CHAPTER VI
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RIGHT TO SEXUAL AUTONOMY

6.1 Introduction

Epidemics are not new to mankind. Throughout its existence the planet has suffered from various epidemics like plague, cholera, smallpox, mass hysteria etc. Today the epidemic that has surfaced the earth is the deadly disease AIDS, transmitted mainly through sexual activity.

First reported in USA in 1981, it exists in more than 168 countries. In India HIV was reported in 1986 from Madras and first case of AIDS in 1986 from Mumbai. In 1999 the official figure quoted was 0.3 million HIV infected people and 68000 cases of AIDS\(^1\).

The Union Health Ministry in 2001, stated that are 3.86 million with HIV positive in India\(^2\). Unofficially it is estimated that 4-10 million people are infected with HIV in India. The worse part is the doubling time for number of people infected with HIV is becoming shorter\(^3\). Prime Minister of India, states that there are 6 million HIV infected in the country\(^4\). It is estimated that 10,000 people will die of HIV everyday in India by next 10-15 years\(^5\). The worst part is majority of HIV infected population does not know their HIV status\(^6\).

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Because women are more vulnerable to the disease, and their lives revolves round sexual functions (wifehood and motherhood) the object of the study is i) to legally empower woman in the area of her ‘sexuality’ to reduce her risks of getting infected, ii) if infected, to enhance her status, dignity and quality of remaining life and iii) to effectively combat the spread of disease.

Before proceeding further it is pertinent to note here the medical truths of HIV/AIDS, for at least two reasons i) certain statutes\(^7\) have been legislated unmindful of medical truths, and ii) in the course of study they shall be useful for suggestions.

**The Medical Truths**

1. The Human Immunodeficiency Virus (HIV) is a virus capable of infecting humans.

2. It is a fragile virus that is easily killed by the techniques for sterilisation.

3. It is commonly transmitted by one person to another through homosexual or heterosexual intercourse, transfusion of infected blood or blood products, or through unsterile hypodermic needles used for it into a person already infected by HIV.

4. Such transmission of the virus can be avoided by the use of simple measures such as the use of a condom during sexual intercourse, screening of blood donors for HIV and the use of sterile hypodermic needles.

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\(^7\) Example Section 53(1) sub clause (viii), (ix) (x) of Goa Public Health Act, 1989.
5. Infection by HIV produces a chronic, manageable illness.

6. Some individuals infected by HIV may go on to develop Acquired Immuno deficiency Syndrome (AIDS).

7. At present we have no cure for AIDS. The diagnosis of AIDS is, in most cases, tantamount to a death sentence.

8. Patients with AIDS may suffer a host of infectious diseases and suffer considerably before they die.

6.1.1 HIV, Women and Vulnerability

The global data, on epidemiology, pathophysiology and clinical manifestation reveal that women and children are worst affected segments of the population. There is overwhelming evidence that HIV/AIDS infection is increasing among women than among men, although men had a higher infection rate when the epidemic began, more than a decade ago. According to UNAIDS Report, there were 36.1 million HIV/AIDS infected people living in the world by the end of 2000. Of these, 16.4 million were women. The pace at which HIV/AIDS epidemic is spreading to women is alarming. A UNICEF document reports that in 1998, 43 per cent of all people over 15 years of age living with HIV/AIDS were women: this is 2 per cent higher than the per cent reported in the previous year. The Indian National AIDS control organisation (NACO)

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11 Adolescents and HIV/AIDS, UNICEF 2001
reports that the HIV epidemic in India continues to shift towards women and young people with an accompanying increase in vertical transmission and pediatric HIV. Thus, globally there is an increasing trend of HIV infection among women.

Although the overall sex ratio of the HIV/AIDS infected population impacts males—more men than women, the death statistics show that so far more women have died of HIV/AIDS than men. In 1999 alone, 2.3 million women were infected with HIV compared to 2.5 million males in the same year. However, the number of women dying of AIDS in the same year was 1.3 million compared to 1.2 million male deaths due to AIDS\(^\text{13}\) (UNAIDS). Furthermore, upto the end of 2000, the AIDS disease killed 9 million women compared to 8.5 million men (UNAIDS)\(^\text{14}\). Clearly, globally the epidemic has taken more women’s lives than men with far reaching implications for families and communities. Thus, globally, not only the proportion of women infected with HIV is increasing, but also there are more women dying of HIV/AIDS\(^\text{15}\).

Age wise data of HIV infected people in India further shows that the age group 15-49 accounts for nearly nine-tenths of the HIV infected cases. Clearly this is more alarming because they are in the reproductive age group with tremendous potential to transmit the virus to their spouses or partners and even to their children\(^\text{16}\). Thus, women having


\(^{15}\) S. Pallikadvath, *supra* note 6, p. 4173.

HIV has a multiplier effect in terms of both vertical and horizontal transmission of the virus\textsuperscript{17}.

In the absence of specific study, the clustered reasons for women's vulnerability to HIV/AIDS and their mortality are as follows:

a) **Biological susceptibility:** Women are biologically more susceptible to contracting a sexually transmitted infection than men. This is because of the shape of the vagina and a greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse, since the quantity of seminal fluid is far greater than the vaginal fluid involved\textsuperscript{18}. The presence of sexually transmitted disease, specially ulcerative lesions of the genitalia, increase the risk of HIV transmission\textsuperscript{19}.

b) **Increase in age at marriage and early debut to sex:** The National Family Health Survey (NFHS) surveys reveal that the age at marriage of girls is on the rise in India. This suggests that the period between puberty and age at first marriage will increase. Studies also support that age at first sex is relatively low in India, whether in rural or urban areas. As these social changes are likely to increase the occurrence of premarital sexual relations in India, adolescent girls will be a higher risk of HIV or other Sexually Transmitted Infections (STIs)\textsuperscript{20}.

\textsuperscript{17} S. Pallikadvath, *supra* note 6, p. 4173.
\textsuperscript{18} T.K. Sundari Ravindran, 'Engendering Health' *Seminar*, 489, May 2000, p. 36.
\textsuperscript{19} Prema Ramachandran, *supra* note 9, p. 21.
\textsuperscript{20} S. Pallikadvath, *supra* note 6, p. 4177.
c) **Changing behaviour in sex**: Survey conducted in the 1980's among college students, responses collected through a questionnaire in a popular English magazine and its analysis and study conducted in 1993 by Indian Market Research Bureau, reveal that there is increase in premarital sex with multiple partners. Similarly sex outside marriage, ie., extra marital sex is on increase. Survey among educated working women and responses received to questionnaires in (Femina 1993) and (Savvy 1993) reveal extra marital rise among women in general.

d) **Non-use of condoms by men**: The family planning campaign in India has tried to promote condoms as a measure for birth control. It protects the couples from unwanted pregnancy and STD. But the proportion of its use is far lower compared to other nations. In India in 1988-89 it was 5 per cent.

Common complaint against condoms is it reduces pleasures of sexual intercourse. Unlike other contraceptives, condoms directly relate to sexual act – which make it an issue of culture sensitivity. Women and men are reluctant to buy them as it causes embarrassment. Also there is Ethno-physiological fear that condom may be lost inside a woman’s body. In a study of the prevalence of and risk factors for HIV infection in Tamil Nadu,

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25 Ibid., p. 532.
26 Ibid., pp. 532-34.
India (1994-95) covering a population of about 97,000, less than 2 per cent of married men were found to be condom users.

e) Responsibility of nurturing the young: In case of couples, married or cohabiting, caretaking responsibilities will fall mainly on the female partner who will become even more vulnerable, both as potential AIDS casualty and as survivor. In India, women not only assume major responsibility for nurturing and socializing the young, home making and ensuring the healthy, development of family members, but are also engaged in formal/informal production and market activities. With heterosexual transmission as major route of infection, women will face the double burden of caring and living in fear of contagion.

f) Powerless within sexual relationship: In India, women in general have a lower social status and are powerless within the sexual relationship in negotiating for safer sex practices.

g) Low awareness: According to National Family Health Survey, the awareness of HIV among women is very low, 60 per cent have not heard of it.

h) Access to health care: Access to health care is an important issue for those infected with HIV as well as those not infected with HIV. Access to health care is more important for women infected with HIV because

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29 Ibid.
of their specific health needs. However, in general women have limited access to health care because of their low status deriving from their illiteracy and economic dependence on men. Studies have shown that women are less likely to be taken to a hospital or given medical care for any given health need as compared to men. This is particularly a serious issue in the rural areas where women depend on men for economic social security. Given the lesser numbers of women with STIs (Sexually Transmitted Infections) consulting a health professional because of social and other reasons, such women are at greater risk of HIV infection because STIs facilitate HIV infection. Thus, the status of women is an important variable influencing the risk of HIV infection.31

i) Non-availability of testing facilities: Knowing HIV status is a vital item of information for providing care to the infected person and preventing the virus from spreading to others people. There is no public facility under the government for HIV testing in India. Consequently, there is no treatment or care available for HIV/AIDS under the government system. Thus, the lack of public facilities to test the HIV status of women, or for that matter any one presents a serious obstacle to providing services.32

j) Reluctance of medical staff in attending HIV infected: The medical staff including doctors and nurses, fear that they may get HIV transmitted if they attend HIV positive patients.33 This could be more

32 Ibid.
serious issue in cases of caesarean deliveries, where the staff would come in direct contact with the patient’s body fluids containing HIV virus. Therefore there is resistance in providing health care to HIV infected women.

k) Female sex workers: HIV prevalence among sex workers is very high. Though there is no exact figure for the country as a whole, in Bombay alone for the year 1992 – the prevalence rate was 41.2 per cent.\(^{34}\)

l) Socially and economically weak: Apart from the regular sex workers, those who provide sexual services in the villages are poor widows and low caste women.\(^{35}\) They are also vulnerable to the disease.

m) Infected semen: Another category of women, though in microscopic minority are those who use sperms supplied by sperm banks. Since semen is potent means for transmitting the virus, at the seminar on Medical Ethics organized in New Delhi by Max Muller Bhavan and All India Institute of Medical Services, have given a call for caution not to use untested donor sperm.\(^{36}\)

n) Perinatal infection: Perinatal infection occurs in 20-50 per cent of infants born to seropositive women. It is estimated that perinatal transmission accounts for 1-10 per cent of all infections.\(^{37}\) In India majority of the HIV infected population does not know their HIV

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34 Pallikadvath, supra note 6, p. 4176.
37 Prema Ramchandran, supra note 9, p. 22.
status. Therefore due to ignorance many infected women of reproductive age may transmit it to the infant perinatally. Since care and nurturing of infants is primarily on women, it makes them doubly vulnerable.

o) Sterilisation method of contraception: As a family planning device, female sterilisation accounts for 71 per cent of the current contraceptive users. That means these women would not be using condom for preventing pregnancy in their sexual relations, marital or non marital. That is chances of male partners transmitting HIV virus to their wives does not stop with sterilisation.

6.1.2 Privacy and Confidentiality

The Paris AIDS Summit Declaration, 1994, recognizes that HIV inflicts irreparable damage on females and communities; that it not only causes physical and emotional suffering but often used as a justification for violations of human rights; that cultural, legal, economic and political obstacles hamper its prevention, care and support systems. There is considerable prejudice in many minds against persons known to be infected by HIV or suffering from AIDS.

