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RIGHTS OF PERSONS AFFECTED BY HIV/AIDS: A HUMAN RIGHTS CONCERN

Under the Guidance and Supervision of

Mrs. Namitha K L

The National University of Advanced Legal Studies, Kochi

Submitted By:

Poornima S Nair

Register No: LM0119010
LLM (CONSTITUTIONAL AND ADMINISTRATIVE LAW)

CERTIFICATE

This is to certify that **Ms. POORNIMA S NAIR, REG NO: LM0119010** has submitted her Dissertation titled "**RIGHTS OF PERSONS AFFECTED BY HIV/AIDS: A HUMAN RIGHTS CONCERN**" in partial fulfilment of the requirement for the award of Degree of Masters of Laws in Constitutional Law and Administrative Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by him is original, bonafide and genuine.

Mrs. Namitha K L

Guide and Supervisor

NUALS, Kochi

Date: 12-10-2020

Place: Ernakulam

DECLARATION

I declare that this Dissertation titled **"Rights of Persons Affected by HIV/AIDS: A Human Rights Concern"** is researched and submitted by me to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirement for the award of Degree of Master of Laws in Constitutional Law and Administrative Law, under the guidance and supervision of Mrs. Namitha K L, Assistant Professor and is an original, bona fide and legitimate work and it has been pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

POORNIMA S NAIR

REG NO: LM0119010

LL.M, Constitutional Law and Administrative Law

NUALS, KOCHI

Date: 12-10-2020

Place: Ernakulam

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POORNIMA S NAIR

REG NO:LM0119010

PREFACE

The world is now going through an unexpected coronavirus (COVID-19) pandemic. As a result of this outbreak, people who are affected with the virus are facing stigma and discrimination. Since the beginning of this pandemic, several forms of discrimination have been reported including attacks on health workers and isolation of people who are already facing stigma and discrimination like the people living with HIV (PLHIV).With the rapid spread of COVID-19 there are concerns whether PLHIVs would be subjected to more discrimination, particularly in the field of healthcare services. Despite the surge in the HIV treatment in recent years, it is shocking that 15 million people living with HIV do not have access to antiretroviral therapy (ART).The lifesaving drugs, antiretroviral therapies and the testing services must be continued to be ensured. Thus, it is more important in these times of global pandemic that we recognise and fight for the rights of persons who are already ostracized for being HIV-positive. A detailed analysis of the rights of persons who are affected by HIV/AIDS is done in this research which is all the more important to prevent discrimination. There can be no valid or effective response to HIV/AIDS without respect for the human rights, fundamental freedom and the dignity of human beings and this research aims to understand the various forms of human rights violation s and gives awareness about the importance of protecting them. The PLHIVs are entitled to all human rights equally on par with other citizens. They also have the right to employment, right to privacy, right to health, right to education, right to marriage, freedom from inhuman and degrading treatment, right to self-determination, right to liberty etc. There must be reforms addressing the human rights violations. Since there is no cure for AIDS, the only best alternative is prevention of the same. Therefore, it is important that we must lay emphasis on preventive measures. The National AIDS Control Programme Phase IV (NACP-IV) had been developed for the period of 2012-2017 with an objective of 'AIDS Free India'. Similarly, UNAIDS '90-90-90' target to be achieved by 2020 is all in place. But how far is the already existing legal frameworks and mechanisms are effective is an important question to be answered for the protection of their rights. The only legislation available for the protection of human rights and prevention of discrimination of PLHIV in India is the HIV AND AIDS (Prevention and Control) Act, 2017, but it is not properly implemented in India. The researcher finally puts many recommendations in order to prevent discrimination and to eradicate HIV/AIDS

ABBREVIATIONS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
NACO	National AIDS Control Organization
UNAIDS	United Nations Program on HIV/AIDS
CSWs	Commercial Sex Workers
IDU	Injecting Drug Use
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
PLWHA	People Living with HIV/AIDS
ICCPR	The International Covenant on Civil and Rights
ICESR	The International Covenant on Economic, Social Cultural Rights
OHCHR	Office of the High Commissioner for Human Rights
TRIPS	Trade-Related Aspects of Intellectual Property Rights
NGOs	Non-governmental organization
UN	The United Nations
WHO	World Health Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
ILO	International Labor Organization
ECHR	European Convention on Human Rights
OAU	Organization of African Unity
AU	African Union
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund

UNDCP	United Nations International Drug Control Program
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
NACP	National AIDS Control Program
NRHM	National Rural Health Mission
ICTC	Integrated Counselling and Testing Centre
ART	Antiretroviral Therapy
UTT	Universal Test and Treat
MC	Male Circumcision
RTI	Right to Information
RCT	Randomized controlled Trial
MSM	Men who have Sex with Men
KSACS	Kerala State AIDS Control Society
TI	Targeted Intervention
STI	Sexually Transmitted Infection
PIL	Public Interest Litigation
AAP	Annual Action Plan
HRGs	High Risk Groups
FSWs	Female Sex Workers
NBTC	National Blood Transfusion Council
AIR	All India Reporter
SC	Supreme Court
HC	High Court
Bom	Bombay
v.	Versus
Pg.	Page
ed.	Edition
Vol.	Volume
SCR	Supreme Court Reporter

SCC	Supreme Court Cases
ILR	Indian Law Reporter
i.e.,	That is
Ors.	Others
Anr.	Another
TB	Tuberculosis
STDs	Sexually Transmitted Diseases
UOI	Union of India
OIs	Opportunistic Infections
PCP	Pneumocystis Pneumonia
WLR	Weekly Law Reports
USA	United States of America
WP	Writ Petition
Supp	Supplementary

LIST OF CASES

INDIAN CASES

Common Cause v. UOI & Ors., 1996(1) SCC 763

Consumer Education Research Centre v. Union of India, AIR 1995 SC 922

Distt. Registrar & Collector v. Canara Bank, 2005 (1) SCC 496

Ex Const. B.S. v. Union of India and Anr., (Unreported – Delhi High Court, CWP NO. 368 of 2000)

G v. New India Assurance Co. Ltd, (1999)3 SCC 754

G. v. NIA Ltd., Writ Petition No. 1562/99 (Unreported- Bombay High Court)

Justice KS Puttaswamy (Retd.) v UOI, Writ Petition (Civil) No. 494 of 2012

Kharak Singh v. State of UP, AIR 1963 SC 1259

Lucy D'Sousa v. State of Goa, AIR 1990 Bom355

LX v. Union of India, CWP – 7330/2004, Delhi HC

Maharashtra State Board of Secondary and Higher Secondary Education v. K.S.Gandh, 1991(2) SCC 716

Mr. X, Indian inhabitant v. Chairman, State Level Police Recruitment Board and Ors., 2006(8)SLR588

Mr. X v. Hospital Z, AIR 1999 SC 495

MX v. ZY, AIR 1997 Bom 406

Navtej Singh Johar and ors. v. Union of India, W.P.(Crl.)No.76 of 2016

Naz Foundation v. Govt. of NCT of Delhi, 160 Delhi Law Times 277

Paschal Banga Kheta Mazdoor Samity v. State of West Bengal, AIR 1996 SC 2426

Pradeep Kumar Biswas v. Indian Institute of Chemical Biology (2002) 5 SCC 111

Pt. Paramanand Katara v. UOI and Ors., (1989) SCC 286

R. Rajagopal v. State of Tamil Nadu, 1994(6) SCC 632

R.M. v. S Pvt. Ltd., (Unreported - (ULP) No.864/99)

Royappa v. State of Tamil Nadu, AIR 1974 SC 555

Satish Chandra v. Union of India, AIR 1953 SC 250

St. Stephen's College v. University of Delhi, (1992) 1 SCC 558

Suresh Kumar Koushal v. Naz Foundation, Civil Appeal No.10972 of 2013

FOREIGN CASES

Bragdon v. Abbott, 118 S. Ct. 2196
Brown v. Board of Education,347U.S.483,494(1954)
Buckingham v. United States of America and Ors., 98 F 2d 735
C. S. Jones v. Post, 0157a: (2001) EWCA Civ 558
Centre d ’accueil Sainte-Domitille v. Union des employés dc service, local 298 (F.T.Q.) [1989] TA. 439
Chalk v.United States District Court Central District, (1987)F2d701
David Wilding v.British Telecomunication sPlc, (2002)EWCA Civ 349
Doe v.Oregon Resorts,2001U.S.Dist.Lexis17449
Doev. Washington University 780 F. Supp 628
Eliana Martinez v. School Board of Hillsborough County - Florida 861 F. 2d 1502
Equal Employment Opportunity Commission v. Prevo's Family Market Inc., 1998 FED App. 0047P(6th Cir)
H v.N,2002 EWCA Civ 195
Hillv. Community of Damien of Molokai, 911 P. 2d 861
Hills v. Potter, (1984)1 WLR 641

Hoffman v. South African Airways,CCT17/00 (28September 2000)
John and Mary Doe v. Dolton Elementary School, District No.148 694 F. Supp. 440
John Doe v. University of Maryland Medical System Corporation, CA-9292832 HAR
N v. Ministry of Defence (Case no. LC 24/98)
North Shore University Hospital v. Rosa, 194AD 2d 727
Raintree Health Care Centre v. Illinois Human Rights Commission et al 655 N. E. 2d 944
S.T.E. v. Peter Bertelsen (I989), 10 C.H.H.R D/6294 (Alta. Bd. of Inquiry)
Simon Thwaites v. Canadian Armed Forces, (1994) CLLC 17040
Soobramoney v. Minister of Health (Kwazulu-Natal), CCT 32/97
Spencer Waddell v. Valley Forge Dental Associates Inc., 276 F 3d 1275
Stewart B. McKinney Found Inc. v. Town Plan and Zoning Commission, 790 F. Supp. 197
Racine Unified School Dist v. Labor and Indus Review Commission, 476 N. W. 2d 707
X v. Commonwealth of Australia, (1999) HCA 63

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CHAPTER-1

INTRODUCTION

"The most important public health lesson emerging from the HIV epidemic is that respecting and protecting the rights of those already exposed to HIV and those most at risk is the most effective way to curb the rapid spread of the epidemic."

-Justice Michael Kirby,Australia

According to the World Health Organisation, the human immunodeficiency virus (HIV) is a retrovirus that infects the cells of the immune system, thereby destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections.Acquired immunodeficiency syndrome (AIDS) is the most advanced level of HIV infection. An HIV-infected person can take 10-15 years to develop AIDS; antiretroviral drugs can further slow down the process.The first line of treatment for a PLHA is ensuring her/his lifestyle.The second is the treatment of OIs.The most commonly occurring OIs in India are Tuberculosis, Candidiasis, Cryptosporidiasis, Herpeszoster, Toxoplasmosis, Bacterial pneumonia, Cryptococcal meningitis, PCP and Kaposi's sarcoma;[1]all of which are treatable and curable. AIDS can be defined by the development of certain cancers, infections, or other severe clinical manifestations. Immunodeficiency results in increased susceptibility to a wide range of infections, cancers and other diseases that people with only healthy immune systems can fight off. As the viral count increases and the immune system is compromised, it becomes essential to try and restore the balance by lowering the viral load in the body of a PLHA.ARVs do this, enabling PLHAs to live longer, healthier lives. The WHO, in 2002, included ARVs in its Model List of Essential Medicines.[2]

Most people are unaware of their status until the last stage, which makes this disease more deadly. Lack of proper diagnostic of the disease and the fact that it is been more than 35 years since HIV was first identified and till now no cure or vaccine has been found out is alarming.

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[1] National Guidelines for Clinical Management of HIV/AIDS,NACO,India[Hereinafter: NACO Guidelines].Available at http://www.naco.nic.in/nacp/clinical.pdf.
[2]"Essential Medicines WHO Model List".Available at http://www.essentialdrugs.org/files/edl2002core.doc.

The propagation of HIV / AIDS without any obstacles is a matter of fact. The dilemma is accentuated by the dual dimensions of the incurability of the disease in combination with the social reaction to the HIV-positive individual being examined.It is only because any step taken towards prevention of further spread, either directly or indirectly impacts individual rights and liberty.The routine practice of mandatory testing, the discrimination of affected employees leading to deprival of their employment opportunities, afflicted women being cruelly discarded from the interactive limits of the society, and the affected children being disowned, are some of the several discriminatory practices that raise significant questions pertaining to human rights of those suffering and the response of different entities to the same. In addition, the lack of proper treatment and care to those suffering only accentuates the problem. There are certain drugs which directly act on virus count and as a result, either delays or prolongs the status quo. But for many of the people, these drugs are neither accessible nor affordable.

In the constitutional perspective, Article 14, 19 and 21 are violated in the case of HIV/AIDS patients, which needs to be seriously looked into.

As far as India is concerned, there was no legal protection to the persons having HIV/AIDS until 2017.It was only in 2017, the *HIV AND AIDS (PREVENTION AND CONTROL) ACT, 2017* was passed, which provide for the prevention and control of spread of HIV and AIDS and the protection of human rights of persons affected by the said virus. This Act contains significant loopholes, which dilute the very purpose of the Act. In this research this Act is carefully analyzed and studied.

This research mainly intends to focus on the constitutional rights of people affected by HIV/AIDS and to find out various human rights violations in the context of HIV/AIDS. The judicial response on the rights of persons affected by HIV/AIDS is also looked into so as to understand the control of judiciary on this issue.

STATEMENT OF PROBLEM

- HIV, having claimed more than 32 million lives so far, continues to be a significant global public health concern. Globally, 7,70,000 people died from HIV-related causes in 2018.
- At the end of 2018, there were nearly 37.9 million people living with HIV, with 1.7 million people newly infected in 2018 globally.62% of adults and 52% of

children living with HIV were receiving lifelong antiretrovial therapy (ART) in 2018.

- Key groups include: men who have sex with men, people who inject drugs, people in prisons and other closed settings, transgender people, and sex workers and their clients. Irrespective of the disease type or local background, they are at increased risk for HIV.
- Key populations also face legal and social challenges that increase their HIV vulnerability and obstruct their access to services for prevention, testing and care.
- No treatment for HIV infection exists. Effective antiretroviral (ARV) drugs, however, can control the virus and help prevent transmission in order to allow stable, long and productive lives for people with HIV and those at serious risk.
- It was estimated that only 79 percent of individuals with HIV actually know their status.
- 23.3 million persons diagnosed with HIV received antiretroviral therapy (ART) worldwide in 2018.

SCOPE AND SIGNIFICANCE OF THE STUDY

Since India ranks third among the world's largest HIV epidemics, with 2.1 million people, the majority of whom live with HIV, belonging to the vulnerable section, it is important to research the human rights abuses of this community. The improvement of health systems is of vital importance, and it is a must to incorporate HIV into broader health systems by eliminating AIDS from isolation. Recently Parliament had passed a legislation for the prevention and control of HIV/AIDS but it was not notified by the Government. A Public Interest Litigation (PIL) was filed in connection to this, which sought immediate notification of the legislation. A bench of Chief Justice Rajendra Menon & Justice.C.Harishankar asked the Health Ministry, “You make a law and are not notifying it”. This is the attitude of the implementing authority. It is a fact that only effective laws and its proper implementation could make changes in the social life of HIV/AIDS persons. This study intends to make such a change by analysis of the existing law on HIV/AIDS and to understand the judicial attitude.

RESEARCH QUESTIONS

1. What is the need to protect persons affected by HIV/AIDS?

2. Whether the fundamental right to life and personal liberty of persons having HIV/AIDS is protected?
3. What is the role of the judiciary in issues on HIV/AIDS?
4. What are the constraints to the authorities in combating HIV/AIDS?
5. Whether there is any violation of the fundamental rights of persons affected by HIV/AIDS?
6. What are the measures taken by the State in order to prevent discrimination of HIV/AIDS affected persons?
7. How far is the access to medical care efficient to HIV/AIDS patients?
8. How far the already existing legal framework and mechanisms are effective?

RESEARCH OBJECTIVES

- To study the condition of persons who are affected by HIV/AIDS.
- To examine various instances of human rights violations of persons affected with HIV/AIDS and to understand the magnitude of the problem.
- To inform about the current status of HIV/AIDS persons.
- To pose the problems they are facing in the right perspective.
- To get to know about the constraints, concerns and limitations of various stakeholders.
- To critically examine various legal instruments on HIV/AIDS in India.
- To find out the Constitutional rights of persons who are affected by HIV/AIDS.
- To elicit feedback as to the premise of the Policy and legal framework.
- To promote general awareness about the rights of persons concerned.
- To avoid stigma and discrimination faced by HIV/AIDS patients.
- To identify various mitigation options that helps to reduce this disease and the stigma attached to it.
- To analyze the lacunas in the existing legal framework.

HYPOTHESIS

The existing legal frameworks for the prevention and control of HIV and AIDS is inadequate and failed to protect the human rights of persons affected.

RESEARCH METHODOLOGY

The methodology adopted in the present research is doctrinal and analytical because of the time constraints.

Limitations: For uniformity and consistency, the researcher has not cited any sources within the content body of the research and instead has put it in the footnotes. The researcher is aware that the 20th edition of bluebook insists that quotations exceeding 49 words must be cited in the body of the work itself yet for the above stated reasons and convenience researcher has not been able to do so.

CHAPTERISATION

CHAPTER 1 - INTRODUCTION

CHAPTER 2 - HUMAN RIGHTS OF HIV/AIDS AFFECTED PERSONS.

CHAPTER 3 - RIGHTS OF HIV/AIDS PATIENTS: A CONSTITUTIONAL PERSPECTIVE AND JUDICIAL RESPONSE.

CHAPTER 4 - INTERNATIONAL LEGAL FRAMEWORK.

CHAPTER 5 - CRITICAL ANALYSIS OF THE HIV & AIDS (PREVENTION AND CONTROL) ACT,2017

CHAPTER 6 - CONCLUSION AND SUGGESTIONS.

The dissertation has the following structure.

The first chapter of the dissertation is an introductory chapter. It contains the background and contemporary relevance of the topic, objectives of the study, the research questions, hypothesis of the study and methodology adopted for the study.

The second chapter titled 'Human Rights of HIV/AIDS Affected Persons' analyses the relevance of human rights and the need for protecting it. The Universal Declaration of Human Rights (UDHR), 1948 is an important international instrument in protecting the rights and freedoms of individuals. It mainly discusses the principles of non-discrimination and equality. The chapter highlights the importance of honouring human rights by the governments and multilateral agencies in the context of AIDS disease. This chapter proceeds to discuss various human rights violations of people living with HIV/AIDS (PLHIVs).The legal, ethical and human rights concerns of PLHIVs are also discussed in this chapter. The scientific aspects relating to HIV/AIDS and the various

factors contributing to the spread of the epidemic are given under various heads. Special emphasis has been given to the human rights of women and children. The chapter is concluded by addressing the need for a human rights approach in the context of HIV/AIDS affected people.

The third chapter titled ‘Rights of HIV/AIDS Patients: A Constitutional Perspective and Judicial Response’ explains the various constitutional rights that are available to people living with HIV/AIDS. The right to privacy, right to health and the right to education embedded under Article 21 of the Constitution of India is often violated in the case of HIV/AIDS patients. The right to privacy of HIV/AIDS patients must be attached first priority over the other rights. This is because, once their HIV positive status is made known to the society, they start facing a lot of humiliations on account of the stigma attached to it. Hence their HIV positive status must be kept secret by the health authorities after the tests are conducted. This is considered to be one of the reasons for the failure of the AIDS prevention programmes. The chapter also examines the role of the judiciary in protecting and uplifting the rights of the people living with HIV/AIDS.

