the reply, it was submitted that there is no fundamental right to engage in the same sex activities. In our country, homosexuality is abhorrent and can be criminalized by imposing proportional limits on the citizen’s right to privacy and equality. It was submitted that right to privacy is not absolute and can be restricted in the interest of decency and morality. Social and sexual mores in foreign countries cannot justify de-criminalization of homosexuality in India, in the western societies the morality standards are not as high as in India. It was further contended that Section 377 is not discriminatory as it is gender neutral. If Section 377 is struck down there will be no way the State can prosecute any crime of non-consensual carnal intercourse against the order of nature or gross male indecency. It was added that Section 377 IPC is not enforced against homosexuals and there is no need to ‘read down’ the provisions of Section 377. Further it was contended that the spread of HIV/AIDS is curtailed by Section 377 and de-criminalization of consensual same-sex acts between adults would cause a decline in public health across society generally since it would foster the spread of HIV/AIDS.

Therefore apart from repealing legislation that criminalises and marginalises MSM, the recognition of positive rights, in the form of a constitutional guarantee of non-discrimination on the basis of sexual orientation, would secure the highest level of legal protection for all sexual minorities. Concomitant to this step would be the introduction of laws that provide positive rights to sexual minorities to partnership, legal recognition of relationships in the context of inheritance, property, parenthood, adoption etc.

**Injecting Drug Users: Victims of Behaviour**

It is a stark reality that IDUs are disproportionately affected by HIV/AIDS and it is recognized that although IDUs are present throughout the country, sero-prevalence among IDUs in northeastern regions of India is among the highest in the world. The stigma and prejudice that is faced by IDUs worldwide has been sufficiently documented, with accounts of shocking human rights violations, such as primitive and illegal methods of incarceration and neglect. The victimization of IDUs has led to the complete neglect of their social,

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health and legal needs, and the consequent disregard of the spread of HIV/AIDS within this group and the risk of HIV transmission from IDUs to their sexual partners and children. Most studies on injecting drug use in India have centered in public urban settings. However, prison settings are another environment in which injecting drug use is widely prevalent.\textsuperscript{101} The drug users constitute a significant number of inmates within prisons, particularly in cities. Approximately 15 drug-dependent prisoners are admitted to Tihar everyday.\textsuperscript{102} Firstly, drug users are covered by a criminal regime that greatly exposes them to arrest and detention. Secondly, imprisonment increases IDUs’ risk of exposure to HIV, as drug use in prison settings is likely to occur in a riskier manner.\textsuperscript{103} Thirdly, drug users are exposed to highest risks within prison settings due to over-crowding, violence, prison rape, sex with other prisoners and deterioration in health. Once released, their exposure to risk makes them and others more vulnerable to HIV/AIDS. This cycle of vulnerability fuels the epidemic among drug users and the general public. It is necessary, therefore, to consider the impact of a penal legal regime on drug use and HIV/AIDS.

The introduction of the NDPS Act in 1985 was India’s response to the global ‘war on drugs’ and had a major impact on the patterns and manner in which drugs were used in India. It replaced earlier statutes on drug use\textsuperscript{104} and introduced a harsh penal regime for trafficking, possession, use and consumption of drugs in accordance with international conventions to which India is a signatory.\textsuperscript{105} This has led to difficulty in drug users attaining ‘highs’ through less hazardous methods of administration (oral intake) and encouraging a shift to riskier methods (injecting drug use).\textsuperscript{106} Additionally, the NDPS Act is supported by the Prevention of Illicit

\textsuperscript{101} In one major prison in Mumbai over 12% of inmates were arrested under the Narcotic and Psychotropic Substances Act, 1985 ("NDPS Act") and there was a daily influx of 5-6 drug users. Another study found that 75.3% of drug users in its sample had been in a police lock up. Less than 15% of prisoners are convicts in Delhi’s Tihar Jail, with 50,000 new admissions every year; 90% of the prison population changes every three months.

\textsuperscript{102} "Treatment and rehabilitation of heroin addict prisoners in Tihar prison", Aasra Parivar. Available at http://education.vsnl.com/aasra/aasra.html. Tihar jail runs one of the few advanced de-addiction and detoxification programmes in the country for its inmates, 70-100 heroin-dependants are undergoing medically supervised detoxification in three facilities run by the administration at any one time.


\textsuperscript{104} The Opium Act 1878, Opium Act 1885 and Dangerous Drugs Act 1930.

\textsuperscript{105} The UN Single Convention of Narcotic Drugs, 1961 and the Convention on Psychotropic Substances, 1971.