Even in a developed country like United States, HIV infected is confronted with prejudice and discrimination. Discrimination is found in

38 Pallikadavath, supra note 6, p. 4176.
39 Ibid., p. 4175.
medical treatment, housing, employment, education, travel and insurance. Woman who contract AIDS are often subjected to physical abuse by their partners, denied medical assistance and rejected by their family and friends. Many children born with AIDS are abandoned and placed in institutions where they receive little love and attention. Discriminatory practices on HIV/AIDS infected are common in India. Instances are there, where a person is taken away to be detained on the ground he was HIV positive, patients not getting treatment including in premier institution like All India Institute of Medical Sciences, patients left outside the hospital gate to be transported by the corporation lorry to the dumping yard, young/widow ostracized by both natal and marital families, a youth discharged in haste along with saline drip attached to him who died later, attendants doing their best not to touch the patients, doctors wearing gloves, caps, masks and gowns, etc. These evidence how prejudiced the society is against HIV infected. Therefore privacy

44 Joan McNamara, supra note 42, p. 473.
51 Ibid.
(confidentiality) becomes the primary concern of the individual, to seek minimize the discrimination and maintain a reasonable quality of life\textsuperscript{52}.

6.1.3 Privacy

The idea of privacy is as old as Biblical periods. Even Adam and Eve tried to hide their nudity with leaves. Privacy is vital to the mental, spiritual and physical well-being of all individuals and also to the morality and personality of individuals\textsuperscript{53}, it is necessary for a secure relationship between individual and individual whether it is between man and wife, son and father or a friend and friend. In other words it concretizes interpersonal relationships of love, friendship and trust.\textsuperscript{54}

Psychologists and sociologists have linked the development and maintenance of the sense of individuality to the human need for autonomy. One of the accepted ways of representing the individual’s need for an ultimate core of autonomy has been to describe the individual’s relation with others in terms of a series of zones or regions of privacy leading to a self. This core self is pictured as surrounded by a series of layer consecutive circles. The inner circle shelters the individuals ultimate secrets, those hopes, fears and aspirations that are beyond sharing with anyone unless the individual comes under such stress, that he must pour out these ultimate secrets to secure emotional relief. The most serious threat to individual autonomy is that someone will penetrate this inner zone and learn the ultimate secrets either by physical or other means. This deliberate penetration of an individual protection shell, his psychological Armour will

\textsuperscript{52} Joan McNamara, supra note 42, p. 473.
\textsuperscript{53} Charles Fried, Privacy, 77 Yale L J, p. 478.
\textsuperscript{54} Ibid., p. 477.
leave him naked to ridicule and will put him under the control of those who know his secrets.

Modern democracies have tried to protect this 'inner core' of an individual. In democratic liberal tradition, intrusions upon a person’s solitude or seclusion or into his affairs, public disclosure of embarrassing facts of a person’s private life, publicity which place an individual in false light in public eyes and appropriation to a person's advantage of another’s name or likeness are said to be invasions of one’s privacy.

Today, all the International and Regional instruments on Human Rights recognize this right to privacy, Article 12 of Universal Declaration on Human Rights 1948, Article 17 of Civil and Political Covenant 1966, Article 8 of European Convention on Human Rights 1950, Article 11 of American Convention on Human Rights, recognise the right to privacy. In India, the right to privacy is not as developed compared to

57 "No one shall be subjected to arbitrary interference with his privacy, family home or correspondence, not to attack upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.
58 i) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, not to unlawful attacks on his honour and reputation. ii) Everyone has the right to protection of the law against such interference or attacks.
59 Art. 8 of the European Convention, cover i; Attacks on physical or mental integrity or moral or intellectual filed on, ii) Attacks on honour and reputation and similar torts, iii) The use of name, identity, or likeness. iv) being spied upon, watched, or harassed and v) The disclosure of information protected by the duty of professional secrecy.
60 i) Every one has the right to have his honour respected and his dignity recognised, ii) no one may be the object of arbitrary or abusive interference with his private life, his family, his home, or his correspondence, or of his unlawful attacks on his honour or reputation and iii) everyone has the right to the protection of the law against such interference or attacks.
United States. Therefore a brief study of it in U.S. should widen our understanding.

a) In United States

In United States, the right to privacy was examined very early. In *Meyer v. Nebraska*\(^61\) way back in 1923, Justice McReynolds while elaborating the liberty jurisprudence observed that "it denoted not merely freedom from bodily restraint but also the right of any individuals to contract, to engage in any of the common occupation of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to his own conscience and generally to enjoy those privileges long recognized by common law as essential to the orderly pursuit of happiness of freeman".

In *Skinner v. Oklahoma*\(^62\) overturning a Statute providing for compulsory sterilisation of hereditary criminals, the court held privacy encompasses the right to procreate.

A major breakthrough came in *Grissworld v. Connecticut*\(^63\) where the US Supreme Court held right to privacy was a constitutional right, its source being the First, Third, Second, Third, Fourth, Fifth and Ninth Amendments to Bill of Rights. In the instant case, striking down Connecticut statute which made use of contraceptives a criminal offence, the Supreme Court held right to sexual privacy extends to all individuals in

\(^{61}\) 262 US 390 (1923).
\(^{62}\) 316 US 535 (1942).
\(^{63}\) 381 US 479 (1965), p. 485.
matters so fundamental as decision whether to bear or beget a child. Similarly in *Eisenstadt v. Baird*, the court held 'constitution' protects choices of the individual married or single to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

In *Jane Roe v. Henry*, the Supreme Court establishing again the right to privacy as constitutional right, held that the right has some extension to activities relating to marriage, procreation, contraception, family relationship, child rearing and education.

The constitutional guarantee of privacy, led many gay and lesbians to challenge sodomy laws in states like Virginia, Georgia, Texas, New York and many other states. Therefore question arose whether right to privacy is an absolute right.

In *Roe v. Wade*, the Supreme Court had held that the right is not absolute and devised a test called 'rational relation test'. It meant a statute to be justified should have a 'compelling state interest' and that 'it be the narrowest means available to effect that interest'. The States Courts

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64 381 US 479 (1965).
65 405 US 438.
66 Ibid., p. 453.
68 Ibid. p. 147.
72 *People v. Uplinger*, 58 NY 2d 936 (1983)
73 410, US 113 (1973)
74 Ibid., pp. 155-56.
in those cases upheld the sodomy laws with varying reasons such as on 'implementing morality'\textsuperscript{75}, 'privacy does not extend to homosexuality'\textsuperscript{76}, '\textit{Roe v. Wade} not a binding precedent'\textsuperscript{77}, 'privacy applies only to marital intimacy and procreative choice'\textsuperscript{78} and 'promoting health of homosexuals' etc. But neither the Supreme Court nor the Lower Courts decisions throw light as to what is 'the state's compelling interest' in the matter like HIV/AIDS infection.

However, the report of AIDS Committee, 1989\textsuperscript{79} says "the strong public interest in protecting confidentiality is i) to encourage individuals to seek and receive treatment, ii) to encourage HIV positive individuals to disclose their status when another persons safety is at risk\textsuperscript{80}.

That is, in matters related to HIV/AIDS, the only object of government to intrude privacy would be to i) to encourage individual to seek treatment and ii) to protect persons who are at risk. This is reiterated in the health statutes of California, Hawaii, New York, Pennsylvania and others.

b) In India

The Indian Constitution does not directly confer upon its citizens the right to privacy as fundamental rights enumerated in Chapter

\footnotesize{\textsuperscript{75} Baker v. Wade, supra note 71.  
\textsuperscript{76} Dronenburg v. Zech, 741 F2d 1383 (DC cir 1984).  
\textsuperscript{77} Hardwick v. Bowers, supra note 70.  
\textsuperscript{78} Baker v. Wade, supra note 71.  
\textsuperscript{79} Report of AIDS Committee, Joan McNamara, supra note 42, p. 473.  
III, nevertheless it a fundamental right emanating from Article 21\(^{81}\) which guarantees life and personal liberty.

Its evolution is traced to \textit{Kharak Singh v. state of Uttar Pradesh}\(^{82}\) where the Apex Court held ‘intrusion into person’s home and disturbance caused to him is the violation of the personal liberty of an ‘individual’. In \textit{Gobind v. State of Madya Pradesh}\(^{83}\) the Court held that Article 21 protects the right to privacy and promotes the dignity of individual. The Court observed the right to personal liberty, the right to move freely and freedom of speech create independent rights of privacy as an emanation from them, which can be characterized as a fundamental right. In \textit{RajaGopal v. State of Tamilnadu}\(^{84}\), the Court held that right to privacy is implicit in the life and liberty guaranteed to the citizens under Article 21 and said “A citizen has a right to safeguard the privacy of his own, his family, marriage, procreation, motherhood, child bearing and education among other matters”.

This right to privacy is not absolute, it can be curtailed in the ‘interest of public’. The Apex Court in \textit{X v. Hospital Z}\(^{85}\) has held, [a]s one of the basic Human Rights, the right of privacy in not treated as absolute and is subject to such action as may be lawfully taken for the prevention of crime or disorder or protection of health or morals or protection of rights and freedoms of others.

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\(^{81}\) Article 21 states: “No person shall be deprived of his life or personal liberty except according to procedure established by law”.

\(^{82}\) AIR 1963 SC 1295.

\(^{83}\) (1975) 2SCC 148.

\(^{84}\) AIR 1995 SC 264.

Similarly the Andhra High Court in *M Vijaya v. Chairman SCC* \(^{86}\) has held ‘In the interest of general public, it is necessary for the state to identify HIV positive cases and any action taken (in pursuance of Art. 47) cannot be termed as unconstitutional.

In both the cases which directly deal with HIV/AIDS the Courts have not stated what constitutes ‘public interest’ nor have they suggested any tests to determine it.

Regarding conflict of right to privacy of an individual and public right, the Andhra High Court quoting the Roman Law principle ‘*Salus populi est suprema*’ (regard for public welfare in the highest law) has held that public right should prevail\(^{87}\).

Regarding conflict of rights between two individuals as it occurred in *X v. Hospital Z*, the Apex Court declared, ‘where there is a clash of two Fundamental Rights, as in the instant case, namely, the appellant’s right to privacy as part of right to life and Ms ‘Y’s right to lead a healthy life which is her Fundamental Right under Article 21, the right which would advance the public morality or public interest, would alone be enforced through the process of the court’\(^{88}\). This is the most welcome part of the decision because it considers the ‘public interest, in the light of the object of ‘to protect persons who are at risk’.

\[^{86}\text{AIR 2001 Andhra 502 p. 514.}\]
\[^{87}\text{M Vijaya v. MDSCC, AIR 2001, Para 55A p. 514.}\]
\[^{88}\text{(1998) 8 SCC 296, p. 309.}\]
Thus in relation to HIV/AIDS, the right to privacy can be curtailed to achieve the twin objects of i) to encourage individual to seek treatment and ii) to protect the persons who are at risk.

6.2 Confidentiality

As said earlier, the discriminatory practices and societal prejudices against the HIV/AIDS infected call for confidentiality. The call comes from those vested with the responsibility for public health, including the World Health Organisation\(^9\), the Council of Europe\(^{10}\), and the U.S. Centers for Disease Control and Prevention\(^{11}\).