In the fourth chapter on ‘International Legal Framework’, various international instruments in protecting the human rights of HIV/AIDS affected persons are discussed in detail. The United Nations General Assembly Declaration of Commitment on HIV/AIDS, recognises the full realization of human rights and fundamental freedoms as a response to global HIV/AIDS pandemic. The dual role of International Labour Organization in protecting and promoting the human rights and the various human rights contained in the code is also discussed in detail in this chapter. The role of UNAIDS in combating HIV/AIDS is also examined.

The next chapter on ‘Critical Analysis Of The Human Immunodeficiency Virus And Acquired Immune Deficiency Syndrome (Prevention And Control) Act, 2017’ is an attempt to examine the existing legal framework in India. The background and history of the HIV & AIDS Act is also looked into. The statutory provisions in the Act are critically analysed and found it to be inadequate for effectively protecting the rights of the HIV/AIDS patients. The Act fails to provide free treatment to HIV/AIDS patients. The Act is found to be improperly implemented in many of the States in India. The only

machinery provided in the Act for the protection of human rights of PLHIVs is an Ombudsman under Section 23(1) and a Complaints Officer under Section 21 of the Act.

The data obtained from an RTI dated 19.08.2020 from the Public Information Officer, Kerala State AIDS Control Society (KSACS) reveals that an ombudsman and complaints officer are not yet appointed in the State of Kerala. No rules for the effective implementation of the Act has also not been made by the State. Unless and until effective implementation of the Act is made, the rights of PLHIVs are at stake.

Last chapter of this dissertation deals with conclusion part and it ends with suggestions for the protection of the rights of PLHIVs and for eradicating the deadly disease.

CHAPTER 2

HUMAN RIGHTS OF HIV/AIDS AFFECTED PERSONS

"To deny people their human rights is to challenge their very humanity"

-Nelson Mandela

HIV / AIDS continues to spread at an unprecedented pace around the world. In the aftermath of the outbreak, the systematic violation of human rights and civil liberties associated with HIV / AIDS has emerged in all parts of the world. It is considered as a social problem that affects not only a person, but also affects society as a whole. An individual issue is one that affects one group or one person. Its resolution lies within that person's immediate environment. Against this, a societal issue is one which affects the society as a whole, or the larger part of society.

Fuller and Myers[3]have defined a social problem as "a condition which is defined by a considerable number of persons as a deviation from some social norms which they cherish".

Merton and Nisbet[4] hold that a social problem is "a way of behavior that is regarded by a substantial part of a social order as being in violation of one or more generally accepted or approved norms".

Raab and Selznick[5] maintain that a social problem is "a problem in human relationships which seriously threatens society or impedes the important aspirations of many people".

THE RELEVANCE OF HUMAN RIGHTS

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.[6]

Thus, Article 1 of the Universal Declaration of Human Rights, quoted above, describes the general concept of 'human rights'. Even when the concept is accepted widespread, there is no uniform agreement on what human rights are or on the substantive content

[3] 1941:320.
[4] 1971:184.
[5] 1959:32.
[6] Universal Declaration of Human Rights, Article 1, G.A.Resolution 217(III) OF 10 December 1948 at http://www.unhchr.ch/udhr/lang/eng.htm.

of the term. What we now call ‘human rights’ had been indeed a subject of debate in the moral, philosophical, legal and political arena.

David Sidorsky, a political philosopher at Columbia University, proposes that the term ‘human rights’ denotes two different but not inconsistent functions. One is the notion of human rights as ‘universal norms or standards that are applicable to all human societies.’ Secondly, the term is also used to affirm the idea that ‘all individuals, solely by virtue of being human, have moral rights which no society or state should deny.’[7] James Nickel, a Professor of Human Rights Law at Arizona State University, expressed this idea, stating that compliance with human rights is mandatory because those rights are fairly treated as independent because they exist and are available as standards of reason and critique, whether or not they are accepted and upheld by a country's legal system or authorities.’[8]

The Universal Declaration of Human Rights (UDHR) emerged as a reaction to the atrocities and oppression caused by the Second World War. Apart from detailing the rights and freedoms of individuals for the first time, it was the first international acknowledgment of the ‘inherent dignity and of the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world’.[9]The UDHR also lays emphasis that ‘a common understanding of these rights and freedoms is of the greatest importance for the full realization’ of the rights contained therein.[10] In fact, the Indian Constitution exemplifies the ‘common understanding’ of basic human rights as it incorporates the principles outlined in the UDHR in the form of Fundamental Rights and Directive Principles of State Policy which are contained in Part III and Part IV of the Indian Constitution, respectively.

It is also important to note that non-discrimination is a cross-cutting principle in international human rights law. The principle is present in all the major human rights treaties and provides the central theme of some of international human rights

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[7] Sidorsky, David,’Contemporary Reinterpretations of the Concept of Human Rights’, Essays on Human Rights, David Sidorsky(ed.), 1979, reproduced in International Human Rights in Context, p.327.

[8] Nickel,James,Making Sense of Human Rights:Philosophical Reflections on the Universal Declaration of Human Rights,Berkley:University of California Press: 1987,pp.561-2 cited in, ‘Human Rights’, ‘Internet Encyclopedia of Philosophy’, Andrew Fagan at http://www.iep.utm.edu/h/hum-rts.htm#H2.

[9] Para 1 of Preamble of the Universal Declaration of Human Rights, at http://www.un.org/Overview/rights.html.

[10] Ibid; at para 7.

conventions. In addition to all human rights and freedoms, the principle extends to all and forbids discrimination on the grounds of a list of non-exhaustive categories, such as sex, race, colour and so on. The principle of non-discrimination, as laid down in Article 1 of the Universal Declaration of Human Rights, is supplemented by the principle of equality: "All human beings are born free and equal in dignity and rights."

BOTH RIGHTS AND OBLIGATIONS

Both rights and responsibilities are entailed in human rights. States accept obligations and duties to respect, protect and fulfill human rights under international law. The obligation to respect suggests that states shall refrain from interfering with or restricting the enjoyment of human rights. The responsibility to protect allows states to protect persons and communities from violations of human rights. The obligation to obey suggests that, in order to promote the enjoyment of fundamental human rights, states must take positive steps. At the individual level, we should all respect the human rights of others while we are entitled to our human rights.[11]

Talking about the Indian perspective, many scholars have taken varied approaches. Amartya Sen rejected the notion of human rights discourse as a form of cultural imperialism favoring the universality of rights based on 'shared humanity.'[12]

In terms of the Indian legal philosophy and attempts to incorporate human rights discourse into the broad framework of the Indian cultural tradition, Vikramjit Banerjee argues that there are three different schools of thought in this regard. The first set traces human rights from international documents, and another set traces it from the Constitution of India, and the third set tries to explore other methodologies as a basis for the conception of human rights.[13]

Human beings are entitled to certain fundamental and 'natural' rights, which define a meaningful existence under the natural rights approach. The fundamental tenet of human rights is the equal dignity of all people. Such rights were designated universal in their application, inalienable in their practice and intrinsic in all individuals. This

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[11] Ashok Kumar,Women's Human Rights,Pg.4,2014.
[12] Sen,Amartya,'Human Rights and the Westernizing Illusion', Harvard International Review,20(3),Summer 1998,available at http://www.mtholyoke.edu/acad/intrel/asian%20values/sen.htm
[13]Banerjee, Vikramjit, 'Human Rights and the Indian Academia:A Need for Civilisational Understanding',(2002)8SCC(Jour)1, available at http://www.ebcindia.com/lawyer/articles/2002v8al.htm.

concept of human rights can be found in the idea of 'natural rights' introduced by the philosopher John Locke in the seventeenth century, who urged that such rights are 'natural' to people as human beings, having existed already in the 'state of nature' before the creation of societies and the creation of the state.[14]Natural rights proponents urged that 'natural rights are rights belonging to a person by nature and because he is a human being, not by virtue of his citizenship in a particular country or membership in a particular religious or ethnic group.'[15]As natural rights are intrinsic and independent of rights provided by the state, the latter can be viewed as having the function of protecting these natural, human rights. In other words, the state is merely a guarantor of rights-it is not the fundamental source of these rights, since the rights inhere in individuals and thus it cannot take them away. In addition to this, the inalienable nature of these rights makes it impossible for a person or individual to dispense with them.

In the sense of HIV / AIDS, many human rights are under attack, including the right to non-discrimination, the right to privacy, the right to proper social security care and the right to work. An essential part of the fight against HIV / AIDS must be the defence of human rights if the disease is to be resolved. The presence of undeniable links between human rights and the issue of HIV / AIDS explains this. In a report submitted by the Secretary-General to the Human Rights Commission in 1995, these ties were clearly established:

Failure to protect human rights raises the risk of transmission of the disease in the first place. Transmission avoidance is a complex and fragile educational and behavioural adjustment mechanism involving intimate and often illicit behaviour. Transmission avoidance focuses on persons coming together to understand how to prevent illness, how to practise safe sex, and how and when they should conduct appropriately. Coercive practises, such as compulsory screening, lack of privacy and segregation, are turning individuals away from prevention, schooling and health care and subverting this behavioural improvement process.

Secondly, persons and communities in society who are marginalised and/or do not experience the full exercise of their rights are especially vulnerable to infection because

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[14] Rama Jois,Justice,M;Ancient Indian Law:Eternal Values in Manu Smriti,Delhi:Universal Law Publishing Co.Pvt.Ltd,2002 n.70,p.324.
[15] 'A Short History of the Human Rights Movement Early Political,Religious, and Philosophical Sources', Human Rights Web at http://www.hrweb.org/history.html.

they have minimal or no access to information, preventive, and health care services related to HIV / AIDS. These communities include women, children, minorities, migrants and indigenous people, men who have sex with men, commercial sex workers, and drug users who inject drugs. In order to prevent contamination, these groups will have neither the knowledge they need nor the capacity to act on it. Infection easily spreads to society at large within such classes.

Finally, the tragic effect of the disease on their life is dramatically magnified by violence against and stigmatization of those already afflicted by HIV / AIDS (those infected, accused of infection, and their family and associates). Such inequality is pervasive. It not only violates the rights of those affected, but also disables them by restricting their access to work, accommodation, health services, and the social service services that are important to them.[16]

The protection of human rights in the case of HIV / AIDS is also essential, not only because of the inherent nature of the rights that occur in order to preserve the human dignity of the infected person, but also because the preservation of those rights forms an important part of the fight against the virus.

There are several instances and reported incidents where blood transfusions caused nearly 9000 cases of HIV in India in the past five years.[17] According to the Times of India report, as many as 8938 people in India have contracted HIV through blood transfusions in the past five years, raising concerns among experts. Data obtained by a newspaper through a right to information request from the National AIDS Control Organisation (NACO) showed that 629 people across India became infected with HIV from blood transfusions from April to October 2014, including 80 people in Maharashtra, 99 in Gujarat, and 147 in UttarPradesh[18].These shocking figures in fact depicts huge human rights violations of the persons affected thereby. Unless and until the State ensures the accountability of blood banks and blood safety measures, it is difficult to come up from

[16] Report of the Secretary-General on international and domestic measures taken to protect human rights and prevent discrimination in the context of HIV/AIDS, Commission on Human Rights, Fifty-first session , 1995. E/CN.4/1995/45, paragraphs 12-14.

[17] BMJ2015;350:h1146 (JSTOR)

[18]DebRoyS.1000HIV+casesinMaharashtraduetoinfectedbloodtransfusion.TimesofIndia29January2015. http://timesofindia.indiatimes.com/india/1000HIVcasesinMaharashtraduetoinfectedbloodtransfusion/articleshow/46047954.cs.

this situation. Rampant corruption in healthcare services in India also impacts this scenario.

STATES' OBLIGATION TO RESPECT AND PROTECT HUMAN RIGHTS

States are under a duty, in compliance with international human rights instruments, to promote and protect all internationally recognised fundamental rights and individual freedoms, irrespective of the political, economic or cultural system. Predominant among these instruments adopted by the UN are the Universal Declaration of Human Rights[19], the International Covenant on Economic, Social and Cultural Rights(ICESCR), the International Covenant on Civil and Political Rights(ICCPR), the Convention on the Elimination of all Forms of Discrimination against Women(CEDAW), and the Convention on the Rights of the Child(CRC). Furthermore, the Declaration of Commitment on HIV/AIDS, adopted on 26 June 2001 by the General Assembly of the United Nations, constitutes a worldwide commitment to a redoubling of national, regional, and international efforts in the fight against the epidemic on all fronts, especially in the field of human rights.[20]

In particular, the Declaration commits States to enact, strengthen or implement rules, legislation and other measures, as appropriate, to eradicate all types of discrimination against persons living with HIV / AIDS and representatives of disadvantaged communities and to guarantee that their civil rights can be wholly exercised.[21]

Much stress is also laid on the implementation of national strategies that "promote the advancement of women and women's full enjoyment of all human rights".[22]

In the fight against human rights abuses in the field of HIV / AIDS, several ILO Conventions and Recommendations can also be invoked with reference to ratifying countries. Although there are no conventions or recommendations directly covering HIV / AIDS, there are many that include job and occupational harassment safety, social

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[19] Even though it is not a treaty, the Declaration is binding on all members of the United Nations as customary law. In addition, the mentioned Conventions have been widely ratified.
[20] G.A.Res.S-26/2,U.N.Doc.A/RES/S-26/2.
[21] Articles 13, 37 and 58.
[22] See especially Sections 59-61.

protection, the prevention of industrial accidents and the adaptation of the working atmosphere for workers affected by ill health.[23]

It should also be stressed that the ILO Declaration on Fundamental Principles and Rights at Work states that all Member States, even if they have not ratified the Fundamental Conventions on those rights, should recognize the ideals and fundamental rights enshrined in the ILO Constitution and the Philadelphia Declaration when they vote freely to join the ILO.

POSSIBLE RESTRICTIONS ON HUMAN RIGHTS

The Universal Declaration of Human Rights permits States, but only under explicitly defined cases, to place limitations on those rights. Such instances will be described as a valid concern in a democratic society, such as public health, the rights of others, public morality or public order and general welfare, and constraints should be held to a minimum.[24]

The most widely cited explanation for states and individuals placing restrictions on human rights in the field of HIV / AIDS is public health.[25]

However, under international human rights law, these restrictions are often not justifiable. This occurs, for example, where compulsory occupational HIV screening is done and affected individuals are unable to access or are removed from jobs. In the fight against AIDS, compulsory screening does not help. On the other hand, considering their diagnosis, it is entirely possible for people who are HIV-positive to live in good health for many years.[26]

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[23]The following Conventions are of particular relevance: Discrimination (Employment and Occupation) Convention, 1958 (No. 111); Occupational Safety and Health Convention, 1981 (No. 155); Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No 159); Occupational Health Services Convention, 1985 (No. 161). For further information on international conventions and how they can be used in the HIV/AIDS context, see: Hodges-Aeberhard, J.: Policy and legal issues relating to HIV/AIDS and the world of work (ILO, Geneva, 1999).

[24]The exercise of certain rights cannot be limited under any circumstances. These include the right to life, the right not to be subjected to torture, the right not to be held in slavery or servitude, protection against imprisonment of debtors, the right not to be subjected to retrospective penal legislation, the right to the recognition of juridical personality, the right to freedom of thought, conscience and religion. For further details see the International Guidelines on HIV/AIDS and human rights:, paragraph 82.

[25] Ibid. paragraph 83.

[26]In about 50% of cases, there is a period of 10 years between infection and the appearance of the first opportunistic infections which characterize AIDS. UNAIDS: AIDS and HIV infection, information for United Nations employees and their families (Geneva, 1999), p. 29.

In fact, their presence at work would not put other persons at risk of infection in the vast majority of occupations. Employers and fellow staff should not be fearful of illness by going into routine interaction with HIV-positive individuals. Using a public phone, opening a lock, exchanging food or cutlery, drinking from water fountains, using toilets or baths, shaking someone's hand, crying, sneezing, none of these will contribute to the virus being spread. Compulsory HIV screening, on the other hand, induces an atmosphere of uncertainty and animosity in the community and leads to the epidemic's dissemination. In these conditions, persons who are HIV positive are more likely to conceal their illness and spread the virus to others, fearing loss of their work or stigmatisation.[27]Prevention measures such as education programmes and the promotion of voluntary and confidential HIV testing, accompanied by prior and subsequent counselling, are preferable approaches to reducing the impact of the epidemic.The international guidelines on HIV/AIDS and human rights stipulate the following in this respect:

It is understood that the right to privacy has been limited by compulsory testing and disclosure of the status of HIV, and that the right to freedom of an individual is violated when HIV is used to excuse deprivation of liberty or segregation.

Although such measures may be effective in the case of diseases, contagious by casual contact and susceptible to cure, they are ineffective concerning HIV/AIDS since HIV is not casually transmitted. Besides, such coercive measures are not the least restrictive measures possible and are often imposed discriminatorily against already vulnerable groups. Finally, and as stated above, these coercive measures drive people away from prevention and care programmes, thereby limiting the effectiveness of public health outreach.[28]

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[27] Exceptions include professions where there is a risk of contact with blood or other human organic liquids, such as health and laboratory workers. The risk is low but real. In these professions extra measures must be taken to ensure that workers are properly familiar of the universal precautions and of procedures to be followed in case of workplace accidents, so that universal precautions are always taken and the necessary equipment is available for that purpose. For further information on the universal precautions, see Appendix 2 of the ILO Code of Practice.

[28] International Guidelines on HIV/AIDS and Human Rights, op. cit. note 2, paragraph 83.

OTHER INTERNATIONAL INSTRUMENTS

The main United Nations agencies responsible for overseeing the application of fundamental rights in the context of HIV / AIDS are the Human Rights Commission and the Sub-Commission on the Promotion and Protection of Human Rights.

The Sub-Commission appointed one of its experts as a Special Rapporteur in the early 1990s to examine the problem of violence against infected individuals and HIV / AIDS patients. Between 1990 and 1993, the Rapporteur issued a number of studies highlighting the need for education programmes, supplemented by sufficient legal security, in order to create a favourable environment for respect for human rights. The Sub-Commission has also adopted a number of resolutions on violence against people living with HIV / AIDS since 1989.[29]

The Human Rights Commission has already adopted several resolutions upholding the prohibition, under international human rights law, of discrimination on the basis of real or suspected HIV status, and reaffirming that prohibitions relating to discrimination in international human rights treaties must be understood as covering discrimination on the basis of a person's health status, such as HIV status. These resolutions invite States to take the required steps to eradicate this form of discrimination, to ensure that the legal , political, economic , social and cultural rights of HIV / AIDS sufferers are fully exercised; to guarantee access to medication; and to include community groups, NGOs and HIV / AIDS sufferers themselves in policy-making in the fight against AIDS.[30]

The Commission on Human Rights adopted Resolution 1995/44 on March 3, 1995, requesting the High Commissioner and UNAIDS to draw up recommendations on the promotion and protection of respect for human rights in the light of HIV / AIDS.[31] In September 1996, the International Guidelines on HIV / AIDS and Human Rights were

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[29] Decisions and resolutions of the Sub-Commission: 1989/17, 1990/118, 1991/109, 1992/108, 1993/31, 1994/29,
1995/21, 1996/33, 1997/40.