\textsuperscript{106} UNAIDS and UNDCPP Study. Although this stringent penal regime governing drug use was meant to control, if not eradicate such use, yet production and consumption of drugs has continued to increase and is reported in more and more countries.
Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988, a draconian legislation that gives extremely wide powers to the government to detain those involved in the 'illicit traffic' of drugs, which includes possession and consumption of drugs.\textsuperscript{107}

It has a direct impact on the manner in which IDUs are able to realize their rights, access services and be empowered. Such stringent criminal sanctions leaves drug users widely exposed to exploitation, harassment, abuse and arrest by the law enforcement machinery. This is problematic from a public health perspective as it can prevent drug users from accessing prevention and harm reduction strategies such as needle exchange programmes\textsuperscript{108} which are employed to reduce the risk of transmitting HIV/AIDS and other blood-borne diseases through provision of clean needles in exchange for used ones, providing drug substitution programmes and dissemination of important health information on use of bleach, overdose management and safe sex.

Several studies have shown, particularly in the context of NEPs, that such programmes have led to control the spread of HIV/AIDS among IDUs without any increase in drug use in that or surrounding communities. For instance, in England, NEPs in Merseyside functioning over a period of years saw HIV prevalence among IDUs reduce to the second lowest of all the English regions (eight per million as against the English average of 34 per million). This has led to HIV infection rates in the Mersey region remaining low. Australia has seen great benefits through its pioneering NEPs. Such programmes have prevented 25,000 new HIV infections and 21,000 new Hepatitis-C infections in 10 years and it is expected that 4500 HIV/AIDS-related deaths have been prevented due to these programmes. It was found that cities with NEPs had an average annual 18.6 percent decrease in HIV prevalence compared to an average annual increase of 8.1percent in cities without NEPs.\textsuperscript{109} The U.S. too, has thrown up several positive findings. New York City has seen a reversal in the HIV epidemic, associated with the provision of NEPs in that city. The rate of new HIV infections for participant

\textsuperscript{107} Section 2 (i), ibid.
\textsuperscript{108} Hereinafter referred as NEPs.
in the NEPs was found to be 2 percent as against 4-7 percent among IDUs not enrolled in NEPs. It was also found that the use of rented syringes decreased by 75 percent, use of borrowed syringes decreased by 62 percent and use of alcohol wipes before injecting went up by 150 percent. The courts, too, have liberally interpreted drug possession laws in state where NEPs have been legalised. Where IDUs were prosecuted for possession of residue drugs in their syringes the court held that the state laws had not only removed all laws that criminalised possession of syringes, but also necessarily decriminalised any trace amounts of drugs in the syringes. The court found that criminalising drug possession in such cases would thwart the public health purpose of NEPs and discourage IDUs from accessing such services.111

Most legal regimes criminalise use, possession, trafficking of drugs etc. without creating safe havens for harm reduction programmes based on sound public health reasons. Unauthorised or illegal NEPs have witnessed extensive police harassment of users and workers and widespread arrests leading to a drastic lowering in attendance to such programmes and the widespread presence of contaminated needles.112 It is now well established that harm reduction strategies are an extremely useful mechanism to curtail and control the spread of HIV/AIDS among IDUs, their sexual partners and children. Not only this has been recognised in international documents113, but also in the Indian government's National AIDS Prevention and Control Programme.114 Apart from a review of the heavily penal legal regime that increases the vulnerability of IDUs, it is vital that harm reduction programmes such as NEPs are legalised to effectively deal with the prevention and control of HIV/AIDS.

Prisoners: The Caged Victims

"The situation of HIV/AIDS in prisons needs urgent attention. It involves the rights to health, security of person, equality before the law and freedom from inhuman and degrading treatment. It must be urgently

111. Interpretation by the European Court of Human Rights as well as the courts in Australia, England and the U.S.
113. See Paragraph 52, UNGASS Declaration of Commitment.
114. See Paragraph 5.10, NAPCP.
addressed for the sake of the health, rights and dignity of prisoners; for the sake of the health and safety of the prison staff; and for the sake of the communities from which prisoners come, to which they return.”


Since the start of the HIV epidemic, prison populations have been subject to coercive measures that are not used in the general community, such as segregation, isolation and mandatory HIV testing. The vulnerability of prisoners of HIV infection increases with potentially unsafe sexual activity (coerced and consensual), tattooing, needle and syringe sharing, particularly given the fact that a large number of convictions are drug-related. Prisoners exposure to risk is also heightened due to floating populations of undertrails and the often closed, overcrowded, violent and unsafe environments in prisons. In India, the courts have acknowledged and followed current trends in penological thought and have passed several judgments recognizing that persons detained in prisons, either as undertrails or convicts, are entitled to the benefit of the guarantee of fundamental rights under the Constitution.\textsuperscript{115}

However, there have been few, if any, amendments to legislation along these lines. The Prisons Act, 1894 has not been thoroughly revised in over a 100 years and many State Prison Manuals still provide for draconian measures such as whipping and reduction of food rations as acceptable forms of punishment. The Mulla Commission on jail reforms in 1983 made serious recommendations about the revision of Prison Manuals and the need to respect the dignity and rights of prisoners.