A person who investigates must establish and secure safeguards of confidentiality of the research data\(^{12}\). To respect the privacy of persons with venereal disease is to respect their wishes not to have intimate information about themselves made available to others\(^{13}\).

But the question arises, whether doctor can reveal the HIV status to the spouse or sexual partner, who are the 'persons at risk'. This is of vital significance because, studies\(^{14}\) in rural South Africa show that 57 per cent individuals would not tell their wives about having contracted

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\(^{10}\) Council of Europe, Committee of Ministers Recommendation No.R (89) 14. On Ethical Issues of HIV Infection in Health Care and Social Settings (Adopted by the Committee of Ministers on 24 Oct. 1989).

\(^{11}\) Centres for Disease Control. Recommended Additional Guidelines for HIV Antibody Counselling and Testing in the prevention of HIV infection and AIDS (30 April 1989).

\(^{12}\) Guideline 12, The International Ethical Guidelines for Biomedical Research Involving Human Subjects.


sexually transmitted disease, 66 per cent would withhold information if infected by HIV, and 71 per cent of men would not inform their casual partners about their HIV infection. The same study showed that majority women claimed a right to know if a man is infected. And there is every reason to believe that a comparable study in India would show similar results.

6.2.1 Confidentiality in Doctor-Patient Relationship

Doctor-Patient relationship is that of an implied contract. Though a doctor cannot be forced to treat any person when he accepts as patients, it is an implied contract, and he has certain responsibilities. This requires that the doctor must i) continue to treat such person ii) with reasonable care iii) with reasonable skill iv) not to undertake any procedure/treatment beyond his skill and v) must not divulge professional secrets.

Professional secrecy is one which a doctor learns after examining and investigating the patient. There is no specific statute providing for confidentiality in India. Section 126 of Evidence Act

96 See, Code of Medical Ethics, Article 10, Cochin University Law Review, 1991, p. 89.
97 Dr. Jagadish Singh, Medical Professor and Consumer Protection Act, Bharat, Jaipur, 1994, p. 23.
98 Ibid.
99 Section 126 of Indian Evidence Act: Professional communications:—No barrister, attorney, pleader or vakil shall at any time be permitted, unless with his client's express consent, to disclose any communication made to him in the course and for the purpose of his employment as such barrister, pleader, attorney or vakil, by or on behalf of his client, or to state the contents or condition of any document with which he has become acquainted in the course and for the purpose of his professional employment, or to disclose any advice given by him to his client in the course and for the purpose of such employment:
protects from disclosure, professional communication between lawyers and clients. No such provisions exist in the case of doctors. They are still governed by the ethical Codes only.

It is principle of Medical ethics that the doctor is under duty to maintain confidentiality which has its origin in Hippocratic oath (first century B.C.) In the oath administered to the Doctors they swear,

"Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of the men which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret. While I continue to keep this oath inviolate, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times, but should I trespass and violate this oath, may the reverse be my lot"\textsuperscript{100}.

Apart from the Hippocratic Oath, the International Code of Medical Ethics lays down "A Physician shall preserve absolute confidentiality on all he knows about his patient even after his patient has died"\textsuperscript{101}.

\textbf{Provided that nothing in this section shall protect from disclosure-}

(1) any such communication made in furtherance of any illegal purpose;
(2) any fact observed by any barrister, pleader, attorney or vakil, in the course of his employment as such, showing that any crime or fraud has been committed since the commencement of his employment.

It is immaterial whether the attention of such barrister, pleader, attorney or vakil was or was not directed to such fact by or on behalf of his client.

\textbf{Explanation:}— The obligation stated in this section continues after the employment has ceased.

\textsuperscript{100} Reproduced from, \textit{X v. Hospital Z}, AIR 1999, SC 495, para 7, p. 499.

Under the Common Law, the guidance issued by GMC on 8th Aug 1988 permits disclosure without consent to the third parties only 'where the doctor, judges that the failure to disclosure would put the health of any of the health care team at serious risk... or to safeguard such persons (Sexual partners) from a possibly fatal infection102.

In India, the *Indian Medical Council Act, 1956* regulates the professional conduct of medical practitioners. Section 20-A empowers the Medical Council to prescribe Code of Medical Ethics. The Council has prescribed “Do not disclose the secrets of a patient that have been learnt in the exercise of your profession. Those may be disclosed only in a court of law under orders of the presiding judge103.

In matters relating to HIV/AIDS, the emerging principle is 'A medical man is privileged to divulge the secret of the patient in the better interest of the community at large'104. As Bayer Ronald puts it 'what is crucial the underlying ethical principle of the confidentiality; while critical, is not the only ethical value. Indeed, when vulnerable unsuspecting persons are placed at risk it may be imperative to breach confidentiality'105.

This central legal principle is traced to an American decision *Torasoff v. Regents of University of California* where it was held that under certain circumstances a clinician has an affirmative duty to warn or protect unsuspecting targets of his patient's violent intentions. Several judges in

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America have held it a duty of physicians to warn family members of the presence of infectious diseases in an individual\textsuperscript{106}.

This is affirmed recently by the New South Wales Supreme Court in \textit{B.T. v Oie}\textsuperscript{107} where the court held that in the context of STDs a doctors duty of care is extended to patients sexual partners\textsuperscript{108}.

The Supreme Court of India in \textit{X v. Hospital Z}, referring to the General Medical Council of Great Britain in its guidance on HIV infection and AIDS which provide, "Occasionally the doctor may wish to disclose a diagnosis to a third party other than health care center professional. The Council thinks that the only grounds for this are when there is a serious and identifiable risk to a specific person. Who, if not so informed would be exposed to infection. A doctor may consider it a duty to ensure that any sexual partner is informed regardless of the patients own wishes"\textsuperscript{109} and held "a duty to maintain confidentiality on an account of the Code of Medical Council cannot be accepted as the proposed marriage carried with it the health risk to an identifiable person who had to be protected from being infected with the communicable disease from which the appellant suffered. The right to confidentiality, if any, vested in the appellant was not enforceable in the present situation\textsuperscript{110}.

In United States some of the States' Statutes on Health, have codified this emerging principle. Example provides confidentiality

\begin{thebibliography}{9}
\bibitem{106} Labowitz Kenneth E, \textit{supra} note 46, pp. 495-515.
\bibitem{107} 1999, NSWSC1087.
\bibitem{108} Sushma Agarwal, 'Partner Notification, New Medical Responsibilities', \textit{Lawyers}, April 2000, p. 11.
\bibitem{109} AIR 1999 SC, 495.
\bibitem{110} Ibid., para 18 p. 500.
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protection for HIV infected. The statute protects all communication that identifies any individual who has HIV infection or AIDS. It protects not only records of blood test but the fact an individual is HIV infected\textsuperscript{111}. The statute also contains a list of exceptions, including release to emergency medical personnel, the health department and sexual partners\textsuperscript{112}. It establishes a civil penalty for willful disclosure that raises from one thousand to ten thousand dollars plus reasonable court costs and attorney’s fees to be paid to the injured party.

The \textit{California Health Code 1985}, protects a person from being compelled in a legal proceeding to identify an HIV positive individual\textsuperscript{113}. The statute clearly identifies exceptions where disclosure is permitted\textsuperscript{114}.

\begin{footnotesize}
\begin{enumerate}
\item Section 325-101-(a) of \textit{Hawaii Revised Statute (1992)} reads: "The records of any person that indicate that a person has a human immunodeficiency virus (HIV) infection, AIDS related complex (ARC), or acquired immune deficiency syndrome (AIDS), which are held or maintained by any state agency, health care provider or facility, physician, laboratory, clinic, blood bank, third party pay, or any other agency, individual, or organisation in the state shall be strictly confidential. For the purposes of this part, the term 'records' shall be broadly construed to include all communication which identifies any individual who has HIV infection, ARC, or AIDS. This information shall not be released or made public upon subpoena or any other method of discovery"\textsuperscript{112}
\item Section 325-101(a) exceptions include: 1) release to the department of health; 2) release made by prior written consent; 3) release made to medical personnel in an emergency to protect the health of the named party; 4) disclosure to inform the sexual or needle sharing contact of an HIV positive patient provided identity not disclosed 5) release of data for the control and treatment of infection provided identity not disclosed; 6) release of a child’s record to the department of human services and child protective services primarily on a need to know basis; 7) release made to patient’s health care insurer to obtain reimbursement for services rendered; 8) release to another health care provider for the purpose of continued treatment and 9) release made pursuant to a court order, after an in camera review of the records, upon a showing of good cause by the party seeking the information. Id.\textsuperscript{112}
\item Section 199.21 of \textit{California Health Code 1985}, reads “No person shall be compelled in any state, county, city, or other local civil, criminal, administrative, legislative, or other proceedings to identify or provide identifying characteristics
\end{enumerate}
\end{footnotesize}
Similar provisions are found in New York Public Health Law and Pennsylvania confidentiality of HIV Related Information Act. The Act is similar to New York’s and protects almost all HIV-related information held by a health or social service worker. Coverage is broad and expected to include not only health and social service workers but also schools, legal services, hotlines and job programs. The Act also lists a number of specific exceptions similar to those found in the New York and Hawaiian statutes.\(^\text{115}\)

What can be observed from the statutes is the protection for individual HIV status cannot be overridden by compelling state interest.\(^\text{116}\) In Indian context, more particularly in relation to women, the time has now come to legislate and confer the right on intending spouses the right to information of sexual status.

### 6.3 Family Care and Support

So far there is no cure for HIV/AIDS. The bio-chemical approach, in its management is inadequate. There is already a high deficit of trained manpower and inadequate health infrastructure in the Indian public health system. The National Population Policy 2000 (NPP) estimated that Indian primary health care system is short of 23,190 sub-primary

\[\text{which would identify any individual who is the subject of a blood test to detect antibodies to the probable causative agent of AIDS.}\]

\(^{114}\) Section 199.21, 199.215, 199.24 and 199.25 provide disclosure exceptions. See 199.21(h) (cadavers); 199.215 (disclosure to health care providers); 199.24 (disclosure to subject’s legal representative, provider of health care, agent or employee of the subject’s provider of health care, and to a provider of health care who procures, processes, distributes, or uses a donated human body part); and 199.25 (notification to endangered spouse, sexual partner or person with whom subject shared needles).

\(^{115}\) Joan McNamara, *supra* note 42, p. 490.

\(^{116}\) Ibid., p. 487.
centres. 1,513 primary health centres and 2,899 community health centres. In the case of trained manpower the shortage is estimated as 27,501 auxiliary nurse midwives (ANMs), 64,860 male multipurpose workers, and 4,224 lady health visitors (LHv.), 5,126 health assistants (male), 2,475 medical officers in PHCs 1,429 surgeons, 1,446 gynecologists, 1,525 physicians, 1,774 pediatricians, and an overall shortage of 6,635 specialists.\textsuperscript{117}

The poor health infrastructure, absence of social security system, and moreover the prolonged-dying interval in HIV/AIDS, makes family responsibility crucial.