[30]Resolutions of the Commission on Human Rights: 1990/65, 1992/56, 1993/53, 1994/49, 1995/44, 1996/43, 1997/33, 1999/49, 2001/33, 2002/32. Reports of the Secretary-General to the Commission on Human Rights: E/CN.4/1995/45, E/CN.4/1996/44.

[31]Resolutions of the Commission on Human Rights concerning the guidelines 1995/44, 1996/43, 1997/33, 1999/49, E/CN.4/2001/L.69 Reports of the Secretary-General to the Commission on Human Rights: E/CN.4/1997/37, E/CN.4/2001/80.

subsequently adopted.[32]These Recommendations describe the frameworks for the implementation of human rights in the field of HIV / AIDS with greater precision and include examples of specific interventions for the attention of states and other social actors.[33] If they are to be implemented successfully, it is vital that they be disseminated broadly at national and local levels and that they become the focus of dialogue with a wide variety of people affected by these problems. In this regard, the tripartite existence of the ILO presents a very useful way of accessing the society as a whole, as it provides a channel to employers and employees through local actors who are genuinely involved in defending their rights. The ILO has, in any case, devoted itself to implementing the HIV / AIDS Guidelines and its Code of Practice, and the world of work is definitely an excellent means of achieving this purpose.[34]

HIV/AIDS AND LEGAL, ETHICAL AND HUMAN RIGHTS CONCERNS

The essential facets of information which would form part of the mainstream and popular discourse in the realm of HIV/AIDS must include talking and discussing about the nature and characteristics of HIV virus or how the virus spreads or the ways in which the spread doesn't take place, the organic structure of the virus, etc. It is also essential to place similar level of importance to legal, ethical and human rights concerns when we talk about HIV/AIDS. It is pertinent to note that in other health-related matters like TB, smallpox, leprosy or plague, we have never discussed about legal, ethical and human rights concerns. Why is it so? Let us examine the reason behind the stigmatization of HIV/AIDS. At the outset, it is seen that everyone of us is interested only in strategizing measures which effectively and appropriately contain the spread of virus. As a direct consequence, our interests as well as societal interest will get promoted and protected.

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[32] Op.cit. note 2. The Guidelines consist of two parts: first, the human rights principles underlying a positive response to HIV/AIDS and second, policy and practice that will protect human rights and achieve HIV-related
public health goals.

[33]The guidelines are drawn up principally with States in mind, but also for other users: intergovernmental bodies, NGOs, networks of people living with HIV/AIDS, community organizations, groups involved in the ethical, legal and human rights issues arising in the HIV/AIDS context, AIDS sufferers' support groups and anti AIDS action groups.

[34]See the Report submitted by the ILO to the Commission on Human Rights at its 57th Session on the steps taken by the ILO to promote the application of the International Guidelines on HIV/AIDS and Human Rights. Agenda item 14 (d): Specific groups and individuals: the protection of human rights in the context of HIV/AIDS, Geneva, 11 April 2001.

Analysis of the available scientific data about the virus reveals that the virus spreads only under specific and clearly determinable circumstances, which are directly attributable to human behavioural pattern such as unsafe sexual practice, intravenous/intramuscular drug usage through syringe sharing, blood transfusion, and mother to infant transmission. Similarly there are ways in which the virus doesn't spread but popularly believed otherwise, like shaking hands, sharing clothes, using same toilet, through mosquito bite etc. Testing of a person as seropositive merely indicates the presence of virus in the body. General immunity and health status, care in terms of healthy diet and responsible conduct style are the various causes that lead to the onset of opportunistic illnesses or diseases such as TB, weight loss, diarrhoea, finding shelter in the infected person, which ultimately leads to AIDS from around 3 to 8 years. There are situations when it often took more than 10 years. As a result, an HIV-positive person cannot be identified by mere observation. The single method of identification is the blood screening technique. However, for all practical purposes, a seropositive person continues to be a healthy person until the onset of various diseases. He/she is as good as any other person who is not seropositive. As of now there is no cure for this disease, however, certain drugs are available which directly act on the virus count and as a result either delays onset or prolongs the status quo. But, it is necessary to note that, for many of the people these drugs are neither accessible nor affordable. Though in other branches of medicines, tall claims are made about cure, still these are yet to be subjected to detailed scientific scrutiny. Previously, it was believed that the spread of virus confined only to specific categories of people, whom we have labelled as 'risk groups' like commercial sex workers, homosexuals, intravenous drug users etc. But, as the epidemiological findings started unfolding, we have come to realize and understand that the spread of virus has no barriers, whatsoever. As a result, the findings clearly reveals that the virus makes its presence virtually in every category of people in our society. The community of seropositive people, whose numbers get multiply every day, are represented by men, women, children with almost every and diverse backgrounds. One more fact about the virus is that the spread of this virus is preventable in nature. Therefore, there must be serious deliberations that must address these concerns and initiate measures so as to prevent further spread of virus and also measures with regard to those who are in 'vulnerable' situations.

Infact the process must lead to regulation of human conduct. It is more so, if such preventive measures is in the nature of 'law' and for a context like HIV/AIDS wherein, inevitably the preventive measures focus on behavior/conduct. Hence, the dilemma is, what should be the premise of such law, if it aims at regulating something that is innate to human life, like sexual practice.

To gain more insight, let us have a glimpse at popular societal response to the virus and the person who hosts such virus. Consistent stigmatization, varied discriminatory practices and claims of isolating those who are tested positive are some of the manifested responses of the society. The nature of discriminatory practices takes many forms in different contexts. They include, employment, access to public places, admissions to schools, housing, treatment, care, marriage etc. The underlying reasons for this kind of reaction can be attributed to the fact of its incurability. In addition to this notions like spread as a result of sinful or immoral sexual practices have contributed to the societal claims that those who are infected and those who are vulnerable must be isolated from the mainstream of societal life, so that societal interests can be protected. Accordingly, isolation has been considered as the appropriate method of prevention. Hence, discrimination and stigmatization act as preclude for eventual isolation either imposed by social norm or as a matter of voluntary decision.

The issue that requires urgent attention is whether the nature of such a legal measure can be premised upon 'isolation' of the infected individual with a view to protect societal interests? Apart from that, another issue is whether discriminating and stigmatizating such person can be said to be in the best interests of the society. Whether measures based on the principle of isolation and leading to several discriminatory practices can be legitimately and constitutionally justified? Whether these measures are pragmatic when it comes to practical enforcement?

The task at hand is to find out a viable alternative to the discriminatory practice of isolation. An alternative is available, whose foundation is premised on 'integration' rather than 'isolation'. This process firmly believes in two significant aspects. They are the societal interests are better protected, if the infected individual is given an appropriate opportunity to integrate with the mainstream of social life. This can adequately be achieved by recognizing rights of beings and facilitating protection and promotion of the same. In addition, this approach reconciles well with the proven basic

facts about the virus. As a result, this approach firmly endorses of the opinion that rights protection better facilitate the individual to indulge in responsible behavior, which is the crux of the preventive measures with regard to HIV/AIDS. Therefore, the purpose of this approach is to accept positive individuals as part of the solution and definitely not as part of the problem. This is a realistic phase where it is possible to contemplate the enduring effect.

In order to efficiently analyze various human rights of HIV/AIDS affected persons, it is essential to see the various factors contributing to the spread of the virus.

FACTORS CONTRIBUTING TO THE SPREAD OF THE EPIDEMIC

1. **Poverty and low economic status create conditions for the spread of HIV/AIDS.**
   In developed and developing countries, AIDS influence is greatest among the poor**.**
   - Those with low incomes may not be able tro afford treatment for STDs or to buy condoms.22% of the population in India live below the poverty line.[35]
   - Poor families may see commercial sex as a lucrative occupation for young and poorly educated daughters. India has a large and flourishing sex industry, estimated in each of the metropolitan cities to be about 100,000. Because of the highly secretive nature of the trade, most sex workers lack legal provisions, face discrimination, and have little means of protecting themselves.
   - The vulnerable and uneducated are more likely to contract STDs and other infectious diseases as they are deprived of their right to risk behaviour information, because they are too illiterate to understand preventive messages and have less access to quality resources. The average rate of literacy is 43 percent for women and 57 percent for men in India.

[35] Source: Press Note on Poverty Estimates, 2011 – 12, Planning Commission; Report of the Expert Group to Review the Methodology for Estimation of Poverty (2009) Planning Commission.

2. **Untreated STDs raise the risk of HIV infection per sexual exposure**

Studies show that people with current or past STDs are 2 to 9 times more likely to get infected with HIV. The lesions caused by untreated ulcerative STDs such as herpes, syphilis and cancroid provide an easy entry for HIV. India has a very high prevalence of sexually transmitted diseases:

- Based on available data, the annual incidence of STDs in India might be as high as 5% of the population with over 40 million new infections per year.
- STD baseline surveys conducted in Madras and Jaipur, as well as among sex workers in Calcutta and in a rural area of Tamil Nadu, that STDs are clearly not an exclusively urban problem. Prevalence rates for urban populations range from 1.2% to 10% and for rural populations up to 7%.

3. **Double standards of morality and gender norms**, leading to conditions where women are denied the same rights as men, are essential factors in the spread of HIV/AIDS. Women have little or no control over decisions relating to sexuality, nor over the sexual behaviour of their male partners or the use of condoms for the prevention of pregnancy or STD/AIDS. A study in Pune, India, illustrates a situation common to many societies. Of a sample of nearly 400 women attending the city's STI clinics, 93% were married and 91% never had sex with anyone but their husbands.
4. **Population mobility** is a key factor in the spread of HIV in India. There are over 180 million migrant workers in India, many of whom are single men or who live apart from their wives and families. Members of the armed forces and long route truck drivers away from home are more likely to have unsafe sex. It is this high mobility of the male population that has brought the virus to the aerial areas. The migrant men comprise 30-40% of the population of large cities, where they also account for much of the clientele of the 'red light' areas. In a study of 5722 male truck drivers in Assam, 82% of the men reported regular sex with CSWs along the national highways; none of the men used condoms regularly; 15% reported a history of sex with men; 36% had been treated for an STD; 40% used cannabis and 2.4% had injected heroin.
5. Economic development has resulted in rapid urbanisation, leading to large slum communities and a surge in unorganised labour groups, such as construction

workers, casual landless workers, and child labourers. In 1996, some 100 million people were estimated to be living in urban slums. Two-thirds of these are children, youth and women who are less literate, lack basic knowledge of safe health practices, and have little or no access to information or health and other supportive services. Poverty, ignorance and violation of basic rights in these areas create conditions that facilitate the spread of HIV.

6. Sexual behaviour and the reluctance to discuss sex and sexuality affects the probability of transmission:

- Behavioural studies conducted by NACO showed that sexual risk behaviour is well established in India. Unprotected sex and a high rate of partner exchange through casual and commercial sex is prevalent, thereby increasing the risk of infection.
- A 1995 study by NACO revealed that knowledge of prevention practices is low especially in rural areas. Misconceptions have still not been dispelled in urban areas also, where knowledge level is presumed to be high. Shockingly, 90% of those infected are unaware of their HIV status.
- Condom use is low. Constraints that are independent of each other, such as the assumption that the use of condoms leads to loss of pleasure, cultural awareness, connexion with birth control, women's passivity and lack of quality assurance, have all contributed to low use of condoms, especially with non-regular partners.
- Reluctance to discuss concerns related to sex and gender, and denial of the presence of risk activity, particularly among young people. The subject of sex is commonly considered a taboo and is closely connected to morals and promiscuity. Homosexuality is also a morally prescribed activity that compels certain men who have underground sex with men. Much of this adds to poor government funding for sex education in schools and for-out-of-school youth, as well as a lack of the right to information and facilities.

7. Injecting drug use (IDU) is potentially a major route for HIV transmission as evidenced by the extremely high prevalence rates in Manipur, Mizoram and Nagaland where some sites have reported prevalence as high as 85.6 %. The pattern of sexual networking and sexual mixing of injecting drug users-many select sexual partners from similar networks i.e., people who shared needles,

traded sex for money, increases the infection rates among them. It must be added that injecting drug use is a legal offence and this drives users underground, preventing them from accessing information and support services for protection from infection.

8. India has a large population of young people, about 400 million below the age of 18. Studies and held experience provide evidence of early onset of sexual activity and low levels of awareness among young people. There is also a comparatively large population of children living under challenging circumstances such as street children and child labourers, many of whom are vulnerable to sexual abuse. As the epidemic matures, there is an increasing pool of potential sexual partners who are already, infected. This is true for both young men, who in many countries tend to have their first sexual encounters with sex workers, and for young women who tend to have sex with older men.

Young people can also be made more vulnerable to HIV by certain taboos, ideologies and social norms. This is particularly the case where voting people are denied knowledge and skills on sexual and reproductive matters, barred from reproductive health services including HIV prevention and STD care and counseling and ostracized if attracted by the same sex. Adolescents are generally left alone to deal with the biological and social transformation of adolescence, often with no caring adults to talk to.

9. Discrimination and curtailing of human rights of women and children, of marginalized populations such as commercial sex workers, and men who have sex with men have resulted in their lack of access to information and acceptable services. This can also heighten the risk of infection and the further spread of the virus.

10. Contaminated blood is also an important source of HIV infection. Of the nearly 2 million bottles of blood that are transfused every year in India, more than half reportedly were supplied by people who sell their blood. Although the Government has made HIV screening mandatory, not all blood banks comply. The main issue is one of supply-demand exceeds the supply and currently, only 60% of the demand is being met which has implications for HIV transmission.

HIV/AIDS: THE NEED FOR A HUMAN RIGHTS APPROACH

It is important to look at the evolution of HIV/AIDS to better understand the need for a human rights approach in combating HIV/AIDS.AIDS was understood initially by both epidemiologists and the general public as a disease of gay men, injecting drug users, prostitutes and their sexual partners.[36] Outside the public health circles and sometimes within the health sector, the disease was met with antipathy; abject homophobia and sexism were faced by PLWHA. HIV-positive girls have been removed from high schools in the states of Indiana and Florida.[37] So great was PLWHA's paranoia, indifference and loathing that HIV-positive staff were fired even if their colleagues were not at risk of infection.[38] Marriage permits have been suspended from partners in some countries where one partner has tested positive for the virus.[39]

While the composition of the virus was recognised by scientists in 1984, until 1996, there was no meaningful medication available to people living with HIV / AIDS. Many public health services focused on prevention, care and the enhancement of opportunistic diseases to control an illness for which there was not a vaccine nor intensive therapy. For their part, UNAIDS, the WHO and the NGOs working to combat HIV/AIDS directed their attention to the abuse and opprobrium directed at HIVinfected people.[40]

Public health authorities have recognised that the standards and procedures used to monitor communicable diseases such as measles, typhoid or most sexually transmitted infections are not relevant to HIV / AIDS. The use of monitoring, prevention and quarantine measures did not deter the spread of the outbreak at the beginning of the outbreak. Too many people who thought they were HIV-positive were forced underground, where the progression of the condition was impossible to trace.

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[36] *See, e.g.,* RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 83 (1987).

[37] GOSTIN, *supra* note 24, at xxv.

[38] *See* Sofia Gruskin, *Negotiating the Relationship of* HIV/AIDS *to Reproductive Health and Reproductive Rights,* 44 AM. U. L. REV. 1191, 1195-96 (1995).

[39] *See* MELISSA LATIGO, MARRIAGE LAWS, LAW DEVELOPMENT COMMISSION OF ZAMBIA (2005), *available at* http://ocw.mit.edu/NR/rdonlyres/Special-Programs/SP-253Spring-2005/B7165652-1EE7 4128-98C8475C29BC728E/0/melissa-latigo.pdf.

[40] The AIDS law community's focus on combating stigma and discrimination is not unique to this field. *See* RISA L. GOLUBOFF, THE LOST PROMISE OF CIVIL RIGHTS (2007) (arguing that in the period before and after *Brown v. Board of Education,* 347 U.S. 483, 494 (1954), U.S. civil rights lawyers focused attention on the stigma associated with segregated education rather than the material deprivations associated with the labor of African American workers).

AIDS also differs from other diseases because of the stigma and discrimination attached to infected persons.[41] Unlike malaria, HIV/AIDS continues to be associated with a wide range of human rights abuses, both those that facilitate HIV transmission, including intergenerational sex,[42] and those that target persons already infected, such as discrimination in employment and in access to services of the state.[43] AIDS has also generated encouraging trends; in the pantheon of modern diseases, HIV is exceptional because of the mass movement that has organized to advocate for research, prevention, care and treatment of the virus.[44] Globally, the mobilization around HIV and AIDS has domestic and international dimensions.

AIDS can only be controlled by protecting the civil and political rights of HIV positive people.Without protection, individuals refuse to be tested for HIV and the resulting decline in accurate information undermines public health efforts to halt the spread of the disease. Conversely, where individuals can reveal their status without fear of reprisal, information flourishes, educational efforts take root, and the prevention of new cases is a realistic possibility. There has been a persistent trend in which discrimination, marginalization, stigmatization and, more broadly, a lack of regard for individuals and groups' human rights and dignity increase their susceptibility to HIV exposure.[45]In turn, an HIV-positive status begets human rights violations, including discrimination and violence. Experts opines that the HIV/AIDS pandemic thrives when economic conditions force workers to migrate in search of employment, bringing forms of social fragmentation that loosen family ties and encourage abandonment of traditional sexual mores and taboos.[46] People who are tested positive for HIV have been denied employment, fired from their jobs, kicked out of hospitals, denied both HIV specific

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[41] JONNY STEINBERG, SIZWE'S TEST: A YOUNG MAN'S JOURNEY THROUGH AFRICA'S AIDS EPIDEMIC (2008). *See also* Jonathan Todres, *supra* note 45, at 426 *citing* General Comment No. 3: HIV/AIDS and the Rights of the Child, CRC/GC.2003/1, 7 (2003) (observing that children of HIV-positive parents carry additional burdens and "may suffer discrimination directly or be stigmatized when others in their communities assume they, like their parents, have AIDS").

[42] PHYSICIANS FOR HUMAN RIGHTS, *supra* note 41, at 70. *See also* Human Rights Watch, *A Question of Life or Death: Treatment Access for Children Living with HIV in Kenya* (Dec. 16, 2008); Human Rights Watch, *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (Dec. 18, 2007).

[43] *See* HUMAN RIGHTS WATCH, LETTING THEM FAIL: GOVERNMENT NEGLECT AND THE RIGHT TO EDUCATION FOR CHILDREN AFFECTED BY AIDS (2005), *available at* http:/ / www.hrw.org/en/ reports/2005/10/O/ letting-them-fail.

[44] *See* Amy Kapczynski, *The Access to Knowledge Mobilization and the New Politics of Intellectual Property,* 117 YALE L. J. 804, 828 (2008).

[45] Jonathan M. Mann et al., *Health and Human Rights, in* HEALTH AND HUMAN RIGHTS 17 (Jonathan M. Mann et al. eds., 1999).

[46] EPSTEIN, *supra* note 12. *See also* Nanu Poku & Fantu Cheru, *The Politics of Poverty and Debt in Africa's AIDS crisis,* 15 INT'L REL. 37, 89-96 (2001).

and general medical treatment, harassed and assaulted by community members who find out their status, and at times they were even killed. Hence, human rights abuses fuel the HIV epidemic. WHO has subsequently identified AIDS as a disease of global poverty because the vast majority of infections were in developing countries. The populations which are infected by AIDS were already societally marginalized or stigmatized, became the most significant risk of HIV infection.