Prison administrations have, however, responded to the epidemic with mass screening programmes. Mandatory testing without informed consent violates the rights of prisoners\textsuperscript{116}. Courts in the U.S. have held that while most decisions about the treatment and welfare of HIV-positive prisoners are up to the discretion of the Department of Corrections,\textsuperscript{117} it is unconstitutional to compel an inmate to undertake a blood test unless the results are to be used to

further other penological interests. One of the main barriers to voluntary testing and counseling is that under the best of conditions, confidentiality is difficult to maintain in a small prison community. Prisoners’ fears of disclosure are magnified in systems where social discrimination is formalized by institutional policies, such as systems that have opted for segregated housing and the exclusion of HIV-positive prisoners from some or all prison programmes. Prison officials justify this strategy as a means of preventing HIV transmission, preventing violence against HIV-positive prisoners, and facilitating medical care for those who are sick. None of these justifications withstand scrutiny. Public health and corrections experts agree that segregation is a poor way to protect sero-negative prisoners from the possibility of infection through sexual contact and injecting drug use. Australian and U.S. courts have held the segregation of prisoners simply on the basis of HIV status to be unconstitutional and a violation of anti-discrimination legislation.

Once prisoners test positive, their chances of receiving necessary and adequate care are very low. As it is, medical care for prisoners all around the world is often abysmal due to the pressure of overcrowding and the security priorities of the prison authorities. Health systems within prisons have problems such as lack of adequate care and emergency capacity, meager infirmary space, inadequate dental and mental health care, poor or no discharge planning, poor record-keeping, restricted access to the medical department and lack of special diets. Where there are large numbers of HIV-positive prisoners, the medical systems experience enormous budgetary constraints in providing antiretrovirals and post exposure prophylaxis for opportunistic infections. If they are able to provide the drugs, many systems fail to monitor the potentially toxic side effects. Further, there is the significant issue of whether or not the State is responsible for providing continued care.

122. In the U.S. this is further exacerbated by the fact that prisoners with HIV are ineligible for Medical aid. In some States 75-80% of State funds earmarked for AIDS or non-Medicare patient care are spent on HIV positive prisoners. See: Rowe and Keintz, National Survey of State Spending for AIDS, Intergovernmental AIDS Reports, Sept.-Oct. 1998, p.1
treatment after a prisoner is released, particularly if s/he contracted HIV within
the prison. 123

Also the denial of treatment, care and access to voluntary participation
in clinical research trails has been viewed as a form of inhuman or degrading
treatment or punishment. 124 In South Africa, the courts held that in the case of
HIV/AIDS, the State must provide better treatment in prisons than is available
outside because HIV-positive prisoners are more vulnerable to opportunistic
infections than HIV-positive persons in the free world. 125 In the U.S. on the
other hand, a recent case has found that inmates do not have a constitutional
right to the treatment of their choice because of the qualified immunity of
prison officials. 126 Courts of Australia and Canada have considered whether a
facility can accommodate an HIV-positive prisoner or a prisoner with AIDS
can withstand confinement in an isolation unit when deciding on punishment;
in both cases the judgment was in favor of the HIV-positive prisoner. 127 One of
the ways that courts have recognised as a severe impact of HIV/AIDS on a
prisoner’s life has been by granting compassionate bail or release. In South
Africa, for instance, a prisoner was released due to his HIV-positive status
because the court found that forcing the prisoner to continue to serve his
sentence would be far harsher for him than any other person with the same
sentence. 128 In Canada, because detention centres could not meet the treatment
needs of prisoners, a detainee was released on his own recognizance. 129

Although incarcerated women have many of the same institutional
issues as male inmates, their vulnerabilities to HIV infection as well as rates of
infection exceed those of male prisoners worldwide. For example, HIV
seropositivity rates are two to three times higher among women than men in
almost all correctional systems in the U.S. 130 Studies reveal that women tend
to commit survival crimes to earn money, lead a drug-dependent life and

123. There is a case pending in Delhi High Court about an HIV-positive prisoner’s access to ARV therapy
after release from prison. Interim orders are providing the patient with medicines. See: Lx. V Govt.
of the NCT of Delhi and Ors, CWP No.7330/2000.
127. See R.v. Thiesen (1999) Ontario Court of Justice (unpublished judgement); McDonald (1988) 38 A
C R 471, Court of Criminal Appeal, New South Wales.
129. See R v. Downey (1989) 42 CRR 286, Ontario District Court, Canada.
130. See New York City Department of Health, Bureau of Disease Intervention Services, HIV
escape brutalising physical conditions and relationships. These vulnerabilities that women face outside the prison settings aggravate problems encountered by them within a correctional environment, thus augmenting the challenges of protecting women prisoners from HIV transmission. Sexual violence and other forms of abuse by prison staff are also commonplace in the lives of incarcerated women increasing their vulnerabilities and violating their human rights.\textsuperscript{132}