This centrality of the family in health promotion and care and support during illness is recognised in most developing societies. Traditionally, the care of the old, the infirm and the sick has been a dominant function of the family in India, with support from the wider community in the form of advice or psychological backing. Women have been the major caretakers in the family, having been socialised into this role from an early age. However, HIV/AIDS poses an extraordinary challenge for the family.\textsuperscript{118}

Family is the primary context in which illness occurs and in most traditional societies, it is also the context in which it is managed, and

\textsuperscript{117} National Population Policy, Report 2000, cited in Pallikadvath, supra note 6, p. 4176.

to some extent treated as well\textsuperscript{119}. The Indian family is essentially characterized by strong emotional ties and sentiments that bind members together and foster sharing and mutual dependence. Even when the family is nuclear in structure, it continues to maintain some links with the extended family and the wider kinship network. Although in recent times, urbanisation and modernisation influences have served to weaken familistic orientation and sentiments\textsuperscript{120}, and there is growing individuation, the family continues to be a source of strength and support for most people, especially during sickness and death\textsuperscript{121}.

Family care in HIV/AIDS is both complex and multifaceted, family care determinants involve family's structural-functional aspect, emotional content of family's relationship, family belief system, care givers dimension, family's perception of the problem, and the characteristics of the person with HIV/AIDS\textsuperscript{122}. Support may be provided in the form of financial help, material help, or sharing direct caring responsibilities. Family's economic security may act as a significant factor. Families with younger children to be educated and settled in life, in business and in marriage, may find it difficult to invest money or time in long term care required for HIV/AIDS\textsuperscript{123}.

\begin{thebibliography}{999}
\bibitem{121} Shalini Bharat, \textit{supra} note 118, p. 182.
\bibitem{122} \textit{Ibid.}, p 182.
\bibitem{123} \textit{Ibid.}, p. 185.
\end{thebibliography}
The fact that HIV is a long term disease may erode financial security of the family, which may push HIV persons to the periphery of family and providing bare essentials\textsuperscript{124}.

Family care givers perception on the disease is very different from others. First HIV/AIDS is perceived as a stigmatising disease with blame put on lifestyles that are characterised by sexual overactivity, promiscuity, uncontrolled sexual behaviour and sexual permissiveness in society. The person is attributed with such a lifestyle and blamed for bringing shame upon the family. The family, therefore, may not consider it its moral duty to extend care. In Africa the family while sheltering the HIV positive member under its roof is also shown to psychologically isolate the individual, leaving him/her alone for most part of the day and/or avoiding physical care for fear of contagion\textsuperscript{125}.

Care also depends upon the family's perception of the HIV positive person as innocent or guilty. Guilty are those who reject the rules of society, like those who have extramarital affairs, go to sex workers, homosexuals, drug users etc. They may receive less care. On the other hand innocents, like those infected during blood transfusions or babies born during pregnancy\textsuperscript{126} may receive more care and attention. That is 'innocents' may receive more care and support than the guilty.

The perception of the 'housewife' as an 'innocent victim' of her husband's sexual conduct, may however not be as simple in developing

\textsuperscript{124} Ibid., p. 186.
\textsuperscript{125} Sahlini Bahrat, supra note 118, p. 187.
\textsuperscript{126} Ibid., p. 188.
societies. For the husband’s family, the wife may be seen as a burden and
denied care and support both as a sick person and as a survivor\textsuperscript{127}. Studies
reveal, in care giving there is gender bias. When the woman shows AIDS
symptoms before her partner does, she is likely to be sent back to her
relatives or abandoned. Similar findings of wife desertion and neglect were
reported\textsuperscript{128}. Care may be more readily and generously given to young, male
adults who are also the main earning members. Women, in this respect, will
suffer by virtue of their economic and social dependence. They will carry
the double burden of care taking and being exposed to the infection through
heterosexual transmission.

Studies also reveal there is evidence to show that in the
treatment and care of sick individuals, their age, gender, earning status and
relationship to the main caretaker are powerful factors in deciding the
quantum and quality of care extended\textsuperscript{129}. An adult male who is the main
earning member is provided maximum care. The woman who is economically
and socially dependent is lowest in this hierarchy.

Women not only assume major responsibility for nurturing and
socialising the young, homemaking and ensuring the healthy development
of activities, HIV/AIDS puts women in a very precarious situation\textsuperscript{130},
making her face the double burden of caring and living in fear of contagion.

\textsuperscript{127} \textit{Ibid.}
\textsuperscript{128} Jackson, H. and D. Civic : ‘Family coping and AIDS in Zimbabwe’, Harare.
Research Unit, School of Social Work. 1994, in Shalini Bharat, \textit{supra} note 118, p. 188.
\textsuperscript{129} Ankrah, E.M. “AIDS and The Social Side of Health”. \textit{Social Science and Medicine},
32(9), pp. 967-980.
\textsuperscript{130} Shalini Bharat, \textit{supra} note 118, p 185.
Because women live in ‘connectedness’ to others her life revolves round her family members, kith and kin. If infected women are ostracised by the family, her basic right to dignity is violated. Therefore, it is important to examine the following rights.

i. Right to reside in the family home (both natal home and matrimonial home)

ii. Right to family medical maintenance

i) Right to Matrimonial and Natal home

Under the present existing laws, whatever property is in the wife’s name belongs to the wife, and whatever in the husband’s name is his property. At the time of marital breakdown, each is entitled to keep property or possessions that she or he has brought into the marital relationship or that is owned in his or her own name. This formal equality of property ownership does not produce equal results. Men who are assumed to be financial providers have greater opportunity to acquire and hold property than women.

Hindu law discriminates against the women in respect of right of residence and partition. Under Section 23 of *Hindu Succession Act 1956*, a female heir is entitled to reside only till is unmarried or if she is

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133 Section 23 of Hindu Succession Act 1956, reads as under,
-Where a Hindu intestate has left surviving him or her both male and female heirs specified in Class I of the schedule and his or her property includes a swelling house
deserted or divorced or widow. If woman leaves her husband then she is not entitled to reside in her parental family. Besides, female heir cannot demand partition till male heirs decide to divide so.

_Hindu Succession Act_ was considered a step forward in giving women equal rights, yet it discriminated in matters related to coparcenary property, the woman’s share and partition. She could be deprived by a will.\(^{134}\)

However, Supreme Court generally has interpreted the law in favour of women. _Tulasamma\(^{135}\)_ case establishes the right of Hindu woman to maintenance from the husband’s property; _Deshmukhs\(^{136}\)_ case the woman continues to be a member of joint family even after her husband’s death; _Kalavatibai\(^{137}\)_ case the absolute ownership of inherited property under Section 14 of HSA, _Sushilabai’s\(^{138}\)_ case the obligation of male heirs to keep the property well arranged and available for the female heirs to enforce the right of residence.

Women are vulnerable to HIV. Their economic power is weak compared to their counterpart males. If married women are neglected by the

wholly occupied by members of his or her family, then, notwithstanding anything contained in this Act, the right of any such female heir to claim partition of the dwelling house shall not arise until the male heirs choose to divide their respective shares therein; but the female heir shall be entitled to a right of residence therein.

-Provided that where such female heir is a daughter, she shall be entitled to a right of residence in the dwelling house only if she is unmarried or has been deserted by or has separated from her husband or his widow.

\(^{134}\) Christine et al, _supra_ note 132, in introduction.

\(^{135}\) _Tulasamma v. Seshadri_ (1977) 3 SCC 99.


members of marital house, some protection should be given to her in the natal home. What is proposed is, necessary changes in Section 23, entitling married women the right to reside.

In case of neglect in the natal home, she should have the right to partition.

Under Mohammedan Law, once a muslin bride is married, she has a ‘right’ to claim maintenance and residence in her husbands residence.  

Muslim woman do not acquire proprietary rights in her husbands property on marriage. She is entitled to fair and reasonable provision from her husband on divorce. In matters of maintenance there is discrimination in comparison to males. Husband gets double the share of wife and son, double the share of the daughter.

To eliminate such discrimination what is desired is to empower women the right to matrimonial and natal home.

ii) Right to Medical maintenance

The existing laws concerning maintenance are largely governed by personal laws. Under the Hindu Adoption and Maintenance Act 1956, under Sec. 18, a Hindu wife is entitled to the maintenance by her husband during his lifetime, she can claim maintenance if the husband has committed any matrimonial offences such as desertion, cruelty, bigamy, contacting leprosy, keeping a concubine in the same house, or conversion

139 Christine et al, supra note 132, p. 121.
140 Ibid., p. 125.
141 Ibid., p. 126.
to another religion. But she ceases to be entitled to maintenance if she is unchaste or ceases to be Hindu. In today’s age of medical advancement the offence of ‘contacting leprosy’ is illogical, leprosy is a fully curable disease. Instead the words ‘communicable disease HIV/AIDS’ may be substituted.

In relation to communicable disease like HIV/AIDS, transmitted mainly through sexual intercourse, the husband may always allege that she is unchaste; the wife may counter allege that she is infected through him only. This then becomes a matter of proof – difficult to prove and ultimately relying upon medical men. Therefore, the suggestion is an amendment be brought to Sec. 18, to delete ‘unchaste’. She should be entitled to maintenance irrespective whether she is chaste or unchaste, whether she is guilty or innocent in contacting HIV.

Under Section 20, Hindu legitimate or illegitimate minor children are entitled to be maintained so long as they are minor (unmarried daughter so long as she is unable to maintain herself out of her own earnings or property) by their mother and father. That is only unmarried daughters, unable to maintain themselves are entitled to maintenance from their parents. Problem arises in cases of married daughter infected with HIV/AIDS, unable to be maintained by husband or father in law. In such cases she would be left with no rights to maintenance. Therefore, married

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142 Law which grants a decree of divorce must secure for wife some measure of economic independence, whatever the ground for divorce, whether it is mutual consent, irretrievable breakdown of marriage or even the fault of the women herself. Reynolds v. Union of India, AIR 1982 SC 1261.
daughters too should have right to maintenance from parents in cases where
marital family members are unable to maintain.

This Section contemplates only father and mother to maintain.
There is no obligation on the other members of the family. Therefore, the
suggestion is to obligate other members of family such as brothers, sisters,
brothers in law, sisters in law etc. Only then there would be a kind of
empowerment to the infected women\textsuperscript{143}.

**Maintenance through Criminal Court (Section 125 of Cr.PC).**

Section 125 Cr.PC provides neglected wife, children and
parents a cheap and speedy remedy to claim maintenance. Persons who can
claim maintenance are (1) wife (married or divorced but not remarried);
(2) legitimate or illegitimate minor child whether married or not; (3) A
legitimate or illegitimate child (not being a married daughter) who has
attained majority, but by reason of physical or mental abnormality or injury
unable to maintain itself; (4) father or mother unable to maintain.

The object of Section 125 is to prevent vagrancy by
compelling a man to support his wife or child or parents unable to maintain
themselves\textsuperscript{144}. It is a measure of social justice specially enacted to protect

\textsuperscript{143} Destitute widowed daughters have a right of maintenance against brothers after the
death of her father when she cannot get sufficient provision from her deceased
(maintain) cannot be refused as the plea that the responsibility has been taken over
by some one else, *Thulasi Kumari v. Raghavan Nair*, AIR 85 Ker 20.