The reaction of governments and multiple organisations to the HIV / AIDS crisis must understand and uphold human rights. In all instances of persons dealing with HIV / AIDS, a fundamental violation of different human rights can be clearly seen. All citizens, even the most vulnerable, must have access to reliable HIV / AIDS information and should have fair access to HIV / AIDS services. In particular, HIV testing must be available to everyone, since testing is perceived to be the entrance point for access to anti-retroviral medications and other essential treatment facilities. Sincere attempts must be made to improve research and to provide connexions to both prevention and treatment.

HUMAN RIGHTS OF WOMEN

De facto and de jure discrimination against women leaves them overwhelmingly vulnerable to HIV / AIDS. One of the root causes of the increasingly growing incidence of infection among women is women's subordination in the family and in public life. In social , economic and personal terms, structural sexism based on gender often impairs the capacity of women to cope with the effects of their own illness or infection in their families.[47]

With regard to infection prevention, equal access to HIV-related information , education, means of prevention, and health services should be applied to the rights of women and girls to the highest attainable standard of physical and mental health, to education, to freedom of expression, to freely receive and impart information. However, even where such knowledge and resources are available, women and girls are often unable to discuss healthy sex or avoid the HIV-related implications of their husbands' or partners' sexual activities as a result of social and sexual subordination, relationship-related economic dependency and cultural attitudes. The protection of women and girls'

[47] Report of the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery of the Advancement of Women, convened by the division for the Advancement of Women,Vienna,24-28 September 1990 (EGM/AIDS/1990/1)

sexual and reproductive rights is, thus, crucial. This includes women's freedom to openly and responsibly exercise power over and decide, free of coercion, discrimination and abuse, on topics pertaining to their sexuality, including sexual and reproductive health.[48] In family and public life, measures to eliminate sexual violence and coercion against women not only protect women from violations of human rights, but also from HIV infection that may result from such violations.

Abuse against women in all its manifestations increases their susceptibility to HIV infection during peacetime and in conditions of conflict. These include, but are not limited to, sexual assault , rape (marital and other) and other types of forced intercourse, as well as traditional practises affecting women's and children 's health. States have a duty to protect women in both public and private lives from sexual abuse.

In addition, states should ensure women's rights to, inter alia, legal capacity and equality within the family in matters such as divorce, inheritance, child custody, property and employment rights, in particular equal pay and employment rights, in order to empower women to leave relationships or jobs that threaten them with HIV infection and to cope if they or their family members are infected with HIV / AIDS. In order to reduce the risk of HIV infection, women should also be able to have fair access to economic opportunities, including credit, sufficient living conditions, participation in public and political life, and the advantages of scientific and technical advancement.

Predominant myths regarding HIV transmission and epidemiology also undermine HIV / AIDS prevention and treatment for women. There is a tendency, regardless of the cause of infection, to stigmatise women as "vectors of illness". As a result, in both public and private lives, women who are or are considered to be HIV-positive face harassment and discrimination. In order to encourage or force their customers to wear contraceptives and have little to no access to health care services without support for prevention practises, sex workers often face mandatory testing. Many woman-focused HIV / AIDS services are geared at pregnant women, but these services also highlight punitive interventions, such as obligatory pre- and post-natal testing accompanied by compulsory abortion or sterilisation, aimed at the risk of HIV transmission to the foetus. Such interventions rarely allow women, through pre-natal preventive education and the

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[48]Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, 415 September 1995 (A/CONF. 177/20).

option of available health facilities, to avoid perinatal transmission and to overlook their needs for care.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) allows the State parties in law, policy and procedure to discuss all facets of discrimination dependent on gender. States are also required to take appropriate measures to change social and cultural patterns that are based on ideas of male and female superiority / inferiority and stereotyped roles. The Convention 's monitoring Committee on the Elimination of Discrimination against Women has underscored the link between the reproductive role of women, their social subordination and their increased vulnerability to HIV infection.[49]

HUMAN RIGHTS OF CHILDREN

India has the third-largest population living with HIV/AIDS[50], and amongst them, children have emerged as a significant group. While there are no current official estimates of children living with HIV in India, we are to accept that approximately 100,000 children in India are HIV-positive[51]. These estimates do not indicate, however, that the number of children affected by HIV / AIDS is much higher than those who are infected. There are apparently another fifty affected for any child that is sick. They have an HIV-positive parent or have been orphaned by AIDS. Some of India's high-prevalence HIV states, such as Karnataka, Tamil Nadu , Andhra Pradesh, Maharashtra, Manipur and Nagaland, are grappling with increased numbers of HIV and AIDS infected and affected children.

The condition and needs of orphans and disabled children, both afflicted and affected by HIV and AIDS, must also be investigated. There are a vast number of children who, in this sense, are mostly left to fend for themselves. They first lose one parent(s) to the disorder, or both, and are then confused because of their stigmatization. Children who are neither infected nor 'double orphans' are exempted from the scope of law and regulation. In paradigmatic cases, after having lost their father to infection, these infants, called single orphans, live with their widowed mother. In order to provide for

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[49] CEDAW, General Recommendation No. 16 (ninth session, 1990). Official Records of the General Assembly, Forty-fifth Session. Supplement N0. 38 (A/45/38), chap IV.

[50] Department of AIDS Control, Ministry of Health and Family Welfare, Government of India, Annual Report 2009-10.

[51] UNICEF, 2007, Barriers to Services for Children with HIV Positive Parents, July 2007, p. 1.

their ailing mother, these children are forced to give up their property rights following their father's death and even their education.When both parents are positive, their conditions deteriorate and they survive under the intense threat of losing both parents. In such a context, the only choices left for their treatment and safety are often either hostels or grandparents facing major constraints on their ability to care for these kids.

Children who have lost the virus to both parents and remain with their grandparents are also not properly cared for. While children are nurtured to the best of their ability by grandparents, their own wellbeing is also an impediment. A child-headed household is a disturbing result of this, where "the very young end up looking after the very old”[52]. Children are dropped out of school and are forced to take on the task of adults to care for the family. HIV is a stigmatised illness because, after the death of both parents, these children suffer from considerable guilt because bigotry and, while pessimistic, others are also considered HIV-positive. Extended relatives, such as aunts and uncles, often also play the role of caregivers for these children, but in those circumstances, there are no practical arrangements for them. In these circumstances, the provision of some sort of subsistence (for example, pensions) and other family reinforcing steps are becoming necessary. Children's health stability and dietary growth may also be compromised by the demands of caring for additional kids.

Kids are cared for in shelters and nursing homes in the absence of primary and family caregivers, as non-institutional options such as adoption and group foster care models also lack definitive funding and are continuously being experimented with. In order to be recognised and licensed and to receive a licence or "fit institution" status, institutional facilities must adhere to a wide range of qualifying regulations. While a variety of such regulations help to include governance structures to address activities such as unauthorized adoptions of shelter homes, the unintentional effect of preventing care facilities with otherwise strong performance histories from obtaining a 'fit institution' status is some of the overall procedural criteria. The shortage of tailored regulatory criteria results in an increasing number of facilities that are not approved which has a negative effect on their finance and functioning.

Children's rights are also covered by all international conventions on human rights and, in particular, by the Convention on the Rights of the Child (CRC), which allows for an

[52]Ibid, p. 26.

international definition of a child as "any human being under the age of eighteen years, unless a majority is reached earlier under the statute applicable to the child."[53] The Indian State is a signatory to the International Conventions on Human Rights and the United Nations Convention on the Rights of the Child in particular. By ratifying different international human rights documents and its own national protection framework, the Government of India is committed to protecting and ensuring children's rights. The Convention on the Rights of the Child (CRC) is an important aspect of the document on human rights. India has been a signatory to the rights of children and the only foreign instrument that combines the full spectrum of legal , political, educational, economic and cultural human rights for children[54]. The Convention reaffirms that children are entitled to all of the rights guaranteed to adults, such as the right to life , the right to non-discrimination, the dignity of the individual, the right to freedom and protection, the right to privacy, refuge, speech, association and assembly, education and health, in addition to the specific rights defined by the Convention for children.

Talking about the human rights violations of the children in the context of HIV/AIDS, it is heartening to note that the innocent children of these HIV parents are denied admissions in educational institutions and in cases they are already admitted, these children are thrown out of the schools the moment they come to know about the HIV positive status of their parents, yielding to the pressure exerted by the parents of other children.

Many of these rights are essential to children's prevention, treatment and support for HIV / AIDS, such as freedom from slavery, prostitution, sexual exploitation and sexual abuse, as sexual violence against children raises their exposure to HIV / AIDS, among other things. The freedom to seek, obtain and impart knowledge and ideas of all kinds and the right to education give children the right to provide and receive any information related to HIV needed to prevent infection and, if infected, to cope with their status. Children who are orphaned by HIV / AIDS shall be protected by the right to special treatment and assistance if they are stripped of their family environment, including alternate care and protection during adoption. In the form of HIV / AIDS, the right of vulnerable children to the full and the abolition of traditional practises that are harmful

[53] Article 1 of the Convention on the Rights of Child, 1989.
[54] The four core principles of the UNCRC are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child.

to the welfare of children, such as early marriage, female genital mutilation, deprivation of equal sustenance and inheritance for females, are also highly important. Under the Convention, children living with HIV / AIDS should be empowered to engage in the creation and execution of HIV-related services for children with the right to non-discrimination and privacy for children living with HIV / AIDS and, eventually, the right of children to make decisions in their own growth and to share views and take them into account in making decisions about their lives. A rights-based policy has been introduced by the Government of India to address the issue of children's rights and rights in the context of HIV and AIDS. At present, however, various states have devised different policy solutions to the problem and there are enormous differences between these proposals and their execution on the ground. A coherent national strategy embracing both the therapeutic and non-clinical aspects of health care as it impacts children is desperately needed.[55]

CONCLUSION

The HIV/AIDS people suffer many discriminations and humiliations almost in every sphere of their lives. Once identified as HIV positive, they face rejections and refusals in the society and are subjected to social isolation and social ostracization too. The emergence of human rights consciousness, brought revolutionary changes in the strategies of the modern governments towards the HIV/AIDS epidemic. This disease can be effectively contained only with the adoption of human rights approach and abandoning the hitherto followed traditional public health approach that ignored the human rights of the HIV people. It is high time this traditional approaches must give way to human rights approaches. These traditional approaches, instead of containing the problem, further aggravated the discrimination against the people living with HIV/AIDS. This novel human rights strategy perceives the AIDS as a human rights issue unlike the traditional perception of public health issue. Any strategy adopted must be concerned with respecting the rights of these HIV people. It must be the duty of every government to equip individuals to take appropriate decisions by educating them and to provide the necessary information to increase their level of awareness of AIDS, because the victims are unaware of this terrible disease.The State must ensure that no person shall be discriminated against in accessing employment, health, education and

[55] www.ncpcr.gov.in.

other services based on their HIV status, actual or perceived. Similarly persons associated with or perceived to be at risk of HIV infection should not be discriminated against. Discriminations against PLHAs in the healthcare sector represents a direct threat to their right to life.

CHAPTER 3

RIGHTS OF HIV/AIDS PATIENTS: A CONSTITUTIONAL PERSPECTIVE AND JUDICIAL RESPONSE

"AIDS is no longer [just] a disease. It is a human rights issue."

- *Nelson Mandela*

A 'right' is the name given to the advantage a man has when he is so circumstanced that a general feeling of approval, or at least of acquiescence, results when he does, or abstains from doing, certain acts, and when other people act, or forbear to act, in accordance with his wishes; while a general feeling of disapproval results when any one prevents him from so doing or abstaining at his pleasure, or refuses to act in accordance with his wishes.[56]According to Holland, creation and protection of legal rights is the immediate object of law. Therefore central to the study of law is the analysis of Rights and Obligations.[57]

During eighties, HIV/AIDS was being recognised as a health hazard which assumed epidemic proportion. Goa was one of the early states which recognised the threat which HIV/AIDS posed. Presence of sizeable number of foreign tourists hastened the process and Goa legislated to contain the spread of AIDS. Provisions were made for mandatory notification without guarantee of confidentiality, quarantine and isolation. The Act was named the Goa, Daman and Diu Public Health Act, 1985.According to this Act, the Public Health Officials and the police were empowered to isolate individuals who were found to be HIV positive. It was in February,1989 that a resident of Goa named Dominic D'sousa was taken to police custody and detained for 64 days. He moved the Bombay High Court in the case of *Lucy D'Sousa V.State of Goa*,[58] praying for quashing the legislation. But the High Court upheld the Act. In the light of this conclusion can be drawn that the Act is a criminal law. More explicitly, being an HIV positive patient means that the infected person attains the status of a criminal without knowing even the cause of infection. However, during those days, HIV infected persons were mostly homosexuals, drug abusers and sex workers. These individuals were / are being viewed as antisocials in nearly all countries and culture had only concern for their disease.The situation now has changed.To be HIV infected is no longer treated as a criminal offence.

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[56] Holland on Jurisprudence,Edn.13,Chapter VII,Pg.82.
[57]See Holland on Jurisprudence,Edn.13,Introduction by Prof.N.R.Madhava Menon.
[58] AIR 1990 Bom 355.

It is because of the reason that it interferes with the policy decision to control AIDS.The present policy is to contain the spread of HIV/AIDS and also to take care of the infected persons. As a result, a balance has been drawn that respects the interests of patients with AIDS and their obligations to society.

It has been accepted that a seropositive person has the right to his body 's freedom and integrity. This is crucial because high-risk groups are required to perform testing. They can call it a human rights infringement. It implies that even a person from high-risk groups must give his testing consent. Forced testing may be regarded as an illegal intrusion into the body and may be invoked by Tort Law. Such consent shall be an informed one. Before testing, a patient must be advised that the results may severely affect his physical and mental health. However, in *Hills V. Potter*,[59]the Court rejected the tort of battery and held tort of negligence as appropriate.In USA the Courts have upheld compulsory testing of persons charged with sexual offences or suspected drug abusing. It was argued that such tests were intended to prevent HIV / AIDS from spreading and were relatively non-invasive.

The Constitution of India, 1950 guarantees to every citizen of the country justice, liberty and equality.The rights of HIV/AIDS infected persons under the Constitution of India can be discussed as below:

THE CONCEPT OF EQUALITY

Article 14 of the Indian Constitution guarantees the right to equality before the law.It reads as follows: “The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.”[60]Therefore the Constitution of India provides that all citizens are equal before law.This right is guaranteed irrespective of race,colour,religion,language,region, or political opinion.This right also provides freedom from discrimination based on social status.However, the HIV/AIDS patients have different stories to share.

An underlying sameness or likeness is indicated by equality. People should hold the same advantages on the grounds of this sameness and should enjoy equal rights, along with the accompanying obligations. Discrimination is antithetical to equality.Article 14

[59] (1984)1 WLR 641.
[60] Article 14 of the Indian Constitution,1950

of the Constitution of India guarantees equality to all persons within the territory of India.[61] The first expression 'equality before the law', which was adopted from the Irish Constitution, is a declaration of the equality of civil rights of all persons within the territory of India.[62] The second expression 'the equal protection of the laws', which is based on the last clause of Section 1 of the Fourteenth Amendment to the Constitution of the U.S.,[63]mandates that equal protection be secured to all persons in the enjoyment of their rights and liberties without discrimination or favoritism.[64]

The governing principle of Article 14 is that all persons and things equally circumstanced shall be treated alike both in rights granted and responsibilities levied.[65]Concurrently, people who are placed in unlike circumstances cannot be treated on par. Accordingly differential treatment does not per se constitute a violation of Article 14. In fact, the Supreme Court has held that to treat unequals differently according to their inequality is not only permitted but also required.[66]Thus, Article 14 permits the enactment of legislation that applies equally to all persons in a group situated differently than others. This is known as permissible legislative classification and to be valid must pass the tests as laid down by the Supreme Court.[67] This classification must also be rational, as it would be violative of Article 14 if it is arbitrary in any manner, that is, if it is unfair or unjust.[68]

It must be noted, however, that this freedom from arbitrary discrimination is only enforceable against the State, as defined by Article 12 of the Constitution[69], and offers no protection against private actors. The definition of 'State' has been expanded by

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[61] "The State shall not deny to any person equality before the law or equal protection of the laws within the terriitory of India." Article 14, Constitution of lndia.

[62] Special Court Bill, 1978. In Re (1979) 1 SCC 380.

[63]Section 1, 14th Amendment, Constitution of the United States of America: "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

[64]Supra n. 3.

[65] Satish Chandra v. Union of India AIR 1953 SC 250, p. 252.

[66] St. Stephen's College v. University of Delhi (1992) 1 SCC 558.

[67] In order to pass the test, tvio conditions must be fulfilled, namely: (1) the classification must be founded on an intelligible differentia which distinguishes between persons or things that are grouped together from others left out of the group, and (2) the differentia must have a rational relation to the object sought to be achieved. Supra n.3.

[68] Royappa v. State of Tamil Nadu AIR 1974 SC 555.

[69] "In this Part, unless the context otherwise requires, 'the State' includes the Government and Parliament of India and the government and the legislature of each of the States and the legislature of each of the States and all local or other authorities within the territory of India or under the control of the Government of India." Article 12, Constitution of India.

judicial interpretation to include some private entities acting under substantial government control.[70] The Report of the National Commission to Review the Working of the Constitution has recommended that Article 12 be amended to bring within the definition of the State 'any person in relation to such of its functions which are of a public nature'.[71] Yet, even if the Constitution is amended to reflect this recommendation, it will still prove to be difficult to actualise the right of equality against private individuals and organisations, without additional support in enforcement.

Currently, virtually the entire private sector is free to discriminate. In light of increased liberalisation of markets and privatisation in all sectors of the economy, alongside the fact that there is a sharp increase in the number of people seeking health care and/or employment in the private sector, law and policy needs to address this community immune to the constitutional guarantee of equality. Though employment in the private sector is covered to a limited extent by law,[72] discrimination in employment or private health care remains unregulated. The rampant private discrimination evident particularly in the context of the HIV/AIDS epidemic calls for immediate legal interventions.

Females are yet to be viewed as equal to their males in our social system. Similarly, girls still continue to be abused. It was not necessary to end the vilified tradition of child labour. Girls are being sold off by their parents to pursue a life of vice. HIV / AIDS patients are an additional strain which society is struggling to adapt, taking into account all these social factors. There is and will continue to be violence against HIV / AIDS patients until a social climate is established where empathy for human misery is given its due share.

Articles 15 and 16 protects them against various forms of discrimination. HIV/AIDS infected persons shall not be discriminated on any grounds and they shall be given equality of opportunity in matters of public employment as per Article 16 of the Indian Constitution. Right against discrimination is a fundamental right available to a citizen

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[70] " The question for determining if a body is a State in each case would be whether in the light of the cumulative facts, as established, the body is financially, functionally and administratively dominated by or under the control of the Government. Such control must be particular to the body in question and must be pervasive: Pradeep Kumar Biswas v. Indian Institute of Chemical Biology (2002) 5 SCC 111, p.134.
[71]The Report of the National Commission to Review the Working of the Constitution, March 2002. Available at http://lawmin.nic.in.
[72]See: Equal Employment Act, 1976 and the Minimum Wages Act, 1948.

of India. No one shall be discriminated on the basis of his HIV/AIDS status in India. They have a right of equal treatment everywhere, and they cannot be denied job opportunities or discriminated in employment matters on the ground of their HIV/AIDS status.