Prison health systems are rarely equipped to deal with the health needs of women.\textsuperscript{133} If an operating health infrastructure exists within the correctional facility, more than likely it was designed to meet the needs of male inmates and is only adapted to treat female inmate patients. This disparity has a direct impact on the health of women prisoners, particularly in the context of HIV. It is a well-documented fact that HIV infection manifests differently in men and women, the later presenting with common gynecological problems before anything else. If there is no obstetrician/gynecologist or other women’s health specialist available, women inmates are less likely to seek medical help at a stage when diagnostic and treatment services could benefit them. Concomitant to access to adequate health care, gender-specific health education is critical for women prisoners to know how to protect themselves from HIV/AIDS infection. However, apart from the positive actions of the State Governments, prisons and prisoners rights in India remain abysmal. Over the last few years, the increasing numbers of deaths of prisoners and undertrials due to lack of medical care has focused attention on the poor state of health facilities in prisons. In some cases moves to introduce condoms in male prisons met with stiff resistance on the grounds that sodomy was criminalized under existing laws and such preventive measures would amount to abetment.\textsuperscript{134} The traditional view that there are no enforceable rights in respect of prison conditions has not only increased the vulnerability of prisoners and those in the custody of the State to HIV/AIDS, by denying them access to prevention


\textsuperscript{134} See for example a case in India. “India’s Anti-Sodomy Law Prevents Condom Distribution to Prisoners.” Available at www.grd.org.
and harm reduction measures, it has also exacerbated discrimination against
and degrading treatment of HIV-positive prisoners. Prisoners enjoy a right to
life and health equal to that of free persons in the care and custody of the
State, it is the State’s duty to ensure that these rights are fulfilled.

Other Victimized Groups: Refugees, Migrants and Trafficked Human Beings

Migration, human trafficking and HIV/AIDS: A Close Nexus

Migration and human trafficking, though separate and distinct processes,
are connected. The pressing need for work and life opportunities has turned
migration into common livelihood strategy, creating a fertile field for
traffickers and unscrupulous ‘employment agents’. Today, trafficking can no
longer be viewed outside the context of labour migration. The line between the
two is fluid, shifting easily between what might be seen as voluntary migration
for legitimate work and what can clearly be recognized as exploitation.
Understanding the connection between migration and human trafficking is
therefore critical to the development of counter-trafficking strategies.

Migration and human trafficking are often distinguished from one
another by the notion that migration is characterized by choice and trafficking
by coercion, deception or force. In practice, the distinction is not so clear.
People often migrate in expectation of a well-paid job, only to find themselves
forced to work under exploitative conditions in plantation, sweatshop,
domestic service or sex work. It is no coincidence that the growth in
trafficking has taken place during a period of increasing national and
international demand for migrant workers that has not been adequately
acknowledged or facilitated. The process of migration involves particular risks
for women and children, who may end up being trafficked into an exploitative
situation and at risk from HIV/AIDS and other health problems.

The links between migration and trafficking are complex and disputed.
Migration itself does not make a person more vulnerable to trafficking.
Neither is trafficking simply ‘forced migration’, a term that also covers flight
from armed conflict, natural disasters, political unrest, poverty or domestic
violence. Even so, there are several relevant points of intersection between

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135. The process of migration in context of this chapter includes the movement of refugees, migrants and
mobile population.
trafficking and migration. 'Willingness to migrate' is an important potential vulnerability factor in trafficking. Whatever its cause-family problems, poverty or flight from armed conflict-uninformed and unconsidered willingness to migrate can result in a person accepting a situation that can result in a trafficking outcome.

Another factor making migrants vulnerable to trafficking is 'unprotected migratory process', in which a girl or woman travels unaccompanied or with unknown persons. 'Non-secured migratory destination' constitutes a third vulnerability factor of this kind. This refers to a girl or woman travelling for a purpose that is uncertain, or for which she has made no preparatory contact or correspondence, and for which she has no confirmed place of arrival (addresses of friends, family, workplace). While these vulnerability factors are addressed through 'safe migration' activity, other vulnerability factors, such as a personal lack of resilience or the direct aggression of traffickers, must also be addressed by anti-trafficking interventions.136

The right to mobility for employment is an important human right, especially where local economies offer limited livelihood alternatives. It is thus essential that HIV and anti-trafficking prevention and intervention strategies be directed at reducing the vulnerability of migrants, not at restricting migration itself. Strategies need to be developed to enhance social and economic opportunities at the source.