\textsuperscript{144} Chistine et al, *supra* note 132, p. 766.
women and children\textsuperscript{145}. The right conferred under this Section is a statutory right of wife\textsuperscript{146} any agreement to surrender is against the public policy\textsuperscript{147}.

The grounds for which a wife can claim maintenance under Section 125 are spelt in Section 125 (3) which are i) if the husband has contracted a marriage with another woman ii) keeps a mistress. The grounds spelt are very narrow.

\textbf{6.4 Medical Ethics and HIV/AIDS}

The Medical profession sees the HIV infected as indifferent, uncaring and with malevolence. Several centres avoid all problems concerning the treatment of such patients by turning the patient away. Doctors in India have refused to treat HIV/AIDS patients in some institutions including the All India Institute of Medical Sciences, the premier public medical institute in India\textsuperscript{148}. Patients face discrimination at every level from ward boy right upto the doctors. Surgeries (on them) are constantly postponed. Patients are left outside the hospital gate and transported by the (municipal) corporation lorry to the dumping ground. Having thrown patients out of the hospital, nurses would write that the patients are absconding, when they were not even fit to walk\textsuperscript{149}. There are cases where patient were sent to infections diseases hospital only to be discharged\textsuperscript{150}.

\textsuperscript{145} Captain Ramesh v. Veena Kaushal, AIR 1978 SC 1807.
\textsuperscript{146} Ranjit Kaur v. Pavittar Sing, 199 Cri LJ 262.
\textsuperscript{147} Sadaswan v. Vjalaxmi, (1986) 3 Crimes 508.
\textsuperscript{148} Labowitz Kenneth, supra note 46, p. 515.
\textsuperscript{149} Chinai Rupa, supra note 47, p. 9.
Where the patient is not turned away, he is made acutely conscious of the fact that he harbors an illness that is terrifying. Attendants do their best not to make any physical contact whatsoever. Sponging of the bed ridden patient is rarely carried out. When contact is inevitable, the attendant dons gloves, cap, mask and gown. We have witnessed doctors donning shielded goggles, plastic aprons and other paraphernalia such that they appear ready for a voyage in outer space.

The person handling the patient's bed pan and urinal does so almost under duress and with extreme disgust. When the patient needs suction of the larynx and trachea, these are done with the face averted to avoid infection by spray past the already formidable defenses of goggles, mask, cap and gown. Whilst no one denies the need, to take care when handling the patient's body fluids and when dealing with his person, should we rob the patient of his dignity in doing so?151

If this is the situation, question arises as to what duties and obligations do the medical profession have towards HIV infected persons.

Duties and obligations of doctors are enlisted in ordinary laws of the land and various Codes of Medical Ethics and Declarations - Indian and International, which are: i) Code of Medical Ethics of Medical Council of India; ii) Hippocratic Oath; iii) Declaration of Geneva; iv) Declaration of Helsinki; v) International Code of Medical Ethics; and vi) Government of India Guidelines for sterilisation.

On the basis of these Codes, a doctor has duty towards patient, public, law enforcers and colleagues. He has a duty not to violate professional ethics do illegal things and hide illegal facts. His duties towards patients are to take standard care, provide information to patient about treatment, gravity of conditions, expenses etc. He is bound to provide emergency care.

It is important to recall the American Medical Association Code of 1847—an assertion that is representative of prevailing international sentiment: And when pestilence prevails, it is their duty (the duty of doctors) to face the danger and to continue their labours for the alleviation of suffering, even at the jeopardy of their own lives.

The General Medical Council of great Britain is equally unambiguous: It is unethical for a registered medical practitioner to refuse treatment or investigation for which there are appropriate facilities, on the ground that the patient suffers, or may suffer, from a condition which could expose the doctor to a personal judgment that the patient’s activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind might raise a question of serious professional misconduct.

In the words of physician philosopher, Edmund Pellegrino 'To refuse to care for AIDS patients, even if the danger were greater than it is,

152 For details see, Dr. Jagadish Singh, supra note 97, pp. 16-22.
154 General Medical Council, Great Britain, in Annexure in E, Jayasurya (Ed) HIV Law, Ethics and Human Rights, UNDP Regional project on HIV and Development, New Delhi, 1995, p. 420.
is to abnegate what is essential to being a physician\textsuperscript{155}. Therefore, the medical profession should be obligated with the following:

6.5 Right to Marry, Matrimonial laws and HIV/AIDS

Marriage as an institution has had a long journey. All societies at all times with some variations and prohibitions have recognised the right to marry and found a family. International community through the Bill of Human Rights recognises it as a human right. It is recognised in Article 16\textsuperscript{156} of the Universal Declaration of Human Rights. Affirming that family is a natural and fundamental group unit of society, Civil and Political Covenant 1966, recognises right to marry in Article 23(2)\textsuperscript{157}. The Economic and Social Covenant 1966, through Article 10\textsuperscript{158} makes incumbent on the state to recognise to protect and provide assistance to family including marriage.

There is no common law governing marriage in India. Personal law based on religion or caste applies. The Hindus, Buddhists, Jains and Sikhs are governed by The Hindu Marriage Act 1955. The Parsi Marriage and Divorce Act 1936, Christians are governed by the Indian Christian Marriage Act 1872 and Indian Divorce Act 1869. The Special Marriage Act

\textsuperscript{155} Pellagrino E, 'Altruism, Selfinterest and Medical Ethics', Journal of American Medical Association, 1987, p. 1940.

\textsuperscript{156} Article 16 of Universal Declaration of Human Rights: Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family....

\textsuperscript{157} Article 13(2) of Civil and Political covenant: The right of men and women of marriageable age to marry and found and found a family shall be recognized.

\textsuperscript{158} Article 10 of The Economic and Social Covenant: The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education dependent children. Marriage must be entered into with the free consent of the intending spouses.

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1954, applies to all Indians married/divorced under this Act. Some communities like Jews and Tribes are wholly or partly governed by their customs. The Muslims are governed by Muslim law, divorce can be obtained on basis of Muslim law or Dissolution of Muslim Marriage Act 1939. In general, the areas the marriage laws regulate are i) age of marriage ii) field of mate selection iii) break up of marriage iv) remarriage v) Maintenance etc.

Right to marry is not an enumerated fundamental right under the Constitution. Nevertheless it is fundamental because it is implicit in Article 21, which guarantees life and liberty, encompassing 'a citizen has a right to safeguard the privacy of his own, his family, marriage procreation, motherhood, child bearing and education'\textsuperscript{159}.

The Apex Court in \textit{X v. Hospital Z}, also has held that having regard to the age and biological needs, a person may have right to marry but this right is not without a duty\textsuperscript{160}. This case which directly deals with HIV/AIDS infection, the Apex Court has carved an exception to the general jurisprudential notion of right. The elements of a 'Legal Right' are that the 'right' is vested in a person and is available against a person who is under a corresponding obligation and duty to respect that right and has to act or forbear from acting in a manner so as to prevent the violation of the right. If, therefore, there is a legal right vested in a person, the latter can seek its

\textsuperscript{159} Rajgopal v. State of TamilNadu, (1994) 6 SCC 632.
\textsuperscript{160} X v. Hospital Z, supra note 103, p. 503.
protection against a person who is bound by a corresponding duty not to violate that right\textsuperscript{161}.

The exception is "if a person is suffering from communicable disease" 'right to marry and duty to inform' are vested in the same person\textsuperscript{162}. The Supreme Court's obiter that right and duty vests in the same person may be morally sound, in saying that a person infected with communicable disease has a duty to inform the other partner. But legally it suffers at least for two reasons i) duties are not enforceable in the courts of law\textsuperscript{163} and ii) one cannot enforce (right or duty) against oneself. It would have been better appreciated if the Court had given each intending spouse a 'right to be informed' about the sexual status, of the other. Because in case of dreaded disease like AIDS, where women are vulnerable, what is necessary is the legal empowerment and not moral codes.

Every religion has its own 'ethics' of marriage. However, sociologically the main objects of marriage identified are "sex gratification, need for dependable social mechanism for the care and rearing of children, transmission of culture, economic needs and inheritance of property"\textsuperscript{164}. Because 'one of the objects of marriage is the procreation of equally healthy children'\textsuperscript{165}, the presumption is the couple are physically and mentally fit to fulfill the duties\textsuperscript{166}. This eugenic idea are scattered in the

\textsuperscript{161} Ibid., para 14, p. 499.
\textsuperscript{162} Ibid., para 37, p. 502.
\textsuperscript{163} P.M. Bakshi, Constitution of India, Universal, New Delhi, 1999, p. 76; See Mumbai Kamgar Subha v. Abdulbhai, AIR 1976 SC 1955.
\textsuperscript{164} Majumdar, D.N., 'The Fortunes of Primitive Tribes', Bombay, 1944, p. 78, cited in Ram Ahuja, Indian Social System, Rawat Publications, New Delhi, 1977, p. 120.
\textsuperscript{165} X v. Hospital Z, supra note 103, p. 502.
works of Plato and Aristotle. Plato in his ‘Laws says’ the judge shall consider and determine the suitableness or unsuitableness of age in marriage, he shall make an inspection of the males naked and of the women naked down to the navel\textsuperscript{167}. Certain diseases transmissible like insanity and vulnerable diseases to children were considered as ‘unpardonable crime against society\textsuperscript{168}. That is why in matrimonial law, it has been provided that if a person was found to be suffering from any including venereal disease, in a communicable form, it will be open to the other partner in marriage to seek divorce\textsuperscript{169}.

6.5.1 Veneral disease

Veneral disease means i) a disease pertaining or proceeding from sexual intercourse ii) communicated by sexual relations with an infected person\textsuperscript{170}.

Veneral disease comprises a number of contagious diseases that are most commonly acquired in sexual intercourse. Included in this group are both a destroyer of life (Syphilis) and a preventer of life\textsuperscript{171} (Gonorehea). The group includes three other diseases Chancroid, Lymphogranuloma venereum and Granuloma inguinale. These five are linked not because of similarity of causative agents, tissue reactions and a symptom produced, but because of the principal means of spread of each

\begin{footnotes}
\item[167] Ibid., p. 211.
\item[168] Ibid., p. 199.
\item[169] X v. Hospital Z, supra note 103, p 502.
\end{footnotes}
disease is by their group name, veneral, which is derived from the name of goddess of love, Venus. Not only are causative agents different morphologically but they also represent five distinct clause of micro organism, Spirochetes, cocci, bacilli, virus and the Donovan body Cabacterium. Other sexually transmitted diseases are Krichomoniases caused by a cell called trichomenas Vaginalis, non-specific urethritis, caused by germ Chlamydia\textsuperscript{172}. There is no doubt that HIV/AIDS is a veneral disease. The principal source of communication is sexual intercourse.

Matrimonial laws, where veneral disease is a ground for divorce are:

1. Section 13(1)(v) of Hindu Marriage Act, – which provides "Any marriage solemnized whether before or after the commencement of this Act, may, on a petition presented, by either the husband or the wife, be dissolved by a decree of divorce on the ground that the other party.
   i) xx xx xx
   ii) Has been suffering from venereal disease in a communicable form.