In the case of *Common Cause v. Union of India and Ors*[73],the Supreme Court of India directed all blood banks to upgrade their centres and obtain licenses from a Licensing Authority.It further directed that a National Blood Transfusion Council (NBTC) together with state-level councils be established. However,these Councils are only recommendatory bodies and have no power or authority.

In a landmark judgment in the case of *MX V. ZY*[74], the Bombay High Court has held that no person could be deprived of his or her livelihood except by procedure established by law. It must also be noted that the procedure must be just, fair and reasonable. It further held that if a person is fit to perform his job functions and is otherwise qualified and does not pose a substantial risk to the fellow workers, then he cannot be denied the job. Further the Court held that a public sector employer cannot refuse an individual's jobs simply because he is HIV positive. It is important to decide whether a person is incompetent to do the job by doing an individual investigation, taking into account the state of medical expertise at the time. It was also held that in proper cases where a person can show that he or she would not be able to pursue his or her career if his status is disclosed and in the interest of administration of justice, the Court will permit the party before it to conceal their identity and prosecute or defend the proceedings under an assumed name.

In another case of *G V. New India Assurance Co.Ltd,*[75]the Bombay High Court has held that a person who is otherwise qualified may not be refused jobs solely on the basis that he or she is HIV positive. Furthermore, the Court held that the HIV status of a citizen could not constitute a basis for denial of jobs, because it would be discriminatory and would infringe the right to equality under Articles 14 and 16 and the right to life under Article 21 of the Indian Constitution.

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[73] (1996)1 SCC 763.
[74] AIR 1997 Bom 406.
[75] (1999)3 SCC 754.

In the case of *S V. Director General of Police*[76], where the widow was denied compassionate employment because her husband had died of AIDS, the Bombay High Court has held that there should be no delay in appointment in all claims of compassionate employment. If there does not exist an appropriate post, a supernumerary post for the applicant within eight weeks and deem her case for grant of service quarters on priority basis in compliance with the law.

In the case of *Mr.X,Indian inhabitant V. Chairman,State Level Police Recruitment Board and Ors.,*[77] the Andhra Pradesh High Court has held that it is in breach of Articles 14 and 16 of the Constitution of India that all HIV-positive individuals are regarded as a single homogeneous community, regardless of the stage of the disease, for refusing to be assigned to the police force. In such conditions, certain people found to be HIV positive may be ineligible for jobs in the police force does not justify the exclusion of all people living with HIV from work. A law that denies the HIV infected person jobs purely on the grounds of his HIV status regardless of his ability to meet the work criteria and regardless of the fact that he or she is HIV-positive, irrespective of the fact that he does not pose any threat to others at the workplace is clearly arbitrary and unreasonable and infringes the whole-some requirement of Article 14 as well as Article 21 of the Constitution of India. Therefore, the court held that the denial of employment to Petitioner, who had fulfilled prescribed physical and other standards, only because he was tested HIV positive impaired his dignity and constituted unfair discrimination. Thus, no person could be denied employment solely on ground that he had tested HIV positive.

RIGHT TO PRIVACY

The right to privacy is included in Right to Life and Personal Liberty under Article 21 of the Constitution of India. Article 21 states that "No person shall be deprived of his life or personal liberty except according to procedure established by law." 'Privacy' is being described as "the state of being free from intrusion or disturbance in one's private life or affairs."[78] Privacy is not an absolute right and is always subjected to reasonable

[77] W.P. No. 15981 of 2005, 2006(2)ALD513, 2006(2)ALT82, 2006(8)SLR588.
[78] Distt. Registrar & Collector V. Canara Bank, 2005 (1) SCC 496.

restrictions. Right to privacy of a person is the right to decide for themselves where, how and to what degree information about them is conveyed to others.

RIGHT TO TREATMENT/HEALTH CARE

People suffering from HIV/AIDS have the equal rights of treatment just as any other person suffering from any other ailment. Their right to treatment and proper care cannot be detained on the ground of their HIV positive status. Any denial towards the proper treatment and due care of HIV positives will amount to the act of discrimination. The Supreme Court of India has issued various directions for the free of cost treatment of HIV/AIDS to those who need it.

Discrimination is particularly prevalent in the health care sector in India. PLHAs are often refused treatment and surgery, denied admission to hospitals or charged additionally for basic services.[79]PLHAs have also been subject to mandatory pre-admission testing and consequently stigmatised by having their hospital beds tagged with 'HIV-positive' or being isolated in special wards with a lower quality of care.[80] By refusing to handle items used by HIV-positive patients, including utensils and bed sheets, and covering only the bodies of patients who died from AIDS-related complications in quarantine bags, health care providers add to the stigma of bigotry that has grown around HIV / AIDS. Inside the health system, these and other indirect ways of prejudice, such as making HIV-positive patients wait longer for treatment than others, threaten to intensify the outbreak.

Discrimination in health care is critical to address for a variety of reasons. Most important, the right to health is enshrined in most constitutions as an aspect of the right to life[81]; thus any barrier to equal access to health care that can be overcome must be dealt with by the State.[82] As such, several countries have policies and guidelines, which promote the health care workers' 'duty of care' and prohibit discrimination of any kind against HIV-positive patients.[83] One of the strategies many countries have used to pre-

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[79] This information is based on news reports and anecdotal data collected by the Lawyers Collective HIV/AIDS Unit.

[80] North Shore University Hospital v. Rosa 194AD 2d 727 [New York Court of App.].

[81] See: Soobramoney v. Minister of Health (Kwazulu-Natal) CCT 32/97.

[82] This is also true in terms of housing; in the U.S.. discrimination in access to housing for PLHAs has been found to be a violation of the right to life. Hill v. Community of Damien of Molokai 911 P. 2d 861 and Stewart B. McKinney Found Inc. v. Town Plan and Zoning Commission 790 F. Supp. 197.

[83] Bragdon v. Abbott 118 S. Ct. 2196 extended the duty to treat HIV-positive patients to private clinics as well as public hospitals.

empt discrimination in health care has been to mandate the use of universal precautions by all health care practitioners irrespective of the patient's serostatus. This policy also eliminates the need for mandatory testing before admission to a hospital.

Another reason to curb discrimination against PLHAs is to maintain a health sector that will continue to treat and care for the sick.The sheer fear of infection and subsequent stigmatisation and discrimination often prevents health care workers from treating HIV-positive patients. One of the most widely recognised ways to avoid discrimination of PLHAs is to protect the rights of health care workers.While there is a common law duty of the employer to provide a safe working environment, it is rarely enforced.The Constitution casts an obligation on the state under Part IV to improve public health vide Articles 38, 39(e) & (f), 42, 47 and 48A. Duty is upon the state for raising the standard of living[84] and improvement of public health.[85] Providing medical benefits and support to people suffering is one of the essential functions of the State and its authorities and various agencies.

Constitution envisages the establishment of welfare state where the primary duty of Government is to secure the welfare of people by providing adequate medical facilities to them, which is done by running hospitals and health care, providing medical care to the people seeking to avail those facilities. Failure to provide timely medical treatment to a person in need of such treatment violates Right to life guaranteed under Article 21 of the Constitution of India.[86]

The Right to equality of treatment to the HIV/AIDS patients have been guaranteed under Article 14 of the Constitution of India,1950. Articles 15 and 16 protects them against all forms of discrimination. Article 39 cast a duty upon the States to ensure right to livelihood to all the citizens including the HIV/AIDS patients, in order to prevent discrimination.

In the matter of *LX v. Union of India*[87], LX, an undertrial prisoner who was tested HIV+ was denied antiviral therapy (ART) against AIDS after his release from the prison.The Delhi High Court ordered the government to continue to provide LX with ART.

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[84] Article 25(1) of the Universal Declaration of Human Rights guarantees the right to a standard of living adequate for health and well-being.
[85] Consumer Education Research Centre V. Union of India,AIR 1995 SC. 922.Para 20 at Page 938.
[86] Paschal Banga Kheta Mazdoor Samity V. State of West Bengal,AIR 1996 SC 2426.
[87]CWP – 7330/2004, Delhi High Court.

Following the Government of India's commencement of the ARV roll-out in April 2004, the High Court ordered the Government to give ART to LX under the ARV roll-out scheme and to refund AIIMS for the costs incurred by them.

RIGHT TO CONFIDENTIALITY

Article 21 of the Indian Constitution provides for the fundamental right to life and liberty.Article 21 does not confer positive rights but protects a person from state action that infringes the right to life and liberty,except that authorised by law.The right to personal liberty under Article 21 has been interpreted,subject to exceptions,to include the individual's right to live with dignity and to safeguard his/her privacy.[88] The definition of confidentiality is related to and stems from the universal right to privacy, that any citizen has the right to a field of activity and personal information that is exclusive to him / her and that he / she has the right to reveal or not to disclose this information if he / she feels in his / her best interest. Any person who has been distinguished to have HIV/AIDS has the right to keep their HIV/AIDS status private. There are several holdings where the Courts have given judgment in favor of HIV positives.Thus,Courts have also found that the right to confidentiality is vital in cases of HIV/AIDS.This has been done by balancing the public interest to maintain confidentiality against the public interest to disclose.Courts have held that HIV positive status falls within a legally recognized zone of privacy and that involuntary or non-consensual disclosure of HIV test results could undermine the public health interest as it discourages persons from getting themselves tested for HIV.[89] Where a newspaper disclosed that doctors in a hospital were HIV positive and threatened to disclose their names,the hospital obtained an injunction for the same from the court.The court found that the public interest in preserving the confidentiality of the doctors with HIV outweighed the public interest in the freedom of press to publish such information and that the latter public interest would not be impeded due to non-disclosure of the names.[90]They are allowed to use pen names before the Court in order to hide their identity. A person diagnosed with HIV / AIDS has the right to keep his or her HIV / AIDS status confidential. Even the Courts have made clear that if they do not want to

[88] Kharak Singh v. State of U.P,AIR 1963 SC 1259.
[89] Jeffrey H. v.Imai,Tadlock & Keeney et al.2000 Cal.App.LEXIS 932
[90] X v. Y,[1988]2ALL ER 648,QBD

disclose their identity, they can use a pseudonym to suppress their identity before the Courts.

Courts have also held that there is an apparent public interest in preserving the confidentiality of those who are HIV-positive, particularly health care workers who report that they are HIV-positive.If health care workers are to be encouraged to notify their status then all care must be taken to protect the confidentiality of such reports.[91]

In *Mr. X v. Hospital Z* [92],the Supreme Court impounded that anyone suffering from this epidemic deserves complete sympathy and respect just like any other human being. The denial of job opportunities for HIV patients is unjust and unlawful. Further, it was held that even though it is the right of the patient to keep his status of HIV private, the right to confidentiality can be enforced in situations where the patient is at the risk of transmitting the disease to his/her spouse.The Court,however,failed to lay down any conditions and protocols by which such disclosure was to be made.It also added that an HIV positive person who marries and transmits the infection to the spouse would be criminally liable under Sections 269 and 270 of the IPC which criminalise those who perform a negligent or malignant act likely to spread a disease dangerous to life.

In the above case subsequently a petition[93] was filed by Lawyers Collective HIV/AIDS Unit on behalf of appellant X,before a three-judge bench of the Supreme Court seeking clarifications and challenging its judgment in the year 1998,wherein the court regarded the right of a PWHA to marry a suspended right.The petition emphasized that the right to marry is a constitutionally protected right subsumed under the rubric of personal liberty.The petition also refers The Universal Declaration of Human Rights of 1948 and the International Covenant on Civil and Political Rights of 1966,which recognize a fundamental human right to marry and raise a family.[94] The learned three-judge bench expunged the observations made previously in this regard and restored the rights of an HIV infected person to marry.This opinion is laudable and a welcome step towards the rehabilitation of the HIV victims.However, it further held that this does not take away

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[91] HIV/AIDS v.Associated Newspaper Ltd. And H v.N [2002]EWCA Civ 195.
[92] AIR 1999 SC 495.
[93] 2002 SOL Case No.657
[94]http://www.lawyerscollective.org/lc-hiv-aids/positive_dialogue/newsletters_1.htm,Online Newsletters.

from the duty of those who know their HIV+ status to obtain informed consent from their prospective spouse before marriage.

In the case of *R.Rajagopal v.State of Tamil Nadu*[95],the Supreme Court of India discussed the right to confidentiality in the context of the publication of biographies, wherein it was held that, none can publish anything concerning matters regarding family, marriage, procreation, motherhood, child-bearing and education without his consent whether truthful or otherwise and whether laudatory or critical.

In India, the blood banking system is anonymous and linked and the donors can be traced to inform them of the possibility of infection. Records of donors are kept with the blood bank for 5 years. The National Blood Policy, 2002 has not addressed the issue of confidentiality except in the limited sense of developing a donor database for ready access and keeping the identity of the donors confidential.

RIGHT AGAINST DISCRIMINATION AND RIGHT TO EMPLOYMENT

The HIV positives, just like any other citizen of India, possess the right against unjust and prejudiced treatment. They cannot be denied employment and cannot be dismissed from their current employment on the ground that they are HIV /AIDS patients.

In the context of employment, People living with HIV/AIDS (PLHAs) are often denied jobs at the time of selection on account of their HIV status.[96] HIV-positive employees are discriminated against by their co-workers and employers and are frequently terminated from employment altogether.[97]Discrimination is also more nuanced and HIV-positive jobs are steadily degraded or retained on payrolls, but are asked not to report to the workplace. One research on HIV-related discrimination in India found that workplace discrimination mainly takes the form of rejection of the HIV epidemic.Hence, not only do companies terminate HIV-positive employees as a matter of course, they also regularly deny compassionate employment and other benefits such

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[95] (1994)6SCC632

[96] Re: "Alain L", File #8706004809-0001-0; COM-327-8.1.1.14 (Quebec H.R.C.).

[97] " Canadian Pacific Ltd. v. Canadian Human Rights Commission (1990) and Pacific Western Airlines Ltd. v. Canadian Air Line Flight Attendants Association and S.T.E. v. Peter Bertelsen (I989), 10 C.H.H.R D/6294 (Alta. Bd. of Inquiry).

as provident fund and gratuity to survivors of deceased HIV-positive employees." [98]The key areas involving conflict in the right of employment of people living with HIV/AIDS and the doctrines applied by the courts to see if there is any discrimination are discussed in detail below.

Fitness and Qualification

An evaluation of medical fitness is critical in ensuring that PLHAs do not face discrimination. In the U.S., this is embodied in the term 'otherwise qualified'.According to School Board of Nassau County v. Arline,[99] as per the Rehabilitation Act, if a handicapped person, is otherwise qualified, meaning fit to perform her/his job and there is no substantial risk of transmission after reasonable accommodations have been made, she/he cannot be discriminated against or dismissed from employment. In *Chalk v. United States District Court Central District,[100]* an HIV-positive teacher who was barred from the classroom and reassigned to an administrative position filed a discrimination action against the school district. The court weighed the hardships of the employee and the employer, and held that the mere theoretical risk of transmission of HIV was insufficient to overcome the fact the petitioner was still capable of teaching and the denial of his employment would amount to irreparable harm.

The South African Constitutional Court in *Hoffman v. South African Airways*[101]explored the concept of medical fitness as a strategy to assess an HIV-positive employee or applicant's qualification to work or continue to work. Because HIV/AIDS is a progressive disease of the immune system, there are several stages in the course of an untreated HIV infection. After the window period, which can last for up to six months after infection, there is an asymptomatic stage during which the immune system is competent and the infection is clinically silent. It is not until the CD4+ count drops below 300 cells per microlitre of blood that the immune system becomes suppressed to the extent that the person becomes vulnerable to secondary infections and if left untreated, progresses to AIDS. The court noted that:

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[98] See: Bharat, Shalini, et al, India : HI V and AIDS related Discrimination, Stigmatization and Denial. UNAIDS Best Practices, Key Material. UNAIDS/01.46E (Geneva : UNAIDS, August, 2001).

[99] (I987) 480 US. 273; See also: Raintree Health Care Centre v. Illinois Human Rights Commission et al 655 N. E. 2d 944.

[100] Chalk v. United States District Court Central District (1987) F 2d 701.

[101] Jacques Charles Hoffmann v. South African Airways CCT 17/00 (28 September 2000).

"During the asymptomatic phase, HIV infected individuals are able to maintain productive lives and can remain gainfully and productively employed, particularly if they are properly treated with anti retrovirals and prophylactic antibiotics appropriate to their condition."[102]

Similarly, in the context of education, it was found in the U.S. that if there is a remote theoretical risk of transmission of HIV and the student is otherwise qualified to be educated in a classroom, she/he couldn't be excluded from regular classes.[103] It has also been held in the U.S. that unless there is a significant risk of transmission, it is unlawful to prevent an HIV-positive student from attending a school's regular education classes and participating in extracurricular activities.[104]However, students of dentistry or dental hygiene who test positive for HIV may be barred from completing their education which involves a large number of invasive procedures that pose a significant risk.[105] In another U.S. case, it was held that it is a form of employment discrimination to bar HIV- positive students or staff members of an educational institution from' accessing public documents.[106]

Doctrine of Significant Risk

The main mechanism that U.S Courts have devised to assess if discrimination has occurred or is justified is 'significant risk'. If there is an eminent risk of transmission to co-workers, then the HlV-positive employee is not protected by the ADA, thus it is not considered discriminatory to terminate her/him.[107] Conversely, if there is no significant risk of transmission, it is a violation of the ADA to remove an employee from her/his position.[108] A regulation of the Equal Employment Opportunity Commission, which administers large sections of the ADA, allows businesses to refuse to hire a worker if that worker would pose a direct threat to the health or safety of other individuals or of the individual himself.[109]

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[102] Ibid.
[103] Eliana Martinez v. School Board of Hillsborough County - Florida 861 F. 2d 1502.
[104] John and Mary Doe (parents of student no. 9387) v. Dolton Elementary School District No.148 694 F. Supp. 440.
[105] Doe v. Washington University 780 F. Supp 628.
[106] Racine Unified School Dist v. Labor and Indus Review Commission 476 N. W. 2d 707.
[107] Spencer Waddell v. Valley Forge Dental Associates Inc. 276 F 3d 1275; John Doe v. University of Maryland Medical System Corporation CA-9292832 HAR.
[108] Doe v. Oregon Resorts 2001 U.S. Dist. Lexis 17449.
[109] Equal Employment Opportunity Commission 29 § C.F.R. 1630.15(b)(2) (2001).

In Canada, in *Simon Thwaites v. Canadian Armed Forces,*[110]the court found that significant risk can best be measured in the context of a particular job and then only in comparison with other risks posed by that workplace. In this way, other tolerable risks arising from the employment establish risk thresholds. If risks of comparable magnitude are acceptable in a particular work environment, then risks posed by a person who is HIV-positive cannot be considered significant. Ultimately, the court held that terminating Thwaites on the basis of his HIV status was discriminatory as he posed no relative significant risk and was medically fit.

Hoffman also held that the constitutional right not to be unfairly discriminated against could not be determined by ill-informed public perception of persons with HIV. The denial of employment to a PLHA impairs her/his dignity and constitutes unfair discrimination, violating the right to equality guaranteed by Section 9 of the *South African Constitution*.[111] Ill-informed public perception is a crucial element of the causes of discrimination against PLHAs. Effective legislation designed to address this issue must include mandates on the State to raise public awareness and disseminate accurate information about HIV/AIDS.