Refugees and HIV/AIDS

Conflict, persecution and violence affect millions of people worldwide, forcing them to uproot their lives. Refugees are those who flee their country of origin across national borders, often to a neighbouring country.137 Far too often refugees face an untenable situation: they are no longer guaranteed the protection of their country of origin and do not receive assistance from host countries. Many host countries are already overburdened by the effect of

137. A refugee is a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country. The 1951 Convention relating to the Status of Refugees. There are some regional variations of this definition. Those who seek safety elsewhere within their own country are called internally displaced persons (IDPs).
HIV/AIDS and are often unable or unwilling to provide the HIV/AIDS related services refugees need and to which they have a right under international refugees and human rights law. Refugees often do not have access to HIV/AIDS prevention commodities and programmes. Access of basic HIV/AIDS related care and support is also rarely given adequate attention. Despite improvements in the availability of antiretroviral therapy in low-and middle-income countries, very few refugees have access to it.

Refugees frequently face stigma, both because of their status as refugees and because of the common misconception that HIV/AIDS prevalence is higher among refugees than in host communities. In fact, historical evidence shows that refugees have been migrating from countries with lower HIV prevalence to countries with higher HIV/AIDS prevalence. Stigma and discrimination needs to be tackled as an integral part of responding effectively to HIV among refugees and host communities. While knowledge about the comparative HIV/AIDS prevalence among refugees and host communities can assist in programme design and implementation, such information does not alter the action that is required to tackle stigma and discrimination. The provision of a comprehensive and integrated national response, that addresses the HIV/AIDS related prevention, treatment, care and support needs of refugees and host communities is the most effective way to reduce the risk of HIV transmission and address the effects of HIV/AIDS.

The many factors that can contribute to the increased risk of HIV transmission among refugees in emergency and post-emergency phases are relatively well understood. Refugees are uprooted from their homes and communities. Livelihoods are lost. The breakdown of social networks and institutions reduces community cohesion, weakening the social and sexual norms that regulate behaviour. Disruption to health and education services reduces access to HIV/AIDS prevention information and commodities, sexual and reproductive health services, as well as HIV-related treatment and care. Exposure to mass trauma such as conflict can increase alcohol and other drug use and influence people's attitudes towards HIV/AIDS risk. Conflict and displacement make women and children, particularly girls, disproportionately

vulnerable to the risk of HIV/AIDS. During conflict, rape is often used as a weapon of war. Women and girls are also subject to sexual violence and exploitation in refugee settings. As refugees struggle to meet their basic needs such as food, water and shelter women and girls are often forced to exchange sexual service for money, food or protection\textsuperscript{139}. Children living without parental support, whether due to separation from or death of family members, are also particularly vulnerable to sexual and physical violence and exploitation which increases their vulnerability to HIV/AIDS.

Factors that can limit the transmission of HIV/AIDS among refugees are less well studied, but some have been identified. These include reduce mobility to high prevalence urban areas, the isolation and in some circumstances, especially in the post emergency phase, the availability of better protection and other HIV related services than in countries of origin or in host communities\textsuperscript{140}. The HIV/AIDS implications for host communities depend on the extent and nature of contact between host communities and refugees. The majority of refugee live within host communities, not in camps. Refugees are also staying longer in their host countries. The average estimated length of stay has increased from nine years in 1993 to seventeen years in 2003\textsuperscript{141}. As refugees stay a long times in host countries and live in close contact with host communities, failure to address their HIV/AIDS related needs not only denies refugee their rights, it also undermines efforts to address HIV complexities. Yet refugees are often overlooked in the HIV national strategic plans in many host countries\textsuperscript{142}.

In 2001, all United Nations member states signed the Declaration of Commitment on HIV/AIDS, recognizing that refugees are at increased risk of exposure to HIV infection and committed themselves to incorporating HIV into programmes that responds to emergencies. The Declaration also called upon UN agencies, national and regional organizations to factor HIV into their assistance to countries affected by conflict and humanitarian crisis.

\textsuperscript{139} See for example the 20th activity report of African Commission on Human and people's Right. 2006. Available at www.achpr.org.
\textsuperscript{140} For example, a survey among Burundians in a Tanzanian camp revealed that 26% of women had endured sexual violence since becoming a refugee. Cited in Holmes W (2001). Health and Human rights; HIV and Human rights in refugee settings, The lancet, 358, p144-146.
\textsuperscript{141} Hankies c et al. Transmission and prevention of HIV and sexually transmitted infections in war setting and armed conflict, AIDS Today, 16, p 2245-2252, 2002.
The realization of human rights is central to reducing vulnerability to HIV/AIDS. Host countries have specific obligations under international refugee and human rights laws. Over 140 countries are party to the 1951 Convention relating to the status of Refugee, committing state parties to provide refugees with the same public relief and assistance as their nationals including medical care. International human rights law provides the framework for a rights based approach to responding to HIV.\textsuperscript{143} UNAIDS and UNHCR recommend the incorporation of refugee into HIV/AIDS policies, strategic plans and programmes\textsuperscript{144} for host communities and ensure appropriate access to comprehensive HIV prevention, treatment, care and support. The laws, policies and programmes should respect, protect and fulfill the rights of all refugees and that there should be no discrimination towards refugees; no discrimination on the basis of HIV/AIDS status in asylum procedures; protection from expulsion and forced return and restrictions on freedom of movement on the basis of HIV/AIDS status, protection of women and children from sexual or physical violence and exploitation, and access for children to national education systems. Refugees should be included in serological and behavioural surveillance system, because such operational research improves understanding of the impact of HIV/AIDS among refugees and host communities.