2. Section 2(viii) of the Dissolution of Muslim Marriage Act 1939, sets out that if the husband is suffering from a virulent veneral disease, a woman married under Muslim law to such person shall be entitled to obtain a decree for dissolution of her marriage.

3. Similarly for the Parsis, the *Parsi Marriage and Divorce Act 1936* provides 'Veneral diseases' as one of the grounds for divorce under Section 32. Section 27 of the *Special Marriage Act* too provides the right to obtain divorce if the other party is suffering from a veneral disease in a communicable form.

4. Under Section 27 of the *Special Marriage Act*, the party to a marriage has been given the right to obtain divorce if the other party to whom he or she was married was suffering from veneral disease in a communicable form.

5. Unfortunately this ground is not available to Christians, who are governed by *Indian Divorce Act, 1869*. The provisions regarding divorce in this Act are very limited. Under Section 10 a wife may petition for dissolution if her husband is guilty of incestuous adultery, bigamy with adultery or of rape, sodomy or bestiality. The ground of 'veneral disease' is not provided in the Act.

The Act was based on the earlier uncodified law in England. Even today in England, under *English Matrimonial Causes Act 1950*, veneral disease is not a ground for divorce, but courts have taken the view that it amounts to 'cruelty', which is a ground for divorce.\(^{173}\)

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\(^{173}\) See Forster and Forster, (1921) p. 438 (CA).
It is true, as suggested by an author, our matrimonial laws needs to be amended, to include 'AIDS' as a ground for divorce. But divorce is not the answer for HIV/AIDS, because AIDS is a death warrant with which one has to live, 'in dignity' and 'die in dignity'. We should also not forget that even the HIV infected have right to marry in a restricted sense.  

6.6 Criminal laws and AIDS

The Indian Penal Code punishes who 'knowingly' communicates the disease.

1. Section 269 of the Indian Penal Code provides as under

"Negligence act likely to spread infection of disease dangerous to life. Whoever, unlawfully or negligently does any "act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months or with fine or with both".

2. Section 270 provides as under

"Malignant act likely to spread infection of disease dangerous to life. Whoever, malignant does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease


175 Because marriage are admissible among HIV +ve, see Justice Sat Pal, 'HIV/AIDS and Human Rights', in M.L. Bansal (Ed) AIDS, ABC TO XYZ, Gulab press Chandigarh, 3rd Ed, 1988, p. 167.
dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine or with both".

The object of section 269 is to prevent people from doing acts, which are likely to spread infectious diseases. If a person suffers from dangerous diseases and, knowing of that fact, such person has physical contact with another, then an offence can be made out under section 269.

Thus, where K knowing that he was suffering from cholera, traveled by train without informing the railway officers of his condition, and M knowing K's condition, purchased his ticket and traveled with him, it was held, that K was guilty under this section, because he must have known that he was doing an act likely to spread infection, and that M was guilty of abetment of K's offence. Similarly if a person suffering from plague dies and A, who had been in contact with that patient, travels by rail, A is guilty under this section.

But a different view was taken in a Bombay case. In this case a prostitute who was suffering from syphilis encouraged and permitted a man, whom she had assured that she was healthy, to have sexual intercourse with her and thus communicated the disease to him, it was held that she was not guilty under this section as the complainant himself is an accomplice. This decision is not rational and sound as the complainant cannot be deemed to be an accomplice; he being unaware of the disease. Communication of syphilis must amount to spreading infection under this

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176 Krishnappa (1883) ILR 7 Mad 276.
177 Nindar Mal (1902) Punjab RCC No. 22 of 1902, also see Chabumain Sahib (1912) 14 Cr.L.J. 45.
178 Rakma (1886) 11 Bombay 59.
section, though it may be doubtful whether syphilis can be called a disease dangerous to life.

The Supreme Court in *X v. Hospital Z*, referring to the provisions has said, "if a person suffering from the dreadful disease AIDS, knowingly marries a woman and thereby transmits the infection to that woman, he would be guilty of offences indicated in Sections 269 and 270 of the Indian penal Code"\(^\text{179}\).

Some authors take the view that in order to check the ill-effects of indiscriminate sexual relations, the above provisions should be pressed into service\(^\text{180}\).

Yes, knowingly spreading the deadly disease is cruel and antisocial act. But the peculiarity/complexity of HIV/AIDS does not call for punishment. The New Delhi Declaration and Action Plan\(^\text{181}\), recognizes that the role of law should be to prevent coercive and punitive actions against persons with demonstrated or suspected HIV infection. Because firstly, literature on the subject reveal that there are virtually no case law reported, implying the difficulty of prosecution to prove or establish the crime. Secondly it is difficult to comprehend that persons who have acquired the virus and are suffering get the satisfaction of punishing the others. Thirdly housing them will be a problem, in a developing country like ours, where there are shortages of Health Centers to test HIV\(^\text{182}\), centers for AIDS care

\(^{179}\) *X vs. Hospital Z*, *supra* note 103, p. 503.


\(^{181}\) Adopted at International Conference, organized jointly by Ministry of Health, Indian Law Institute, UN Development Programme, WHO and other National and International Co-sponsors, held in Delhi in 2001.

\(^{182}\) Pallikkadvath, *supra* note 6, p. 4176,
are far from realization. Fourthly, it will be difficult to punish in fringe cases like, what if a woman about to deliver a baby comes to know? Is she to be punished because 'she knowingly' communicated the disease to the offspring? Fifthly, it is against the spirit of contemporary legal thinking, because many statutes relating to HIV/AIDS do not go for punishment. Sixthly, the very act of instituting a criminal proceeding, the charge of knowingly communicating the disease, indicates the accused is infected with AIDS, which in turns violates one's privacy. Lastly, such a law 'would deter potential victims from seeking medical advice, reassurance and guidance for fear of bringing themselves within possible criminal offence of 'knowingly passing the disease'.

Therefore, criminal law of punishment and the civil law of compensation are scant redress for people who acquire a deadly condition. Even if such cases can be brought before the court in time, that is before (possibly) both the victim and the culprit have died, little beneficial vindication will be secured. Punishment or money after acquisition of the condition is a small comfort to those who suffer. Therefore, the thrust should be more on preventive measures than on coercive and punitive measures.

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184 California Health Act, 1985, S 1999.21, protects persons from being identified in a legal proceedings; The role of law should be to protect the fundamental rights, including right to privacy – New Delhi Declaration Plan, 2001.
186 Ibid., p. 330.
6.7 AIDS and State Interventions

6.7.1 Isolation

Imposing quarantine (isolation) penalties against persons who 'knowingly' spread infections is quite old. 'When Columbus returned from his encounter with the New World in 1497, there was an outbreak of disease, supposed to be venereal, in the city of Edinburgh, Scotland. The king of Scotland issued a proclamation, which commanded the infected to be transported to the Island of Frith\(^\text{188}\). Since then whenever epidemics have broken, be it plague, smallpox, mass hysteria etc. laws have been passed to make quarantine arrangements\(^\text{189}\).

The first legislation on AIDS was enacted in Sweden in March 1983, which required reporting of suspected and confirmed cases of AIDS\(^\text{190}\).

The only state in India to have a specific law on HIV is the Goa Daman and Diu Public Health Act, 1988. Section 53(1)(vii) authorizes the Government to isolate and keep persons who are found to be HIV positive for AIDS by serological tests in separate institutions or wards for such period as may be considered necessary.

On the same lines as the Goa Public Health Act 1988, the Government of India sought to introduce the AIDS Bill in 1989. The Bill was not passed. Section 5(c) of the Bill, empowers the designated authority "to remove himself forthwith to a hospital or other place for special care.


\(^{189}\) See M.D. Kirby, supra note 185, pp. 325-327.

\(^{190}\) Gurmeet Hons, supra note 188, p.100.
and medical treatment where the authority considers it necessary so to do in the interests of such person and also to prevent the spread of HIV infection”191.

Isolation is "unfair, unjust and unreasonable both in substance and procedure and violative of Article 14 (right to equality). Article 19(1)(d) right to move freely throughout the territory of India and Article 21 (deprivation of personal liberty)"192. It is against medical truth, because HIV/AIDS is not easily communicable.

Similarly Clause (viii) of the said that an HIV patient shall be provided with materials and equipment etc. which will not be used by any other person; and Clause (x) linen mattresses etc used by diseased AIDS patients shall be immediately destroyed" are against established medical truths.

Yet the Division Bench of Bombay High Court in Lucy v. State of Goa193 has held that the provision do not violate Article 14, 19 and 21. Regarding isolation the Court observed.

"Isolation undoubtedly, has several serious consequences. It is an invasion upon the liberty of a person. It can affect a person very adversely in many matters including economic. It can also lead to social ostracization. But in matters like this, individual right has to be balanced in the public interest. In fact liberty of an individual and public health are not opposed to each other but are well in accord.

191 Section 5(c), the Acquired Immuno Deficiency Syndrome (AIDS) Prevention Bill 1989, Bill No. xx of 1989.
Even if there is a conflict between the right of an individual and public interest, the former must yield to the latter. That apart, isolation is not merely in the interest of the society. In a given case, it may be also be in the interest of an AIDS patient, because he may become desperate and lose all hopes of survival and therefore, has to be saved against himself. Perhaps bearing in mind all these factors, the experts have considered isolation as one of the preventive measures.

The Courts’ wordings ‘to be saved against himself’ suggests that the HIV infected have to be saved from killing himself, or at the most it suggests that the patient should be treated. It does not spell what public interest is. This is against the sprit of public interest in relation to HIV/AIDS infected, because the only public interest in HIV/AIDS is the treatment and prevention of spreading to others who are at risk as discussed earlier.

6.7.2 Compulsory Detention

In United Kingdom, Public Health (Control of Diseases) Act 1984, allows orders to be made for patients believed to have AIDS to be removed to hospital and detained. Restrictions can be placed on the handling and removal of the body of AIDS patient.194 As explained in the Act itself it was intended to use in exceptional circumstances.

In P.N. Swamy v. SHO Hyderabad195 question arose whether sex workers infected with HIV/AIDS can be detained in rescue home; and

194 M.D. Kirby, supra note 185, p. 327.
whether such action amounts to violations of Article 21 of the Constitution. The Division Bench of Andhra High Court after referring the judgment of Supreme Court in *Kausalya* 196 and Division Bench of Bombay High Court in *Lucy* 197 held that such action does not violate Article 14 and 21 of the Constitution. The Division Bench directed those sex workers who are found to HIV +ve be sent to welfare homes for a period of two years during which they may be provided adequate medical facilities and train them in vocational courses.

The critique is 'the specter of being imprisoned hospital (or otherwise) may dissuade many people from being treated for the illness', which ultimately is the public interest. Moreover detention would be ineffective, because the number of persons at risk is very high. There being no cure, housing them would be a major problem.

6.7.3 Reporting

In countries such as Denmark, Iceland, Norway, Sweden, Hungary, Canadian provinces of Columbia, Ontario and Saskatchewan have legislations which require medical practitioners to notify to health authorities.

In India the AIDS prevention Bill 1989, (not passed) had similar provision. Under Section 4, every Medical Practitioner who in his course becomes cognizant of existence of HIV infection in person, he is to

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198 M.D. Kirby, supra note 185, p. 327.
199 Ibid., p. 328.
report it to the designated health authority in the manner and form prescribed\(^{200}\).