Doctrine of Reasonable Accommodation

When an employee is found to be HIV-positive or living with AIDS but does not pose a significant risk in a particular employment, and is otherwise qualified, the doctrine of 'reasonable accommodation'[112] applies. In the U.S., recipients of federal funds including postal services must provide reasonable accommodation to handicapped employees as long as it does not cause undue financial or administrative hardship for the employer.[113]

There are two approaches on the issue of reasonable accommodation. First, if the employee is HIV-positive and does not pose a significant risk of transmission, she/he can demand reasonable accommodation so as to prevent economic disability, particularly if she/he has progressed to a stage of illness where she/he is too sick to

[110] (1994) CLLC 17040.
[111] Supra n. 32.
[112] According to the ADA, there are two components of the obligation to reasonable accommodation: either altering the physical environment to make it accessible to and usable by the individual with disabilities, or altering the job so that its essential functions can still be performed by that person.
[113] Buckingham v. United States of America and ors. 98 F 2d 735. See also: David Wilding v. British Telecomunications Plc (2002) EWCA Civ 349; C. S. Jones v. Post 0157a: (2001) EWCA Civ 558 for reasonable accommodation in the context of general ill health.

work. From the other perspective, as long as the employer provides reasonable accommodation with comparable hours and pay, it is not considered discrimination to change an employee's position in the organisation.[114] However, employers must concretely show that the employee poses a significant risk to the organisation and/or they tried to reasonably accommodate the employee without undue financial or administrative burden to defend allegations of discrimination successfully.[115]

Another critical issue in the context of employment discrimination is the impact of mandatory HIV testing. Pre-employment mandatory testing itself amounts to discrimination based on arbitrariness and a lack of rational nexus. That is, if the aim is simply to collect proof that the individual is HIV-seropositive, an employer does not have the right to request a medical test.[116] Further, it is discriminatory to demote an employee on the assumption of positive serostatus and demand an antibody test to confirm an allegation.[117] When recruits are enlisted into the armed forces, they are often required to undergo medical examinations including mandatory HIV tests. If the recruit tests positive, it is discriminatory to discharge him on the basis of his serostatus. Australian as well as Namibian courts have found that dismissing or excluding an officer or recruit on the basis of his HIV status constitutes unfair discrimination.[118]

In India, as around the world, HIV specific anti-discrimination judgments have primarily dealt with employment, health care and the armed forces; the latter two are of Special concern in the Indian context. Following *School Board of Nassau County v. Arline,[119]* in the landmark case *MX v. ZY,[120]* the Bombay High Court held that it is arbitrary, unjust and unlawful to dismiss a worker who is already eligible and fit to meet the conditions of the job, and does not pose a danger to those on the workplace.The courts have also acknowledged that mandatory pre-employment testing is not acceptable. Any rule mandating medical fitness as a prerequisite to employment must

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[114] Equal Employment Opfortunity Commission v. Prevo's Family Market Inc. (Electronic citation 1998 FED App. 0047P (6th Cir)); John Doe v. University of Maryland Medical System Corporation CA9202832 HAR.

[115] Simon Thwaites v. Canadian Armed Forces (1994) CLLC 17040; David Wilding v. British Telecommunications Plc (2002) EWCA Civ 349; C. S. Jones v. Post Office (2001) EWCA Civ 558.

[116] Centre d 'accueil Sainte-Domitille v. Union des employés dc service, local 298 (F.T.Q.) [1989] TA. 439 (Tribunal d'Arbitrage).

[117] Doe v. Oregon Resorts US. Dist. Lexis 17449.

[118] N v. Ministry of Defence (Case no. LC 24/98); X v. Commonwealth of Australia (1999) HCA 63. In X, the case was remanded to the Tribunal to determine whether bleeding safely was an inherent requirement of military service in the context of a soldier's duty to be available for deployment.

[119] 408 So.2d 706 Fla.Dist.Ct.App.1982.

[120] AIR 1997 BOM 406.

have the objective of assessing the person's capacity to fulfil the job's requirements and the extent to which she/he poses a threat or health hazard.[121]Therefore, it is unlawful to terminate an employee on the basis of HIV status unless she/he is not medically fit to do the job or there is a significant risk to the safety of other workers.[122]India is also one of the few places where compassionate employment is granted to survivors of deceased HIV-positive employees of the State, upholding the right to, earn a livelihood under Article 21 of the Constitution.[123]Denying benefits or failing to provide alternate employment amounts to discrimination.[124]It is also unlawful to deny an officer the opportunity of an appointment based on HIV status, unless he is not medically fit to fulfil the responsibilities of the post.

RIGHT TO INFORMED CONSENT

Consent is derived from the right to autonomy. For that right to be protected no medical intervention, for diagnostics or treatment, should be undertaken unless the patient consents to it. Informed consent demands that the patient is informed about his/her condition or the purpose of a diagnostic test, and the risks involved in the medical intervention thereby enabling the patient to make an informed choice about the test or medical treatment.Informed consent is necessary to equalize the imbalance in the relationship of the parties. Consent for any medical intervention should be taken from the patient in writing,be voluntary,full and informed and explained in a language that the patient understands.Consent should be specific to any proposed medical intervention,be it a diagnostic test or treatment.The person giving consent may withdraw it.The patient has every right to refuse and withdraw consent prior to the actual test being conducted.In the case of HIV/AIDS,which attracts extreme forms of stigma and discrimination,only the strictest enforcement of informed consent requirements would justify the conduct of trials within the country and satisfy human rights requirements.

National AIDS Control Organization (NACO) has issued comprehensive guidelines against prescreening tests conducted on prospective employees. Compulsory HIV

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[121] Pt. Paramanand Katara v. UOI and Ors. (1989) SCC 286.
[122] R.M. v. S Pvt. Ltd. (Unreported -The Industrial Court at Mumbai, Complaint no. (ULP) No.864/99).
[123] G. v. NIA Ltd. Writ Petition No. 1562/99 (Interim order dated 24 November 1999- Unreported Bombay High Court).
[124] Ex Const. B.S. v. Union of India and Anr (Unreported – Delhi High Court, CWP NO. 368 of 2000).

testing should not be enforced as a precondition for work or the provision of health services in private enterprises, according to the HIV testing policy. Testing should be performed after receiving informed consent, with pre- and post-test counselling, and should be voluntary.Any health programme that does not maintain the dignity of a patient or deprives him/her of the basic right to income generation,access to medical care or social support based on his/her health status is harmful in the long term.It is important that while formulating a legislation on HIV,voluntary consensual testing should be encouraged keeping in mind human rights of persons,and the defining principles of informed consent for testing and medical treatment.

CONSTITUTIONAL RIGHTS OF CHILDREN AFFECTED BY HIV/AIDS

Constitution of India provides for right to education, right to food, protection from harm, right to health, right to nutrition and right to non-discrimination. According to Article 21 of the Constitution, no citizen shall be denied the right to life and liberty except according to the procedure established by law – protection of a child's life and liberty thus becomes extremely essential in this regard. This also ensures that the right of the infant to survive is essential that includes the right to be alive, to have enough food, good health, and to have a home and family. Under Article 21 A, the task of providing free and compulsory education to all children in the 6-14 age group has been entrusted to the State.[125] In the context of OVC infected and impacted by HIV / AIDS, the State is bound to ensure free and compulsory education for children. Without prejudice, the State must eliminate all obstacles encountered by every child to accessing education, including social and financial obstacles.

In the case of *Maharashtra State Board of Secondary and Higher Secondary Education v. K.S.Gandh[126],*the Supreme Court held that the basic right to education previously recognized under Article 21 and now in Article 21 A, also includes access to education and information on sexual health.The Court observed that education system should be so devised as to meet these realities of life.

Protection from exploitation is provided under Articles 23 and 24, which allow for the abolition of trafficking and forced labour and the abolition of employment in any

[125] Inserted by the Constitution 86th Amendment Act,2002.
[126](1991)2 SCC 716.

factory, mine or dangerous jobs for children under 14 years of age. Similarly, the policy Directive Principles of State Policy account for the right to early childhood treatment, schooling, wellness and nutrition.

CONCLUSION

All persons have the right to equality and equal protection of laws. No person shall be discriminated against in accessing employment, health, education and other services based on their HIV status, actual or perceived. Similarly persons associated with or perceived to be at risk of HIV infection should not be discriminated against. Discrimination against PLHAs in the health care sector represents a direct threat to their right to life. It is also vital that an employee or student cannot be dismissed, removed or denied merely on the basis of HIV status. It is the employer's responsibility to reasonably accommodate any HIV-positive employee who is otherwise qualified to work in a position that is commensurate with his/her qualifications. There must be a rational nexus to mandate HIV testing for accessing employment or other services. Thus, employers cannot arbitrarily test simply to ascertain an employee's HIV status. Discrimination against PLHAs is important to be addressed effectively in order to maintain a health sector that will continue to treat and care for the sick.

Talking about the judicial response to the issues faced by persons affected by HIV/AIDS, the Supreme Court has neither settled the issue conclusively nor has it determined the final rights and duties of the PWHA but has given ad hoc guidelines. Considering the right to marry, the Supreme Court is of the view that it cannot be accepted in absolute terms. A PWHA may have a right to marry, but this right is not without a duty to disclose his medical condition. But this is definitely different from extinguishing or even suspending the right to marry itself. Legally married couples with one or even both of them being HIV+, can be fully prepared both mentally and financially to enjoy marital bliss. Healthy people and health departments must see that the people living with HIV enjoy the same rights of education, marriage, employment and family life along with other common people. Social support is a significant aspect in such circumstances and must be extended through judicial interventions. Society needs to be sensitive towards these people.

The courts must be specially sensitized in dealing with delicate issues relating to HIV patients. All the cases are not identical. Therefore, considering the facts and

circumstances of each case, the courts must carefully evaluate and calibrate the option before imposing any criminal sanctions on such persons. Moreover, AIDS is not the outcome only of sexual indiscipline. Therefore, traditional theoretical bases of religion and criminal law like sins or public morality, must be modified to form a viable and durable strategic, social, and legal fabric.

CHAPTER – 4

INTERNATIONAL LEGAL FRAMEWORK

INTRODUCTION

This chapter explores the relevance of international human rights law in the response to the HIV/AIDS epidemic at national and international levels. In a research conducted by United Nations Programme on HIV/ AIDS ('UNAIDS'), India has the world's third-largest HIV/ AIDS affected population, second only to South Africa and Nigeria.[127] While the global commitment to combat the epidemic has undoubtedly yielded results in the form of a decreasing number of new infections each year [128] and India has not been far behind in this regard;[129] several concerns of people affected by HIV / AIDS, in particular those related to discrimination, mainly on grounds relating to HIV / AIDS, continue to be key policy initiatives.[130]

The office of the High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued the International Guidelines on HIV/AIDS and Human Rights in 1998. These Guidelines were built on expert advice so as to integrate the principles and standards of international human rights law into the HIV/AIDS response.

The Commission on Human Rights in 2001 and again in 2002 confirmed that access to AIDS medication is a crucial component of the right to the highest attainable standard of health, enshrined the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. The Committee on Economic, Social and Cultural Rights, which monitors

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[127] UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS), The Gap Report, 17 (2014), available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf (Last visited on
December 14, 2014).

[128] UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS), World AIDS Day 2014 Report-Fact Sheet, 5, available at http://www.unaids.org/sites/default/files/documents/20141118_FS_WADreport_en.pdf (Last visited on December 14, 2014).

[129] NATIONAL AIDS CONTROL ORGANISATION (NACO), Annual Report 2014-2015, 403 (Discusses how overall, India's HIV epidemic has slowed down, with a 57 percent decline in new HIV infections between 2000 and 2011).

[130] NACO Report, supra note 3, 403 (The five cross-cutting themes that are being focused under NACP-IV are quality, innovation, integration, leveraging partnerships and stigma and discrimination).

the Covenant, in 2000 made clear that the right to health included among other things access to treatment and HIV-related education.

In addition to these specific international human rights instruments, all Member States of the United Nations had adopted a Declaration of Commitment on HIV/AIDS in June 2001 which pledged to scale up the response to HIV/AIDS within a human rights framework. The Ministerial Conference of the World Trade Organization (WTO) held at Doha in November 2001 announced that the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should be understood to encourage public health and enable patents to be overridden if emergencies such as the AIDS outbreak are to be resolved.[131] The amendment, promulgated as the Doha Ministerial Declaration, clarified that members may lift patent protections in a state of emergency and reaffirmed the understanding that member states should not be prevented by WTO rules from taking measures to protect public health.[132] The Doha Declaration specifically recognized that "[e]ach Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those related to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency **...."[133]**In 2003, a second Doha Accord explicitly authorized the use of compulsory licensing to import essential medicines for states without manufacturing capacity,[134] a move that was made permanent in 2005.[135]

That same year, India amended its Patent Act to become formally TRIPS-compliant, but embedded important procedural and substantive protections which may affect the price of ARVs and other essential medicines in India and around the world.[136]

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[131]World Trade Organization,Ministerial Declaration of 14 November 2001,WT/MIN(01)/DEC/2,6-7Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/W/2, Nov. 14, 2001 (01 -5770) at 6 and 17.

[132] Id.

[133] Id at 5(c).

[134] World Trade Organization, Decision of the General Council of 30 August 2003, WT/L/540 and WT/L/540/Corr.1.

[135] Press Release, World Trade Org., Members OK Amendment to Make Health Flexibility Permanent (Dec. 6, 2005), *available at* http://www.wto.org/English/news-e/pres05_e/pr426_e.htm

[136] The Patents (Amendment) Act, No. 15(2005) (India).

In response to these developments, in July 2002, the OHCHR and UNAIDS convened a group of experts to update the International Guidelines on HIV/AIDS and Human Rights.

The United Nations human rights instruments and mechanisms provide the normative legal framework as well as the necessary tools for ensuring the implementation of HIV-related rights. Through their consideration of States reports, concluding observations and recommendations, and general comments, the UN treaty monitoring bodies provide States with direction and assistance in implementing HIV-related rights. The Special Procedures of the Human Rights Council, including special representatives, thematic and country rapporteurs, and working groups also are in a position to monitor respect for HIV-related rights. The Human Rights Council also asks the Secretary-General to seek input from States, United Nations bodies, programmes and specialist agencies as well as international and non-governmental organisations on the measures they have taken to encourage and enforce, where necessary, programmes addressing the urgent HIV related human rights of women, children and disadvantaged communities linked to HIV in the light of prevention , treatment and access

Specific human rights of people living with HIV/AIDS include: the right to non-discrimination and equality before the law; the right to liberty and security of person; the right to privacy; the right to marry and to start a family; the right to education; the right to work, the right to the highest attainable standard of mental and physical health; the right to an adequate standard of living and social security; and the right to enjoy the benefits of scientific progress and its applications.

INTERNATIONAL RESPONSE

In order to safeguard their human rights and prevent the spread of HIV / AIDS, the Union of India has signed numerous conventions, agreements and declarations relating to HIV / AIDS for the protection of the rights of those who are HIV-positive, those afflicted by HIV / AIDS and those most vulnerable to HIV / AIDS. The two conventions that aim at non-discrimination based on creed, political affiliation, gender, or race are the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights(ICESCR). They also cover within their ambit non-discrimination HIV/AIDS affected people.

The Universal Declaration of Human Rights also lays down that the principle of non-discrimination is the basis of human rights law. It equally applies to people who have HIV/AIDS because they have to suffer a very high level of stigma and discrimination. It lays down specific work-related provisions for HIV/AIDS infected people, which includes the right to life, liberty, and security of person, right against forced testing and treatment. The declaration also lays down that all people, including HIV+ persons have the right to work and participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

People diagnosed with HIV+ are also entitled to the rights enshrined in Art. 25(1) of the Declaration of Human Rights, which includes the right to adequate standard of living, medical care and necessary social services, and the right to security in the event of unemployment according to their needs and their treatment choices.

The UNAIDS Guidelines, 1996 emphasizes the duty of the states to engage in law reform. It also directs the states to identify legal obstacles in order to form an effective strategy of HIV/AIDS prevention and care. It also lays emphasis on enactment of anti-discrimination and other protective laws that would protect HIV/AIDS diagnosed people from discrimination in both the public and private sectors and to ensure their privacy, confidentiality, and ethics and will prioritise education and conciliation and allow for speedy and efficient administrative and civil remedies.

United Nations General Assembly Declaration of Commitment on HIV/AIDS.

The United Nations General Assembly's Declaration of Commitment on HIV/AIDS notes that "the full realization of human rights and fundamental freedom for all, is an essential element in a global response to the HIV/AIDS pandemic."[137]

Guidelines on HIV/AIDS and Human Rights.

- Represents the joint recommendations of health , human rights, government and civil society experts, including people living with HIV / AIDS, on how to protect and promote, respect and fulfil human rights in the context of HIV / AIDS.

[137] David Patterson, (2002) international Law, Human Rights and HIV/AIDS HIV/AIDS Legal network, 417 rue saint - pierre, suite 408, Montreal H2Y, 2M4 Canada Ref. No. 02.0365.

- Focused on current concepts of human rights, converted into practical measures that can be taken as part of an appropriate plan for HIV / AIDS.
- They are not a formal treaty, but are based on international Human Rights treaties that must be observed by all states that have ratified them.
- Have been welcomed by the UN Commission on Human Rights and by Human Rights, Development and Health organizations around the world.

The international guideline on HIV/AIDS and Human Rights are introduced to be used in the promotion and protection of Human Rights in the context of HIV/AIDS. The guidelines are designed to provide a tool to assist status in creating a positive response to the pandemic based on Human Rights, a response that is effective in reducing the transmission and impact of HIV/AIDS. The guidelines attempt to take existing Human Rights norms and mould them into a series of practical, concrete measures which states can adopt to fight the epidemic.[138]

The guidelines were prepared for and adopted by the second international consultation on HIV/AIDS and Human Rights held at Geneva in Switzerland in September 1996. This consultation brought together 35 experts Government officials, PLWHIV/AIDS Human Rights activists, academics, representatives of regional and national networks on Ethics, Law and Human Rights and representatives of UN bodies and agencies, N.G.O's and A.S.O's. The guidelines, therefore, were developed with considerable community input. The guidelines have been officially welcomed by two UN Agencies, i.e., the Commission on Human Rights and the Sub-Commission on Prevention of Discrimination and Protection of Minorities.

There are 12 Guidelines in all, each containing action-oriented measures to promote and protect Human Rights and achieve HIV-related public health goals. They are as follows.

1. States should establish an appropriate national HIV / AIDS response system that maintains a structured, participatory, open and accountable strategy and combines HIV / AIDS policy and programme obligations across all levels of government.[139]

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[138] An Advocates guide (Sep, 1999) to the International Guidelines on HIV/AIDS and human rights (ICASO) the International Council AIDS service organization.
[139] Olaide Gbadamosi Esq,(2005) Unisco, Unaides HIV/AIDS Human Rights & Law Network for Justice Democracy.