**Victims of human trafficking and HIV/AIDS**

Trafficking is a complex development issue. It is an economic problem, as the vast majority of women seeking to escape poverty are lured into trafficking by the false promise of economic gain. Trafficking is a health problem as trafficked women and children are at high risk of HIV infection. It is a gender problem, as unequal power relations reinforce women's secondary status in society. Lastly, it is a legal problem, as its victims are stripped of their human rights and lack any access to redress for the crimes committed against them.\textsuperscript{145}

\textsuperscript{143} See also UNCHR- The state of the world's refugees: Human displacement in the new millennium. UN Publications, 2006.

\textsuperscript{144} For detailed examination of this and other best practice examples see UNAIDS/UNHCR (2005) strategies to support the HIV related needs of refugees and host populations. Geneva.

\textsuperscript{145} USAID-Strategic treatment for the Asia Regional Anti-Trafficking Initiative. 'May 25,1999 (draft) Washington, D.C., 1999.
Trafficking is the illegal moving and selling of human beings across and within countries and continents in exchange for monetary and/or other compensation. While the majority trafficking cases occurs for sex work, there are many other reasons for human trafficking: forced marriage, forced labour, domestic service, organized begging, camel jockeying, circus work, illicit adoption, pornography production and organ trafficking for the transplant market. As noted, most of those trafficked are women and girls, but boys are also trafficked, in particular as camel jockeys or forced labour, for adoption and in some areas as sex workers. Such workers comprise a large proportion of children whose sexual exploitation leaves them vulnerable to HIV/AIDS infection. Human trafficking and HIV/AIDS are connected to a wide range of development issues like socio-economic and gender inequality, migration, education, rights and health. These factors increase the risk of being trafficked and simultaneously increase the vulnerability to HIV/AIDS.

There are various structural and socio-economic factors that highlight the nexus between HIV/AIDS and human trafficking. The victims of human trafficking are highly vulnerable to HIV/AIDS epidemic due to poverty, low levels of literacy, gender inequality, rural to urban and intrastate migration of male populations, injecting drug use, weak public health infrastructure and stigmas related to sex and sexuality. The issues of stigmatization and discrimination are common to both HIV/AIDS and human trafficking. Like trafficking, stigma and discrimination associated with HIV/AIDS are often gender-related. Because of such gender-related stigma and discrimination, one must be cautious in highlighting the link between human trafficking and increased HIV/AIDS risk with regards to returning female migrants or trafficked survivors. The trafficking of human beings is a gross violation of human rights, including the right to live with dignity, the right to free mobility and self determination and the right to justice. When burdened with HIV/AIDS, the stigma and the discriminatory treatment their victimization is aggravated.

NGOs active against trafficking increasingly face the reality of HIV/AIDS, with one out of every three rescued victims testing HIV-positive. A few NGOs run programmes for the care and support of HIV positive survivors of trafficking. Such programmes include the treatment of
opportunistic infections, referral services and the provision of temporary shelters. Some recent, state-level assessments of trafficking and HIV/AIDS through consultations and workshops with NGOs have been noted. UNDP has started a project in 11 states of India, the 'Trafficking and HIV/AIDS Project' (TAHA), in collaboration with NACO and the Department of Women and Child Development. The main component of the project is to mainstream HIV/AIDS and trafficking and strengthen the linkage between the two to support a coordinated response by policy formulation and change.

Most anti-trafficking organizations have responded to HIV/AIDS in crisis terms rather than in a planned manner. There is a need to look beyond present interventions, which only seek to create greater awareness of HIV/AIDS and provide care and support services in communities like sex workers or migrants. These responses need to be expanded to reduce overall social, economic and gender inequality and violence.

The absence of effective legislation, poor enforcement mechanisms and ineffective border controls, are some of the factors commonly cited as contributing to or accelerating the traffic in human beings, both nationally and regionally. In particular, weak governance makes the poor vulnerable to the risk of being trafficked. Contributing factors in this respect include the absence of effective legislation, policies and institutional structures to address women and child trafficking; poor law enforcement combined with corruption, which can lead to police, border officials and politicians being bribed by traffickers; and the exclusion of poor and vulnerable groups, including women, indigenous peoples and members of ‘low’ castes, from basic social and economic services. When these people seek redress or protection from the authorities, they are subjected to an insensitive ‘pushback policy’. Cultural and linguistic barriers also heighten their lack of access of such services as exist.