The critique is compulsory reporting 'would have a chilling effect' on voluntary submission to tests and it would deter potential victims from seeking medical advice reassurance and guidance for fear of bringing themselves within possible criminal offence of knowingly passing on the disease\(^{201}\).

Leakage of information results in loss of privacy and identification which would result in discrimination, therefore, there should be no legal provision in any legislation (even proposed) which provides for reporting.

6.8 **The Vectors of HIV – sex workers**

6.8.1 **Introduction**

Prostitution or the practice of indulging in promiscuous sexual relations for money or other favors is an age old institution in India. Kautilyas 'Arthashastra' written in 300 BC, has a chapter on 'Ganikas' (female sex workers) which discuss the norms, behaviour prerogatives and responsibilities of FSWs\(^{202}\).

Studies do not reveal their exact number. Some of the estimates are, Bombay (1,00,000), Calcutta (1,00,000), Delhi (40,000), Pune (40,000)\(^{203}\). The Bharatiya Patita Uddhar Sabha (BPUS) a voluntary

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\(^{201}\) M.D. Kirby, *supra* note 185, p. 328.


\(^{203}\) Moni Nag, *supra* note 24, p. 519.
agency dedicated to welfare of FSW’s estimates, there are 8.7 million FSW’s living in 87,000 kothas (brothels) in addition to 7.5 million call girls in India\(^{204}\). But sex workers are not confined to cities alone. Sex workers are found in most villages\(^{205}\). HIV prevalence among sex workers is very high. Though there is no exact figure for the country as a whole, in Bombay alone for the year 1992 – the prevalence was 41.2 per cent\(^{206}\). Each FSW caters to 5 clients per day and approximately works for 300 day a year, which means there are 150 million sexual encounters per year with FSW. With 85% seropositivity amongst these FSW and estimated efficacy of transmission of 0.01-0.1 per sexual encounter each year 15,000-30,000 of the clients get infected in Mumbai alone\(^{207}\). Next it is passed from the CSWs to the ‘non high risk’ ‘occasional visitor’ to them. So the men with high risk behaviour should occasionally get infected. They in turn infect their wives who in turn passed on the infection to their babies\(^{208}\).

Young sex workers are more in demand than their older colleagues and are forced to entertain more clients. A study reveals that 15-18 year olds serve an average of 2-8 clients a day\(^{209}\). These young sex workers are more prone to HIV. The International Labour Organisation (ILO) points out that children have a higher risk of contracting HIV from sexual activity than do adults. Immature reproductive tracts, hormonal

\(^{204}\) Telegraph, Jan. 5, February 1, 1992, New Delhi (edn).
\(^{205}\) Pelto PJ, *supra* note 34, pp. 105-106.
\(^{206}\) Pallikadavath, *supra* note 6, p. 4176.
\(^{207}\) *Ibid.*
fluctuations, permeability of key tissue walls increase risk of transmission. Once exposed, they have limited protection against the disease, as their immune systems are not developed 210.

A study conducted 211 on sexual practices by sex workers reveal that 89% of the sex workers were involved in peno-vaginal sex. The other marginally low 0.4 practiced anal and 10.6 oral sex. Only 32 per cent of the peno-vaginal sexual practices were found to be protected by a condom. The most common reason for non use of condom is lack of satisfaction.

Since the risk of transmission of all STDs including AIDS is very high in peno-vaginal sex, any prevention measure should address both the sex worker and the client.

6.8.2 International endeavours

The International community recognized very early to address the cause of sex workers. In 1902 Congress on International Traffic in Women and Children was held in Paris. In 1904, International Agreement for suppression of White Slave Traffic was adopted. In 1921 International Convention for the suppression of the Traffic in Women and Children was held in Geneva. In 1933, International Convention for the Traffic in Women of full age was held in Geneva.

In 1949, The UN General Assembly adopted the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others. The preamble to Convention says that “Prostitution


and the accompanying evil of the traffic in persons for the purpose of prostitution are incompatible with the dignity and worth of the human person and endanger the welfare of the individual, the family and community".

Under the Convention, the acts of procuring, enticing or leading away another for the purpose of prostitution are punishable offences\textsuperscript{212}. Persons who keep and manage brothels are also punished\textsuperscript{213}. The state parties agree to take measures to prevent rehabilitate and socially adjust the victims\textsuperscript{214}. The parties undertake to protect immigrants\textsuperscript{215}. Parties also undertake to take care and maintenance of victims of International traffic\textsuperscript{216}.

The Convention is purely preventive in nature. It does not address the reproductive needs of sex workers.

**6.8.3 Prohibitory Legislations in India**

Prohibitory legislations in India date back to 1668, where the East India issued regulations against prostitution. The **Indian Act of 1884** (the Foreigners Act) gave authority to the Government of India to pass externment order on pimps and prostitutes. The **Indian Penal Code 1860** Sections 372 and 373 prevents the influx of women into prostitution under certain age and against their wish. **The Contagious Diseases Act 1869** repealed in 1888, enabled the provinces to enforce registration and
compulsory medical examination of 'common prostitutes' and their detention until cured\textsuperscript{217}.


Prostitution \textit{per se} is not a criminal act, as indicated by the definition of brothel. The definition of 'brothel' includes any house, room or lace which is used for purposes of sexual exploitation or abuse for the gain of another person or the natural gain of two or more prostitutes\textsuperscript{218}. This implies, where single person practices prostitution for his or her own livelihood, without another prostitute or some other person being involved in the maintenance of such premises, his or her residence will not amount to brothel\textsuperscript{219}.

Prostitution in itself is not an offense under the Act\textsuperscript{220}. Prostitution according to the amended Act (ITA) means 'the sexual exploitation or abuse of persons (male or female) for commercial purposes'. This clearly implies that those who have to be punished under the Act are those who exploit persons through prostitution\textsuperscript{221}.

The Act punishes persons who keeps or manages a brothel\textsuperscript{222}, lives on the earnings of prostitution\textsuperscript{223}, procures induces or takes person for

\begin{footnotesize}
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\item \textsuperscript{217} Geetanjali Gangoli, \textit{supra note 210}, p. 83.
\item \textsuperscript{218} Section 2(a) ITA 1988.
\item \textsuperscript{219} Christine et al, \textit{supra note 132}, p. 754; see \textit{Rama Desai v. State and others}, 1963, \textit{ALL LJ} 894, para 15.
\item \textsuperscript{220} \textit{State of Maharastra v. Premchand}, AIR 1964 Bom 155.
\item \textsuperscript{221} Christine et al, \textit{supra note 132}, p. 754.
\item \textsuperscript{222} Section 3 ITA.
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sake of prostitution, detains a person in premises where prostitution is carried on.

The Act punishes sex workers who carry on prostitution in notified areas and who seduces or solicits public member for purposes of prostitution.

The Act empowers the magistrate for removal of sex workers from a brothel, closure of room or house where prostitution is carried and removal of prostitutes from any place in the interest of general public.

Thus the thrust of the Act is preventive in measure. It aims to control trafficking for 'prostitution' and to protect 'public' order by setting forth the conditions under which women can practice sex trade. It does not focus on the reproductive needs of the sex workers.

The Act was intended to deal with traffickers. However, women in prostitution are provided no safeguards or rights to encourage them to testify against their pimps or traffickers. As a result Section 7 and 8 are the most used provisions. It creates undue hardship for women engaged

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223 Section 4.
224 Section 5.
225 Section 6.
226 Section 7.
227 Section 8.
228 Section 16.
229 Section 18.
230 Section 20.
231 Geetangali, supra note 210, p. 84.
in prostitution exposing them to police harassment as well as exploitation by pimps and customers.  

6.8.4 Attempts to Legalise Prostitution

In 1988, in Maharastra, a Bill called 'A Bill to provide for the Regulation and Control of activities of prostitution and brothels with a view to prevent the growth of the disease known as Acquired Immunity Deficiency Syndrome (AIDS)' was introduced. The statement of objects said "the object in bringing this legislation is to prevent and control the growth of the Acquired Immuno Deficiency Syndrome (AIDS) disease. The medical experts have opined that the main cause of this disease is common prostitution. About 90% of the prostitutes are suffering from venereal diseases. It is also reported that about 1 lakh common prostitutes are found in Bombay and they are the major cause of worry for medical authorities. In view of imminent danger of the spread of AIDS, it has become very important and necessary to have such legislation. Hence this Bill".

To achieve the objectives it provided for i) compulsory registration and ii) display of list of prostitutes in the brothel iii) minimum age clause of 21 years and iv) compulsory medical examination of registered sex workers every three months.

The Bill defines prostitution as 'prostitution' as "means and includes the profession carried out by a woman to have a sexual intercourse with a man with or without consideration with the knowledge that such person is not her husband".

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232 Christine et al, supra note 132, p. 761.
The definition is so wide that it can include any sexual activity outside marital sex. Implicit in the definition is the notion that non-marital sexual activity is tantamount to 'prostitution', promiscuity and immorality.

In 1994 another Bill called 'Maharastra Protection of Commercial Sex Workers Act, was introduced. The purpose of bill as stated in the Preamble was “ and whereas various venereal diseases, sexually transmitted diseases including AIDS involving such persons and their customers are spreading the said and other diseases in geometric progression, engendering public health at large”. “And whereas urgent measures are called for to check the spread of the disease and to protect the health of the commercial sex workers and their customers and innocent persons having sexual relations with such customers”.

The Bill proposed to set up a Board, and it was to be i) responsible for welfare schemes for the benefit of sex workers ii) consenting authority in civil and criminal cases filed against sex worker iii) registering authority for sex workers. Failure to register with the Board is liable to imprisonment upto 7 years iv) to ensure periodical compulsory medical tests for STDs v) to quarantine sex workers infected with STD, till cured (Section 17).

The most violative of human rights is the proviso, is “All the persons suffering from Sexually Transmitted Disease shall be liable to be branded with indelible ink on their persons to indicate the presence of Sexually Transmitted Disease and the Board shall have authority to decide

234 Geetanjali Gangoli, supra note 210, p. 86.
from time to time, the manner of markings, subject to the instructions of the Government in this regard236.

Compulsory registration of sex workers stigmatizes rather than protecting them. It is impractical too, because, prostitutes who are infected will join the unofficial prostitute237. Quarantine laws to be effective; there should be coincidence of need and capacity238. There being no cure for HIV/AIDS, the number being enormous, the possibility of isolating and housing them is not possible. Compulsory medical tests often have led to illegal and unethical experiments. Example it is alleged that unapproved drug Bovine Immunodeficiency Virus Vaccine was tested on Bombay female sex workers239.

The official policy also recognizes this and aims at banning unethical, illegal and uninformed medical testing of women and child victims for HIV/AIDS/STDs240.

The net result of targeting women in red light areas, is that it "increases public and police violence upon them, decreases their ability to assert themselves; allows customers to demand and force unsafe sex upon

236 Section 4(i).
238 M.D. Kriby, supra note 185, p. 377.
them; and increases the rate of HIV infection among women .. customers and the family of the customers.\textsuperscript{241}

Inspite of prevention laws, official policies on elimination of commercial sexual exploitation, sex trade "continues to exist and would continue to exist in whatever magnitude or form", therefore legal address to sex workers should be according to their needs.