2. States should ensure, by political and financial assistance, that community consultation takes place at all levels of the creation, execution and review of HIV / AIDS policies and that community organisations are able to efficiently carry out their programmes, particularly in the fields of ethics , law and human rights. [140]
3. States should review and amend public health legislation to ensure that public health problems posed by HIV / AIDS are properly resolved, that their prohibitions on casually transmitted diseases are not unfairly applicable to HIV / AIDS and that they are compatible with international human rights obligations.[141]
4. To ensure that they are consistent with international human rights obligations and are not misused in the context of HIV / AIDS or targeted against vulnerable groups, states should review and reform criminal laws and correctional systems.
5. States should enact or improve anti-discrimination and other protective laws that safeguard disadvantaged persons, people living with HIV / AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in study concerning human subjects, emphasise education and conciliation, and allow for speedy and effective regulatory and civil remedies.
6. States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.[142]
7. States should create and encourage legal advocacy programmes to inform people impacted by HIV / AIDS about their rights, offer free legal services to uphold those rights, gain experience in HIV-related legal issues and use, in addition to the courts, means of defence, such as offices of ministries of justice, ombudspersons, units for health grievances and commissions for human rights.[143]

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[140] Ibid.
[141] Ibid.
[142] Olaide Gbadamosi Esq,(2005) Unisco, Unaides HTV/AIDS Human Rights & Law Network for Justice Democracy.
[143] Ibid.

8. States should promote a supportive and enabling environment for women, children and other vulnerable groups, in collaboration with and through the community, by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support for community groups.[144]
9. States should encourage the broad and continuous dissemination of artistic education, training and media services specifically intended to improve the awareness and perception of attitudes against bigotry and stigma associated with HIV / AIDS.[145]
10. States should ensure that governments and the private sector establish codes of conduct on HIV / AIDS issues that convert the values of human rights into codes of professional duty and practise, with frameworks to incorporate and execute such codes.[146]
11. To ensure the protection of HIV-related human rights , particularly those of people living with HIV / AIDS, their families and populations, states should ensure surveillance and compliance mechanisms.
12. States should collaborate to exchange information and expertise on HIV-related human rights issues across all relevant programmes and agencies of the United Nations framework, including UNAIDS, and should maintain successful processes to safeguard human rights in the field of HIV / AIDS at the international level.[147]

WHO, UNESCO, UNAIDS, ILO

(a)WHO

The mandate of the World Health Organisation (WHO) is to collaborate with Member States , national and foreign bodies to ensure that all populations reach the best possible quality of health The WHO has various programmes, events, campaigns and communications coordinated on the basis of health and development issues. In 2000, WHO launched the ‘Health for All’ strategy which was intended to ensure that all people in the member countries had access to health care and could to attain equal health

[144] Ibid.
[145] Ibid.
[146] Ibid
[147] Olaide Gbadamosi Esq,(2005) UNESCO, UNAIDS HIV/AIDS Human Rights & Law, Network for Justice Democracy.

outcomes. The concept has influenced many European countries' efforts to establish national health services and to ascertain the factors that affect people's health, as part of the quest to address health inequalities. The strategy has also been vital in providing a source of ideas for human rights and ethics in health. WHO also has a Human Rights and Health Team whose objective is to assist WHO and member states to adopt human rights approaches to health, boost the right to health in international law, and promote health related human rights. WHO acknowledges that promoting and protecting health and protecting and respecting human rights are closely linked and that violating one adversely affects the other.

The United Nations as an organization has a human rights component that includes the High Commissioner for Human Rights (OHCHR), and the Human Rights Council. These bodies oversee the human rights state of affairs within member states, promote and protect the enjoyment and realization of all rights by all people as established in the Charter of the United Nations and international human rights laws and treaties.[148]

Amnesty International is an internationally renowned organization that campaigns for the respect of internationally recognized human rights. Amnesty International believes that every human being should enjoy the rights protected by the UDHR and other international human rights instruments. Amnesty International fulfills its mandate by conducting research and taking action to prevent and end human rights abuses. The organization focuses on different human rights aspects including poverty and human rights where it advocates for the right to live with dignity which entails the right to adequate housing, food, education and healthcare. Amnesty International is carrying out research into how violating the right to live with dignity intensifies poverty and its adverse effects. Amnesty International has been very instrumental and vocal in holding governments and businesses accountable for violations that worsen poverty. In addition to human rights organizations that advocate human rights including health as a human right, there are also courts of law both national and regional in nature.

The European Convention on Human Rights established the European Court of Human Rights (ECHR). The Convention formulates the functions of the Court and the rights and guarantees that member states have undertaken to uphold. The Court's task is to

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[148] Office of the United Nations High Commissioner for Homan Rights, http://www.ohchr.org/english/about/index.htm and http://www.un.org/rights

ensure that member states respect and uphold the rights guaranteed in the Convention. The Court receives complaints from individuals, states, and organizations and upon reviewing the complaints, if it finds that a state has violated the rights within the Convention, it delivers judgment against the state. These judgments are binding and member states are obliged to comply. The Court has been instrumental in ensuring that states respect human rights and in 2006 received over 80,000 applications or complaints and passed 1,560 judgments that year. Based on this, it is correct to assume that the Court can be utilized to ensure that the right to attain the highest standard of health is adhered to by member states.

The African Court of Human and Peoples' Rights was established in 1998 under the auspices of the Organization of African Unity (OAU), now referred to as the African Union (AU). The protocol that created the Court came into force in 2004, but the Court's statute has not yet been circulated and there is not much information on the Court's operations at this point. It is worth remembering that 12 years after the OAU was created, the Court was formed and this has contributed to some academics branding it as an afterthought. The Court's mandate is to ensure that member states respect and promote the rights and duties created by the African Charter on Human and Peoples' Rights and other international human rights treaties that were ratified by member states.

Individuals and NGOs recognized by the OAU/AU can bring cases before the Court, only if the state in question has made a declaration accepting the jurisdiction of the Court. The African Charter on Human and Peoples' Rights provides that every individual shall have the right to enjoy the best attainable state of physical and mental health and member states are required to protect the health of their citizens. Though the workings of the Court are yet to be determined, its existence and mandate to ensure respect of the rights of individuals, demonstrates that the Court can be influential in protecting the right to health.

The Inter-American human rights system consists of a Commission on Human Rights and a Court of human rights. The Commission is an organ of the Organization of American States and as early as 1961 it carried out on-site visits within member states to investigate the human rights situation. The Commission examines complaints regarding particular human rights violations. The Commission ensures that member states respect human rights by publishing reports on the human rights situation in the

different states. It also recommends measures that states may adopt to protect human rights and submits cases to the Court of Human Rights for litigation.

The Court of Human Rights was created by the Inter-American Convention on Human Rights and it adjudicates cases of human rights violation brought against member states. In order for a case to be brought before the Court, the state in question has to have made a declaration accepting the Court's competence. Under the Inter- American system, only a state party to the Convention can bring a case or petition before the Court or the Commission.

There are several religious organizations whose focus is on HIV/AIDS work in the fields of caring ministries, education and training, information and networking and to educate people about the ethics of HIV/AIDS. Though their objective may not be to protect human rights, through their advocacy work for and on behalf of HIV/AIDS patients, they inevitably advance the rights of patients and the need to protect the right to health. Also, some religious organizations do not specifically target HIV/AIDS or any epidemic or disease, but simply choose to work with people who are ill and to make a difference in their lives.[149]

(b) UNESCO

United Nations Educational, Scientific and Cultural Organization (UNESCO) is mandated to contribute to peace and security in the world by promoting collaboration among nations through education, science, culture and communication in order to further universal respect for justice, for the rule of law and for the human rights and fundamental freedom. UNESCO's contribution to the fight against the HIV/AIDS pandemics, in co-operation with UNAIDS co-sponsors, Member States, civil society partners and the private sector, concentrates on[150]:

- Integrating HIV/AIDS preventive education into the global development agenda and national policies.
- Adapting preventive education to the diversity of needs and contexts.
- Encouraging responsible behaviour and reducing vulnerability.

[149] United Nations (2006). Political Declaration on HIV/AIDS. United Nations General Assembly, 60th Session, 2 June 2006.New York.
[150] UNAIDS (2001) HTV AIDS & Human Rights - Young people in action United nation Educational, Scientific and cultural organization sector of Social and Human Security. Mioullis 757321

- Exploring the ethical dimensions of the HIV/AIDS pandemic.

(c) UNAIDS (United Nations Programme on HIV/AIDS)

UNAIDS in a part of the United Nations and its objectives are to

a) Prevent the spread of HIV.

b) Provide care and support for those infected and affected by the disease.

c) Reduce the physical, emotional, mental and occasional handicaps of individuals and communities as a result of HIV/AIDS.

d) Lessen its impact on the society.

UNAIDS and the UN High Commissioner for Human Rights (OHCHR) published the international guidelines on HIV/AIDS and human rights as a joint policy and also as a pool to help states implement and achieve an effective rights-based HIV/AIDS response.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together eight UN agencies in a common and concerted effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank. UNAIDS both mobilizes the responses to the epidemic of its eight co-sponsoring organizations and supplements these efforts with special initiativesIts goal is to direct and help extend the international response to HIV on all fronts: medical, public health , educational, economic, cultural , political and human rights. UNAIDS works with a wide range of partners to share knowledge , skills and best practise across borders, including government and NGOs, business, scientists and laymen.[151]

[151] UNAIDS (2001) HIV AIDS & Human Rights - Young people in action United nation Educational, Scientific and cultural organization sector of Social and Human Security. Mioullis 757321

(d)ILO

HIV/AIDS and the World of Work

International Labour Organization which gives guidelines and monitors issues related to the work has come out with code of practice at the workplace. It seeks to prevent occurrence at the workplace as well as care for those living with HIV/AIDS in the workplace. The code also seeks to protect the fundamental rights of those living with HIV/AIDS such as the right to non-discrimination, equal and equality before the law, privacy, freedom of movement, work and social security. The code extends to both public and private sector businesses and staff, as well as to both formal and informal aspects of employment. Many of these include states, companies and staff and their organisations, personnel in the area of occupational health, HIV / AIDS practitioners and all related stockholders.

Several ILO Conventions and Recommendations can also be invoked, with respect to ratifying countries, in the fight against human rights violations in the HIV/AIDS context. Although there are no Conventions or Recommendations dealing specifically with HIV/AIDS, there are several instruments which deal with protection against employment and occupational discrimination, with social protection, with the prevention of accidents at work and with the adaptation of the work environment for workers affected by ill-health.[152]

It should also be stressed that the ILO Declaration on Fundamental Principles and Rights at Work states that all Member States accept the ideals and fundamental rights enshrined in the ILO Constitution and the Philadelphia Declaration when they vote openly to join the ILO, even though they have not ratified the Fundamental Conventions on those rights.

[152] The following Conventions are of particular relevance: Discrimination (Employment and Occupation) Convention, 1958 (No. 111); Occupational Safety and Health Convention, 1981 (No. 155); Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No 159); Occupational Health Services Convention, 1985 (No. 161). For further information on international conventions and how they can be used in the HIV/AIDS context, see: Hodges-Aeberhard, J.: Policy and legal issues relating to HIV/AIDS and the world of work (ILO, Geneva, 1999).

THE ILO CODE OF PRACTICE ON HIV/AIDS AND THE WORLD OF WORK

The ILO Code of Practice on HIV / AIDS and the world of work, is a vital document as it is the first international HIV / AIDS instrument directly linked to the world of work. Recognition of HIV/AIDS as a workplace issue is the important and underlying feature of this code.[153] This is because three quarters of adults living with HIV are hired by employers, and also because of the role that allies in the field of employment play in the global endeavour to counteract the dissemination of the disease and its implications. We can demonstrate below how, in keeping with the International Standards on HIV / AIDS and Human Rights, the Code should foster human rights in the workplace. For this context, we will first discuss the goals, area of operation and composition of the Code and then end with a brief review of the human rights that it aims to promote.

SCOPE, AIMS AND STRUCTURE OF THE CODE

The Code sets out guidance for policy implementation at global, sectoral and business levels and for the implementation of workplace programmes.[154] This includes HIV / AIDS prevention; its impact mitigation; the care and support of workers infected and affected by the virus; and the elimination of stigma and discrimination based on actual or perceived HIV status. The Code extends to both public and private sector employers and employees (including career applicants) and to all forms of employment, both formal and informal.[155] Compliance with the principles found in the Code is voluntary and does not bear legal obligations, unlike the International Labour Conventions. Therefore, it is a versatile method that can be tailored to meet the requirements of a specific country or workplace, including the needs of countries with a high prevalence, where care and treatment are becoming increasingly necessary, and countries where prevention is the key need.[156]

The Code also lays out the duties of social partners, unlike most other foreign instruments handled only by Nations, and a whole chapter is dedicated to advising governments, employers and employees and their organisations with respect to their

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[153] Section 4.1
[154] Section 1.
[155] Section 3.1
[156] Section 2.

rights and responsibilities.[157] The Code itself is the product of a mechanism of social dialogue, representing a consensus founded on tripartite consultations and debates. The Code is based on ten fundamental principles:

• Non-discrimination

• Recognition of HIV/AIDS as a workplace issue

• Gender equality

• Healthy work environment

• Social dialogue

• Non-requirement of screening for purposes of exclusion from work or work processes

• Confidentiality

• Continuation of employment relationship

• Prevention

• Care and support

A number of human rights are closely linked to these principles and the Code provides detailed advice on how to apply them concretely in the workplace. Under Article 19 of the ILO Constitution, each Member State of the ILO is required to submit to the competent authority, in the case of India, the Parliament, the instruments adopted by the Conference within one year of the conclusion of the session of the Conference and, in extraordinary circumstances, within 18 months of the conclusion of the session of the Conference concerned. Action taken in this regard is required to be reported to the Director General ILO. In addition to the presentation of the Recommendation before the competent authority, there is no other requirement to be met by the Member States, except for the submission to the ILO of quarterly reports showing the degree to which the terms of the Recommendation have been or are proposed to be adopted. Government of India ratified ILO Convention No. 144 (Tripartite Consultations) on 27-2-1978. The Convention provides that all ratifying member states shall operate procedures which ensure effective consultations, with respect to the matters concerning the activities of the International Labour Organization between representatives of the

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[157] Chapter 5 of the Code.

government, of employers and of workers. Employees and employers shall be represented on an equal basis in all bodies through which consultations are carried out.

HUMAN RIGHTS CONTAINED IN THE CODE

- **The right to non-discrimination and equality before the law**

It is generally accepted that international human rights law forbids all types of discrimination based on HIV status. As explained below, the Commission on Human Rights has stated that the prohibition of discrimination requires discrimination on the grounds of HIV status; the concept of non-discrimination in the field of HIV / AIDS has been unceasingly insisted on by various resolutions of the United Nations and other international bodies.[158]

Non-discrimination is a basic precept of the Code which can be seen in a variety of its provisions, such as, for example, anti-discrimination of access to jobs and the protection of job relationships;[159] access to welfare under social security systems and employment schemes[160], as well as working conditions such as remuneration, fair working conditions and terms of employment.[161]The Code stipulates that:

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.[162]

According to the definition given in the Discrimination (Employment and Occupation) Convention, 1958 (No. 111), discrimination is used to include HIV in this Code:[163]

[158] Articles 2 and 7 of the Universal Declaration of Human Rights; Articles 2.2 and 3 of the International Covenant on Civil and Political Rights, Articles 2, 3 and 26 of the International Covenant on Economic, Social and Cultural Rights, Article 2 of the International Convention on the Rights of the Child.
[159] Sections 4.8 and 8.1
[160] Sections 4.10, 9.5, 9.6 and 5.1
[161] Section 9.1
[162] Section 4.2
[163] The definition also includes sexual orientation. See Section 3.2 of the Code.

"any distinction, exclusion or preference made on the basis of real or perceived HIV status, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation[164]

In order to remove stigmatisation and discrimination based on HIV status, the Code lists a series of actions that governments and social partners can take. It advises that policymakers should provide the appropriate legislative framework in collaboration with social partners and HIV / AIDS experts and, where possible, revise labour laws and other regulations.[165] Workers and their representatives should, for their part, check with their employers on the introduction of an effective strategy for their workplace to deter the spread of infection and to protect all staff from HIV / AIDS discrimination.[166] Employers should not require HIV/AIDS screening or testing and should ensure that work is performed free of discrimination or stigmatization based on HIV status[167]. They should also take disciplinary proceedings against any employee who practices such discrimination or who violates the workplace policy on HIV/AIDS.[168] Workers' representatives should bring cases of HIV-related discrimination at their workplaces to the attention of the appropriate legal authorities.[169] The Code also deals with the inclusion of social partners in education programmes, especially those aimed at preventing discrimination. Without taking into account discrimination against women, no treatment of the issue of discrimination in the HIV / AIDS context is complete. A fundamental principle of the Code is equality between men and women.[170] De facto and de jure discrimination towards women leaves them particularly vulnerable to HIV / AIDS. One of the principal causes of the rapid spread of infection in many parts of the world is the subordination of women within the family and in public life. In their

[164] Convention n°111 does not prohibit explicitly discrimination based on real or perceived HIV status but article 1 (1) (b) of the Convention permits ratifying States to add, after consulting representative workers' and employers' organizations, additional grounds. The Committee of Experts on the Application of Conventions and Recommendations has recommended, and the ILO Governing Body has been discussing, an additional Protocol to Convention n° 111 to include, among other grounds "state of health" and "disability", which in turn would cover HIV/AIDS.

[165] Section 5.1 j). Furthermore the competent authorities should supply technical information and advice to employers and workers concerning the most effective way of complying with legislation and regulations applicable to HIV/AIDS and the world of work. They should strengthen enforcement structures and procedures, such as factory/labour inspectorates and labour courts and tribunals. Section 5.1 k)

[166] Sections 5.2 a), 5.3, and 5.3 f)

[167] Section 5.2 e)

[168] Sections 5.2 f) and 5.2. g)

[169] Section 5.3 g)

[170] Section 4.3

marriage or relationships, countless women are in a situation of economic dependency and sexual subordination and are thus not in a position to negotiate safer sexual relations.[171] In this regard, the Code emphasises the need to recognise that HIV / AIDS has different effects on men and women and states that gender relations are more equal and women are empowered to deal with HIV / AIDS.[172] The Code advocates for an integration of gender relations in research[173], in education and training programmes[174], in counselling[175], in guidance provided before and after HIV voluntary tests are taken[176], and in employee assistance programmes[177].

Other groups who experience prejudice and are also at higher risk of infection, including homosexual men and members of ethnic minorities, are often given particular consideration in the Code. The Code provides an indicative list of factors for some groups of employees which increase the risk of infection.[178] It calls on governments and social partners to take steps to identify groups of workers susceptible to infection, to identify factors that increase their risk of infection, and to adopt risk-overcoming strategies.[179] They can, among other aspects, ensure that effective prevention and preparation programmes for these workers are in operation.[180]

- **The right to freedom of association and assembly**

The right to freedom of assembly and association is protected by international law,[181]especially by two fundamental and widely ratified ILO Conventions.[182]

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[171] For further information on the causes of vulnerability among men and women, see Appendix 1 of the Code on the sexual dimension of HIV/AIDS and Section 3.2 on the definitions of the terms sex and gender.
[172] Section 4.3
[173] Section 5.1 g)
[174] Sections 6.2 c), 6.3 and 7.2
[175] Section 9.2
[176] Section 8.4
[177] Section 9.8
[178] For further details see Appendix 1 of the Code on factors increasing the risk of infection.
[179] Sections 5.1 q) and 5.3.l)
[180] Sections 5.1 q), 7 and 7.2
[181] Articles 20 and 23.4 of the Universal Declaration on Human Rights; Article 8 of the International Covenant on Economic, Social and Cultural Rights; Articles 21 and 22 of the International Covenant on Civil and Political Rights; Article 15 of the International Convention on the Rights of the Child.
[182] Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87), and the Right to Organise and Collective Bargaining Convention, 1949. (No. 98).