There is very little convergence between the laws and policies related to HIV/AIDS and those related to human trafficking. By and large, the HIV/AIDS concerns of trafficked persons are not addressed in anti-trafficking law or policy, while trafficked persons are not recognized or specially targeted in HIV/AIDS law and policy. In most of the countries examined, a number of existing laws and regulations indirectly address issues that affect people infected with or affected by HIV. However, some of these laws and
regulations act against the rights and well-being of such people. In contrast, the laws regarding human trafficking are imprecise, discriminatory and mostly abusive of the rights of trafficked persons (i.e. 'victimizing the victims'), including those who are also migrants refugees, sex workers and PLHAs.

HIV/AIDS infection is mediated by almost the same set of factors that causes vulnerability to human trafficking: namely, that it is increasingly seen in people aged between 15-24 years, people with low literacy levels and occupation skills and people from 'lower' economic background; among women and girls; in environments where violence and alcohol and drug use are high and where poverty prevails; and among young entrants forced into sex work. Studies show that brothel-based sex workers are most likely to become infected with HIV in the first six months of work, during which time they have least bargaining power and are forced to service more clients.

No single vulnerability factor can be identified as a cause of human trafficking and HIV. Instead, these factors are closely intertwined with one another in complex and intricate ways, often reinforcing one another. Sometimes one factor, such as poverty, increase the likelihood of another, such as forced migration, creating a chain of vulnerability. It is important to note that the mere presence of one or more vulnerability factors does not mean that a person will be trafficked. Many people in highly vulnerable situations do not end up as trafficked due to mitigating factors such as community 'safety nets', while some in situations of lower vulnerability are nonetheless trafficked. Therefore, it is important to identify local-specific vulnerability factors in order to determine appropriate policy and programmatic interventions against trafficking.

HIV/AIDS and human trafficking present similar determinants and consequences, and require similar rights-based responses with sufficient focus on underlying development factors. Both affect vulnerable and disempowered populations often associated with poverty and gender inequality. Both are associated with unsafe migration and sex work. Finally, both involve stigma and discrimination against affected or infected persons. Logically and for synergistic reasons, it is imperative to address trafficking issues within HIV/AIDS programmes.
Migrants and HIV/AIDS

Some 150 million migrants currently live and often work outside their country of citizenship, and between two and four million people migrate permanently each year. Of these, some 20 to 30 million have been displaced because of wars, ethnic tensions, and human rights abuse. Others move within countries in order to seek employment, to seek better living or working conditions, to seek markets or education, or to join family members. Mobile people can be described broadly as people who move from one place to another temporarily, seasonally or permanently for a host of voluntary or involuntary reasons.

Key employment groups involving mobility include truckers, seafarers, transport workers, agricultural workers, itinerant traders, mobile employees of large industries (e.g. mining, oil companies), and sex workers. Migrants are mobile people who take up residence or who remain for an extended stay in a foreign country. Women comprise some 47 percent of migrants, and dominate migration in some regions.

Studies on certain highly mobile groups have identified travel or migration as a factor related to HIV infection. In many countries, regions reporting higher seasonal and long-term mobility also have higher rates of HIV infection, and higher rates of infection can also be found along transport routes and in border regions. The epidemiological studies focusing on more stationary migrant populations in several countries show that non-nationals are disproportionately affected by HIV/AIDS. Such studies indicate that migration and mobility increase vulnerability to HIV/AIDS—both for those who are mobile and for their partners back home. Given the large numbers of migrants and mobile people, this vulnerability has far-reaching and tragic consequences. Yet governments have not yet done enough to address HIV/AIDS among those who are mobile.

147. Reasons may include family reunion, professional or economic opportunity, poverty, war, human rights abuse, ethnic tension, violence, famine, persecution, medical or health care needs. See also UNAIDS Technical Update, Refugees and AIDS, 1997.
148. The military, including peace-keepers, can also be a mobile population. For more information on the military, see AIDS and the Military: UNAIDS Point of View, May 1998.
149. For a review, see International Migration, 36/4, 1998.
150. See, for example: Anderson J, Melville R, Jeffries DJ et al; Ethnic differences in women with HIV infection in Britain and Ireland: the study group for the MRC collaborative study of HIV infection in women. AIDS 10, 89-93, 1996.
A response early in the epidemic was an attempt to keep HIV-positive people out of a country by laws that restrict their entry or stay. Some 60 countries have such restrictions, most of which are applied to long-stay visitors, seasonal workers, migrant workers, and foreign students. However, according to the WHO, UNAIDS and the Office of High Commissioner for Human Rights, these restrictions have no public health justification. 151 Such restrictions may in fact increase migrants' vulnerability to HIV/AIDS by driving them underground and discouraging them from coming forward for prevention information, testing counselling and support-in both sources and destination countries. Being mobile in itself is not a risk factor for HIV/AIDS; it is the situations encountered and the behaviours possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV/AIDS.