### 6.8.5 Reproductive Health Needs of Sex workers

The International Conference on Population and Health defines reproductive health as follows: "Reproductive health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, in all manners relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how to do so."\textsuperscript{242}

This approach has been criticized because i) it has grown from the population control perspective and ii) it is based on experiences of women and men within families and marriages. As such it does not meet the health needs of sex workers.\textsuperscript{243}

The population control perspective can be gathered from five year plans. The first few focused in male sterilisation in combination with

\textsuperscript{241} The National Commission for Women Report, \textit{quoted} in Geetanjali \textit{supra} note 210, p. 86.
\textsuperscript{243} Geetanjali Gangoli, \textit{supra} note 210. p. 80.
contraceptives for women. From late seventies there was a shift in focus almost exclusively to female contraceptives.\textsuperscript{244}

Most contraceptive methods propagated by State Population Council were the use of hormonal, long acting contraceptives on sex workers.\textsuperscript{245} This is objected by health activists of sex workers, because hormonal contraceptives do not suit the need of sex workers, and also have other ill effects such as menstrual chaos, bleeding etc. what 'they need is a form of birth control that they can control, and does not cause major chaos to their health. But they desperately need protection from STDs.\textsuperscript{246}

That is the need of a sex worker is a contraceptive that prevents STD. The best available method would be the 'condoms' or 'rubber sheath'. The second need of sex workers is their health.\textsuperscript{247} Studies brought out to show that women spend a significant portion of their income for their health concerns.\textsuperscript{248} Studies also reveal that women in sex trade have greater financial autonomy in all matters than married women and spend more money and attention on their health than latter.\textsuperscript{249}

Women in the sex trade have access to a variety of medical care, including public hospitals, private doctors, clinics run by NGOs, ayurvedic

\textsuperscript{244} Ibid., p. 82.
\textsuperscript{245} Geetanjali Gangoli, supra note 210, p. 82.
\textsuperscript{246} Ibid.
\textsuperscript{247} Ibid., p. 91.
\textsuperscript{248} National Commission for Women, Societal Violence on Women and Children in Prostitution. A Report by the National Commission for Women, Govt. of India, New Delhi, 1995-96.
\textsuperscript{249} Findings of Cartin Evans and Helen Lambert, 'An Ethnographic Study of Sexual Health and Related Health Seeking Behaviour Among Commercial Sex Workers and Poor Women in Northern Calcutta Slum' quoted in Geetanjali Gangoli, supra note 210, p. 91.
doctors and quacks. The use depends on their ailment and financial position\textsuperscript{250}. The related issue is how the medical personnel perceive women in sex trade.

Sex workers see the medical profession as indifferent, uncaring and sometimes malevolent. Sex workers point out that doctors use sex workers as bodies to experiment with and their lives are seen as unimportant. This view is expressed in the context of contraceptive methods and drug trials for HIV and AIDS\textsuperscript{251}.

Most medical practitioners, however, do not see linkages between poverty, gender differentials and infection, but engage in a policy of 'blame'. Sex workers have pointed out that in public hospitals, doctors and staff treats them badly once they realize that they work as prostitutes. Doctors have refused to treat women because of fear that they might be carrying the virus. Women from red light areas have been subjected to compulsory testing for HIV\textsuperscript{252}.

More often than not, the clinicians ask embarrassing question as to how much the woman charges per client, how many clients she has had for the day, does she enjoy sex herself. Family histories and names of husbands are often required prior to obtaining 'case papers'\textsuperscript{253}.

\textsuperscript{250} Geetanjali Gangoli, \textit{supra} note 210, p. 91.
\textsuperscript{251} \textit{Ibid.}, p. 95.
\textsuperscript{253} National Commission for Women, \textit{supra} note 248.
A workshop on ethical concerns in AIDS problem organized by FIAMC, Bio-Medical Ethics Centre, in 1991, addressed to the obligations of health professionals, patients and society in the face of HIV/AIDS. A study of it reveals that a strict enforcement of medical ethics is required.254

In order to prevent spread of HIV/AIDS from the group ‘sex workers’, there should be control over sexual relations in commercial settings, by way of meeting the two important needs of them. The first need can be met by popularising and promoting safe sex method by use of condoms. This is a difficult task “because the fear of losing her clients to other sex workers and not in a position to try to negotiate safer sex as they may be controlled by madams and pimps”.255 Yet by empowering them with the right to refuse sex without condom, and they stand united together for this cause, they will be in a position to exercise more control over their clients and the object may be achieved.

The second need namely the discriminatory practices by medical personnel and denial of medical treatment is met by i) right to access to information on HIV, ii) right to access to medical treatment iii) the right to receive treatment free from discrimination and iv) the right to confidentiality.

6.9 Condom – An Empowerment to Women?

Condoms were originally devised and used everywhere primarily as a preventive for sexually transmitted diseases mostly in sexual

254 Gurmeet Hans, supra note 188, p. 108.
relations of men with female sex workers\textsuperscript{256}. At present, it is primarily used as contraceptive. The Govt. of India through its Family Planning measures popularized it to the extent that it runs the largest programme in the world for distribution of condoms. The number distributed annually is 1020 million\textsuperscript{257} (1989-90). The other major sources of condoms are Indian private sector. Yet as compared to other nations, it is very low. The proportion of reproductive age couples using condoms in India is 5\% (In 88-89), compared to Japan (45\% in 1986) and Hong Kong (26\% in 1986)\textsuperscript{258}.

Prevalence of condom use:

The all India average of condom users is 12 per cent among all contraceptive users\textsuperscript{259}.

In the role of condom use, women are in a subordinate position. Modesty in Indian tradition does not expect women to take active role in sexual relationship\textsuperscript{260}. In case of FSWs severe competition and economic pressure leaves them no option to enforce or ensure condom use against their clients' reluctance\textsuperscript{261}. Despite high prevalence of STD among FSWs the usage is very low.

\textsuperscript{258} Moni Nag, \textit{supra} note 24, p. 532.
The main constraints on use of condoms in India are 1) poor quality 2) low effectiveness 3) inadequate knowledge about its advantages 4) cultural sensitivity and 5) difficulties of storage and disposal. The common complaint against condoms is it reduces the pleasure of sexual intercourse. The poor quality is associated with thickness and non lubrication. Recent studies reveal they often tear off during use making it low in its effectiveness. Inadequate knowledge associated with condoms like using same condom more than once, damaging it with finger nails, withdrawing it only after the penis flaccid and holding its rim, lubricating it with cream etc lessens its advantage. Cultural sensitivity regarding condoms is higher than other methods because it is directly related to sexual act. Open display and open discussion is still avoided. Getting them is still an embarrassment.

For common citizen the role of condom is principal means for protection against STD. Therefore, the Government should over come the above constraints by i) producing better quality condoms ii) better education regarding proper use, storage and disposal, iii) cultural sensitivity to be removed by messages propagated with empathy, humour and respect for human dignity iv) Vending machines to be installed at public utility services points such as Bus stations, Railway stations, Telephone Booths make mandatory laws for commercial establishments

262 Moni Nag, supra note 24, p. 532.
263 Ibid.
264 Telegraph, 1992, January 5, New Delhi (edn.).
266 Moni Nag, supra note 24, p.583.
such as Hotels, Telephone booths, to compulsory install such vending machines v) school text books to have few pages devoted on sex-education.

Because women are vulnerable to HIV/AIDS, safe sex method should be a tool of empowerment. A condom can be a tool of such empowerment. Women should have the right to refuse sex without condom, both in marital and non-marital relationship.

In marital relationship between husband and wife, if the wife has reason to believe promiscuously, she should have right to refuse sex without condom. If a wife is forced to have sex, it should amount to 'marital rape'. In non-marital relationship, refusal to wear a condom should be treated as sexual assault, with remedy under the law of torts.

In commercial settings (prostitution) sex workers should have the right to refuse sex without condom. Sex workers should have remedies under tortuous liability.

Medically it is not yet proved that female condoms can be effectively used to control HIV and STD infections. It is recommended for use when the male partner is not willing to use the condom. The important advantage of female condom is that it is in the control of women. It is of particular importance in commercial settings – in particular for sex workers.

6.10 HIV/AIDS Infected and Employment

In United States many law suits against employers have come before the Courts. Some of the causes involved are, refusing to hire an

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267 Palakadvath, supra note 6, p. 4180.
applicant who announced in job interview that he was HIV positive; insisting applicant to test for HIV: communicating medical report to fellow employees, termination of employment on learning that he is HIV; etc.268

In *School Board of Nassau County Florida v. Airline*269 it was held that person with infectious diseases are 'otherwise qualified' for employment, if they do not pose a 'significant risk' of communicating the disease. The Court emphasized that law should be carefully structured to replace "reflexive" reactions to actually perceived handicaps. Most of the Courts in USA have held the view that HIV diagnosis does not provide a sufficient basis for unfair treatment by employers270.

The same view is taken by Bombay High Court in *MX v. ZY*271 and has held that employment cannot be denied merely on the ground of HIV status. The Court observed "—The Rule providing that person must be medically fit before he is, employed or to be continued while in employment is, obviously, with the object of ensuring that the person is capable of or continues to be capable of performing his normal job requirements and that he does not pose a threat or health hazard to the persons or property at the workplace. The persons who are rendered incapable, due to the ailment, to perform their normal job functions or who pose a risk to the others persons at the workplace, say like due to having...

infected with some contagious diseases which can be transmitted through the normal activities at the workplace, can be reasonably and justifiably denied employment or discontinued from the employment inasmuch as such classification has an intelligible differentia which has clear nexus with the object to be achieved, viz., to ensure the capacity of such persons to perform normal job functions as also to safeguard the interests of others persons at the workplace. But the person who, though has some ailment, does not cease to be capable of performing the normal job functions and who does not pose any threat at workplace during his normal activities cannot be included in the aforesaid class. Such inclusion in the said class merely on the ground of having an ailment is, obviously, arbitrary and unreasonable. The impugned rule which denies employment to the HIV infected person merely on the ground of his HIV status irrespective of his ability to perform the job requirements and irrespective of the fact that he does not pose any threat to others at the workplace is clearly arbitrary and unreasonable and infringes the wholesome requirement of Article 14 as well as Article 21 of the Constitution of India.

Thus, in conclusion it may be said that women are vulnerable to HIV/AIDS due to various reasons including physiological. 'Privacy' and 'Confidentiality' are necessary for the infected to fight against the prejudices and discrimination of the society.

AIDS is a non curable disease. To live a quality of life and die in dignity family care and support is essential. The existing women's 'right to matrimonial home' and 'right to maintenance' are insufficient, discriminative and ineffective.

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The only object of the State in relation to HIV/AIDS is to encourage individuals to seek treatment and protect persons at risk. State's intervention measures such as isolation, detention and reporting are detrimental to the infected and injure their dignity.

Criminalisation under Sec. 269 and 270 of IPC 'knowingly passing the disease' do not solve the problem. So is the legalisation of sex trade. The spread of disease can be controlled by meeting the 'health' and 'social security' needs of sex workers.