Migrants and mobile people may be highly marginalized while in transit, at destination, or on their return home. They may be subject to discrimination, xenophobia, exploitation and harassment, and have little or no legal or social protection in the host community. Such marginalisation increases vulnerability to HIV/AIDS infection due to no access to HIV information, health services, and means of HIV prevention (condoms, treatment for sexually transmitted infections). Cultural and linguistic barriers heighten their lack of access, as do unfamiliarity with the community, and the instability of mobility. Migrants in some countries face the possibility of involuntary testing for HIV, and deportation, if found to be positive. 152 Their HIV status may be revealed to authorities in their destination or source countries, or to their communities and families. Such breaches of confidentiality give rise to stigma, discrimination and rejection. Deportation from country in which advanced HIV/AIDS care is available to one in which such care is not available may mean greater suffering and an early death.

Financial, human and institutional resources in many countries are extremely limited for HIV/AIDS prevention and care programmes. The

resources that are available are most often targeted to local populations, with limited or no resources going to the needs of migrants and people moving through the community. The projects on HIV/AIDS and mobility established in some developing countries by international agencies and NGOs have generally been limited in social and geographical coverage, and also in time. Few national AIDS plans deal with population mobility in ways that take into account its importance to the epidemic. The challenge is thus for governments to acknowledge the need to address HIV/AIDS among migrants and mobile people.

Almost all countries are affected by migration and by population mobility—as sending or receiving countries and/or because of population movement within their borders. This population mobility could be a major factor driving the HIV epidemic in a country, and yet neither the mobility itself nor the migrants and mobile people involved are usually addressed in strategic planning or in national HIV/AIDS plans. In national and community strategic planning any mapping of the epidemic and the factors driving it should include attention to migrants and mobile people, their realities, and their vulnerabilities. At the same time, regional and international bodies must use their institutional advantages to promote effective responses to migration, mobility and HIV/AIDS. The resources must be increased and/or shifted to deal more strategically with the issues involved.

Responses to HIV/AIDS for migrants and mobile people start with creating an enabling environment. An enabling environment has three components. First of all the ability to protect oneself by making informed choices and being supported in these choices. Then the specific prevention programmes grounded in the psychological, social and cultural constraints and opportunities of migrants and mobile people, followed by access to 'migrant/mobile-friendly' care and support for those living with HIV/AIDS.

Various international and regional laws protect the rights of migrants and mobile people. However, national laws, and regulations should be reviewed to ensure that the rights of migrants and mobile people are protected in the following areas like, Protection of family unity including the ability to

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153. For example IOM and UNAIDS have signed a cooperation agreement that among other things seeks to promote strategic responses to HIV/AIDS among migrants and mobile people.
bring spouses and children to the destination country, legal access to local health care services, protection against discrimination, application of local labour protection to migrants and mobile populations, including minimum wage and the right to organize, availability of legal process and legal support, including in the context of deportation, protection of confidentiality of HIV status, access to basic social security during transit and at destination, ratification of the International Convention on the Protection of All Migrant Workers and Members of their Families, as well as other international instruments that protect migrants and seasonal workers.154

An important feature of HIV/AIDS epidemic is the extent to which its growth has revealed historical and abiding social, economic and political inequalities in every society globally. Not only does HIV/AIDS render social, political and economic disempowerment more visible, but it also capitalizes on such inequities to create vulnerabilities among the least privileged and the most marginalized groups discussed above. These marginalized groups being the victims of gross human rights violations are more susceptible to the epidemic. Such situation reveals that this health problem cannot simply have a medical solution. Social, political and legal solutions are required to adequately deal with the epidemic and its implications in context of human rights of PLHAs and people associated with them. In many ways the HIV/AIDS epidemic has transformed the human rights discourse. As the global incidence of HIV/AIDS infection continues to rise and remains a stigmatized condition, it has become a global norm or at least ‘best practice’ to institute various anti-discrimination mechanisms to protect the human rights of PLHAs, the marginalized groups as well as people associated with them at the behest of the United Nations. It is not however, enough to think of international human rights framework in simply a functional way, as good public health practice but rather as a way to achieve social equity, justice and health for all. But practically human rights abuses against people infected and affected by the HIV/AIDS epidemic are rampant. Discrimination and stigma act as a barrier which limits the people’s access to human rights approach. The

international and the national human rights standards in context of HIV/AIDS still need to be developed and refined in order to protect and promote human rights and fundamental freedoms of people infected and affected by the epidemic.