While the Code does not contain provisions specifically relating to freedom of association and assembly, it establishes social dialogue as a fundamental principle, which is impossible without those two elements. On this subject, it mentions:[183]

Cooperation and trust between employers, workers and their representatives and the government, with the active participation of workers infected and affected by HIV / AIDS, where appropriate, requires the successful implementation of the HIV / AIDS policy and programme. The Code repeatedly emphasises the importance of social partners' involvement in the planning of all activities relating to the protection of workers from HIV / AIDS, whether in the areas of prevention, education , training or care and support for HIV / AIDS prevention.[184] It encourages negotiation of working conditions at the national, sectoral and workplace / enterprise levels,[185] and furthermore, urges governments to recognise the importance of the world of work in national HIV / AIDS programmes, for example by ensuring that the composition of national AIDS councils includes representatives of employers, workers, people living with HIV / AIDS and of ministries responsible for labour and social matters.[186]

- **The Right to Work**

International human rights law instruments protect the right to work[187] The International Guidelines on HIV/AIDS and Human Rights states that:

The right to work implies the right of any person, with the exception of the requisite technical credentials, to have access to jobs without any prerequisite. This right is infringed when an applicant or employee is required to undergo compulsory HIV testing and is denied employment or dismissed or denied access to benefits for employees on the basis of a positive result. States should ensure that people with HIV / AIDS are permitted to work as long as they are able to execute job functions. It has been established in the Code as:

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[183] Section 4.5

[184] See in particular Chapters 6 and 7 on workers' education and the training of the stakeholders, and Chapter 9 on care and support.

[185] Section 5.2 a) and b), and Section 5.3 a) and b)

[186] Section 5.1 a)

[187] Article 23 of the Universal Declaration of Human Rights, Articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights, the Employment Policy Convention, 1964 (No. 122) and the Termination of Employment Convention, 1982 (No. 158), among others.

HIV illness is not a cause of job termination. As with many other conditions, people with HIV-related illnesses should be able to work as long as they are medically fit for the appropriate work available.[188]

The Code calls on employers to encourage people with HIV and AIDS-related illnesses to work as long as they remain medically fit for appropriate work, in order to allow workers living with HIV or suffering from an AIDS-related illness to maintain their jobs.[189] They should also take measures to reasonably accommodate workers with AIDS-related illnesses, in consultation with workers and their representatives.[190] This could include: rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements.[191] The employment relationship may cease only if a worker with an AIDS-related condition is too ill to continue to work and if alternative working arrangements including extended sick leave have been exhausted,[192] in which case this must take place in accordance with anti-discrimination and labour laws and compliance with general procedures and full benefits.[193]

- **The Right to Privacy**

The Human rights law also recognises the right to privacy[194] This right encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing, and to respect confidentiality of all information relating to a person's HIV status.[195]

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[188] Section 4.8; see also Section 8.1
[189] Section 5.2 e). Section 7.1 calls on management to be trained so that they can explain reasonable accommodations at the workplace.
[190] Section 5.2 j). Section 7.3 also calls for workers' representatives to be trained so that they can help and represent workers with AIDS-related illnesses to access reasonable accommodation when so requested.
[191] Section 5.2 j)
[192] Section 5.2 e)
[193] Ibid.
[194] Article 12 of the Universal Declaration of Human Rights, Article 17 of the International Covenant on Civil and Political Rights, and Article 16 of the International Convention on the Rights of the Child. The Occupational Health Services Recommendation, 1985 (No. 171) likewise recommends that provisions should be adopted to protect the privacy of the workers and to ensure that health surveillance is not used for discriminatory purposes or in any other manner prejudicial to their interests. The WHO/ILO Statement from the Consultation on AIDS and the workplace (Geneva, 27-29 June 1988), promotes the right of all workers to medical confidentiality with respect to all medical data, including HIV/AIDS-related information.
[195] International Guidelines on HIV/AIDS and Human rights, op.cit. note 2, paragraph 97.

The Code contains a whole chapter on the HIV test[196] and states, as a fundamental principle, that "HIV screening[197] should not be required for job applicants or persons in employment".[198] The Code envisages three situations in which HIV testing in the workplace may occur: in the context of an epidemiological study,[199] after occupational exposure,[200] or at workers' request and with their informed consent.[201] The Code recommends voluntary HIV testing as the gateway to care and support.[202] However, whatever the circumstances, the Code establishes specific rules to ensure that tests are performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements. In this way, people who want to take a test need not be afraid to disclose their HIV status without their consent, exposing them to discrimination and stigmatisation.[203] The Code also states that, as a condition of eligibility, HIV testing should not be required for national social security schemes, general health policies, vocational programmes and dental insurance.[204]

Regarding confidentiality of HIV/AIDS affected people, the Code states the following fundamental principle:

There is no rationale for asking job applicants or workers to disclose personal information related to HIV. Co-workers should also not be obliged to disclose such personal information about fellow workers. Entry to personal data related to the HIV status of a worker should be bound by confidentiality laws compatible with the ILO Code of Practice on the Protection of Worker's Personal Data, 1997.[205]

Information related to HIV / AIDS consists of information related to therapy, diagnosis, medication and reward reception.[206] Confidentiality rules are addressed to

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[196] Chapter 8.

[197] Screening is defined in Section 3.2 as 'measures whether direct (HIV testing), indirect (assessment of risktaking behaviour) or asking questions about tests already taken or about medication'.

[198] Section 4.6. Section 5.2 e) states that employers should not require HIV/AIDS screening or testing, and Section 8.1 further states that any routine medical testing, such as testing for fitness carried out prior to the commencement of employment or on a regular basis for workers, should not include mandatory HIV testing.

[199] Section 8.3

[200] Section 8.5

[201] Section 8.4

[202] In this connection, it recommends that social partners should encourage support and access to confidential, voluntary counselling and testing. Sections 5.2 l) and 5.3 m)

[203] For further details see the International Guidelines on HIV/AIDS and Human Rights, op.cit. note 2, paragraph 97.

[204] Section 8.2

[205] Section 4.7

[206] Section 9.7 a)

governments, private insurance companies, employers, and trustees and administrators of social security programmes and occupational schemes.[207] The Code states that it is only in accordance with the Occupational Health Services Recommendation, 1985 (No. 171) that access to medical data should be allowed. More specifically, the Code provides that employers must ensure that information relating to HIV/AIDS is kept exclusively in medical files and that workers' organisations should not have access to personal data relating to the HIV status of a worker.[208]

- **The Right to Social Security**

The right to social protection is a fundamental human right recognized in various international instruments.[209] Article 25 of the Universal Declaration on Human Rights states as follows:

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

At its 89th (2001) Session, the International Labour Conference emphasised the importance of adequate social security systems to respond to the needs of persons affected by HIV / AIDS and their families.[210] Persons living with HIV/AIDS are often forced to leave work, become isolated in their communities, and thus suffer a reduction in their income-earning capacity. Without sufficient public support programmes , particularly in the least developed countries, the resulting cost of illness will lead families to severe poverty. Care and support for persons affected by HIV/AIDS are a fundamental principle of the Code. Apart from the workers' health protection measures, the Code recommends that governments, employers and workers' organizations should take all steps necessary to ensure that workers with HIV/AIDS and their families are

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[207] Section 9.7

[208] Access to information, the undertaking of trade union responsibilities, rules of confidentiality and the requirement for the concerned person's consent must be in accordance with ILO Occupational Health Services Recommendation, 1985 (No. 171) and strictly restricted to medical personnel. See Sections 5.2.g) and 5.3.j)

[209] Articles 22 and 25 of the Universal Declaration on Human Rights; Articles 9 and 11 of the International Covenant on Economic, Social and Cultural Rights; Articles 26 and 27 of the International Convention on the Rights of the Child.

[210] Social security: Issues, challenges and prospects, Report VI, International Labour Conference, (89th Session), 2001, ILO, Geneva, pp. 5-8.

not excluded from the full protection and benefits of social security programmes and occupational schemes.[211] It also encourages governments to support, carry out and publish the findings of research, especially into the costs of the epidemic for workplaces and social security systems, and to mobilize funds locally and internationally to undertake that research.[212] Governments should take proper account of the progressive and sporadic existence of the illness and tailor schemes in the design and execution of social insurance services , for example by making benefits available as and when requested and by expeditious consideration of claims.[213]

- **The right to share in scientific progress and its benefits**

The right to share in scientific advancement and its benefits is recognized in the Universal Declaration of Human Rights[214] and in the International Covenant on Economic, Social and Cultural Rights.[215] In the words of the International Guidelines on HIV/AIDS and Human Rights:

The right to enjoy the benefits of scientific progress and its applications is important in the context of HIV/AIDS in view of the rapid and continuing advances regarding testing, treatment therapies and the development of a vaccine. More basic scientific advances which are relevant to HIV/AIDS concern the safety of the blood supply from HIV infection and the use of universal precautions, which prevent the transmission of HIV in various settings, including health care. ... In this connection, however, developing countries experience severe resource constraints which limit not only the availability of such scientific benefits but also the availability of basic pain prophylaxis and antibiotics for the treatment of HIV-related conditions. Furthermore, disadvantaged and/or marginalized groups within societies may have no or limited access to available HIV-related treatments or to participation in clinical and vaccine development trials. Of deep concern is the need to share equitably among States and among all groups within States basic drugs and treatment, as well as the more expensive and complicated treatment therapies, where possible.[216]

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[211] Section 9.6. Governments should ensure that benefits under national laws and regulations apply to workers with HIV/AIDS no less favourably than to workers with other serious illnesses (Section 5.1 f).
[212] Section 5.1 g) and h)
[213] Section 5.1 f)
[214] Article 27.
[215] Article 15.
[216] Paragraph 103.

The Code refers to the universal precautions to be adopted in the presence of blood and body fluids and contains several provisions concerning their application. Employers must ensure that they have good knowledge of the universal precautions and procedures to be followed in the event of an incident or accident at workplaces where workers are in contact with blood and other organic liquids.[217]

The Code recommends that governments encourage initiatives aimed at supporting international campaigns to reduce the cost of, and improve access to, antiretroviral drugs in order to help developing countries with very limited resources.[218] Other provisions of the Code relating to access to treatment and health are examined in the next section.

- **The Right to Health**

The right to the highest attainable level of physical and mental fitness, closely related to access to the advantages of scientific advancement, is recognised by numerous international instruments.[219] In order to ensure that this right is fully exercised, States must take the necessary measures for the prevention , treatment and control of epidemic diseases and the creation of conditions to ensure access to health services and medical care in the event of illness.[220]

The International Guidelines on HIV/AIDS and Human Rights explain this right in the HIV/AIDS context:

States should ensure that sufficient HIV-related information , education and care, including access to sexually transmitted disease facilities, means of prevention (such as condoms and clean injection equipment) and voluntary and discreet pre- and post-test counselling tests are given, in order to encourage individuals and others to protect themselves from infection. States should also ensure access, within the general context of their public health policies, to adequate treatment and drugs.[221]

[217]Section 5.1 h and i). Section 7.6 is devoted to training for workers who come into contact with human blood and other body fluids, and Section 8.5 to tests and treatment after occupational exposure.
[218] Section 5.1 p)
[219] Article 25 of the Universal Declaration on Human Rights; Article 12 of the International Covenant on Economic, Social and Cultural Rights; Articles 24 and 25 of the International Convention on the Rights of the Child.
[220] Article 12.2 c) and d) of the International Covenant on Economic, Social and Cultural Rights.
[221] Paragraph 121.

Treatment and support of people impacted and afflicted by HIV / AIDS are part of the basic values of the Code. On this subject, it states the following:

Solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes.[222]

The Code includes a whole chapter on treatment and assistance for people living with and infected by HIV, as well as provisions on prevention, the advancement of voluntary and discreet testing and steps to be taken in the case of exposure to the virus.[223] As a complement to all possible efforts to ensure access to health services for infected workers, the Code encourages parity of treatment with other serious illnesses[224], the provision of counselling and occupational health services,[225] linkages with self-help and community-based groups,[226] non-discrimination in the provision of benefits under national legislation,[227] and the adaptation of existing benefit mechanisms to the needs of workers with HIV/AIDS.[228] The Code also mentions the possibility that certain employers may be in a position to provide access to treatment and medication for their workers. Where health systems operate at work, they can provide the fullest possible spectrum of health systems in collaboration with government and other partners to prevent and control HIV / AIDS and to assist HIV / AIDS workers.[229] These programmes could include the availability of antiretroviral medications, the treatment of HIV-related symptoms, dietary guidance and vitamins, the reduction of stress and the treatment of common opportunistic infections such as STIs and tuberculosis.[230] The Code takes into account the fact that it is not possible to offer medical or counselling care in the workplace in certain situations. It therefore calls for employees to be aware about resources available beyond the enterprise, and underlines the benefit which such services offer by extending outside the employees to include their families, in particular

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[222] Section 4.10
[223] Chapter 9.
[224] Section 9.1
[225] Sections 9.2 and 9.3
[226] Section 9.4
[227] Section 9.5
[228] Section 9.5
[229] Sections 9.3 and 5.1 m)
[230] Section 9.3

their children.[231] The Code further highlights the importance of finding ways to expand facilities through informal activities to workers.[232]

- **The right to education**

Every person is entitled to education.[233] Education is aimed at the growth of the human being in its entirety and at enhancing respect for human rights and fundamental freedoms.The International Guidelines on HIV/AIDS and Human Rights state:[234]

Three large components that apply in the sense of HIV / AIDS comprise this right. Firstly, all children and adults have the right to obtain HIV related education , especially about prevention and care ...Secondly, States should ensure that both children and adults living with HIV/AIDS are not discriminatorily denied access to education… because of their HIV status…

Thirdly, States should, through education, promote understanding, respect, tolerance and non-discrimination in relation to persons living with HIV/AIDS.

Prevention through the provision of information and education is a fundamental principle of the Code[235], which contains two entire chapters on the subject. Chapter 6 is concerned with workplace and community information and education programmes. Chapter 7 deals with the training of the various groups involved in the world of work: managers, peer educators, workers' representatives, health and safety officers, and labour inspectors. Finally, the Code contains specific provisions encouraging information and education programmes, occupational training and awareness-raising among children and young people.

The Code encourages employers to initiate and support programmes in their workplaces, in consultation with workers and their representatives, to inform, educate and train workers.[236] Workers' organizations should support these efforts by developing

[231] Section 9.
[232] Sections 5.1 l), 5.2 m) and 5.3 k)
[233] Article 26 of the Universal Declaration on Human Rights; Article 13 of the International Covenant on Economic, Social and Cultural Rights; Articles 28 and 29 of the International Convention on the Rights of the Child
[234] Paragraph 10.
[235] Section 4.9
[236] Sections 5.1 d), 5.2 c), and 5.3 e) and h)

educational materials and activities appropriate for workers and their families,[237]including regularly updated information on workers' rights and benefits.

- **The fundamental rights of children**

The need to provide special protection to children[238] is recognized by international human rights law[239]. The fundamental ILO Conventions on the elimination of child labour protects children from exploitation in the world of work.[240]
In addition to enjoying rights specifically recognized in several international instruments, children also benefit from most of the human rights as enjoyed by adults.

The Code contains many specific provisions which, in the sense of HIV / AIDS and the world of work, protect children. It notes that policymakers should ensure, in programmes to eradicate child labour, that priority is paid to the effects of the disease on children and young people whose parents are sick or have died as a result of HIV / AIDS.[241] Furthermore, employers, workers and their representatives should encourage and promote information and education programmes on the prevention and management of HIV/AIDS within the local community, especially in schools,[242] and should, in collaboration with government and other relevant stakeholders, collaborate in the establishment of assistance programmes for workers and members of families.[243] Such services may be especially attentive to the needs of children who have lost one or both parents to AIDS and who could then drop out of school, be forced to work and become more vulnerable to sexual assault.[244] This can be achieved by providing

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[237] Section 5.3 c). Appendix I of the Code contains basic facts about the transmission of HIV and the impact of the epidemic on the population as a whole and the labour force in particular.
[238] The word 'child' is defined in accordance with Article 1 of the International Convention on the Rights of the Child as 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier'.
[239] The Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights (especially Articles 23 and 24), the International Covenant on Economic, Social and Cultural Rights (especially Article 10), the statutes and instruments pertaining to specialized agencies and organizations concerned with child welfare. See on this subject the Preamble to the International Convention on the Rights of the Child.
[240] The Minimum Age Convention, 1973 (No. 138); the Worst Forms of Child Labour Convention, 1999 (No. 182). The 113 States which have ratified Convention No. 182 are under the obligation to take immediate measures to prohibit and eliminate the worst forms of child labour, whatever is their economic situation.
[241] Section 5.1 n)
[242] Section 6.6
[243] Section 9.8
[244] Section 9.8 b)

vocational training and apprenticeships, as well as through direct or indirect financial assistance.[245]

CONCLUSION

The purpose of this chapter is to outline the international and national legal instruments that apply to HIV/AIDS and to examine those instruments, as well as government policies. In avoiding the dissemination of HIV / AIDS and reducing its effects on those already afflicted or infected, respect for human rights is fundamental. It is the duty of all States, irrespective of their political , cultural or economic systems, to promote and protect those rights which are universally recognised by the instruments of international human rights law as fundamental rights and individual freedoms. Few of these tools, however, deal explicitly with HIV / AIDS. International human rights principles have been converted into specific and applicable steps to be adopted by governments and other stakeholders in the areas of legislation, politics and institutional procedure by the International Guidance on HIV / AIDS and Human Rights, with the goal that human rights should be protected in the field of HIV / AIDS. The ILO Code of Practice on HIV/AIDS and the world of work is a further instrument for the protection of the rights of infected and affected persons, with particular reference to the needs of the workplace and the broader legal and policy framework governing the world of work.

States should support and cooperate with international mechanisms for monitoring and reporting on the measures they have taken for progressively realising access to comprehensive HIV / AIDS prevention , treatment , care and support, including antiretroviral and other medicines, diagnostics and related technologies. States can also provide appropriate information to organisations tracking their success in complying with their international legal commitments in their reports. The data found in these reports should be broken down in a way that seeks to recognise and address perceived inequalities in access to prevention, recovery, care and assistance, and should make use of current appraisal instruments, such as metrics or audits, or create new ones, to monitor compliance. Non-governmental organisations, particularly those serving persons living with HIV / AIDS and disadvantaged populations, should be fully

[245] Section 9.8 c)

engaged in the preparation of such reports and in acting on the findings and recommendations obtained from those oversight bodies.

CHAPTER -5

CRITICAL ANALYSIS OF THE HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (PREVENTION AND CONTROL) ACT, 2017

INTRODUCTION

Laws are made by governments. They are enacted to respond to the specific needs and demands of its citizens with a view of protecting and promoting their rights and for stheir development. Laws specify the rights and duties of citizens and also impose penalty for their violations.[246] Upto 1985, no country had adopted comprehensive laws for People Living with HIV/AIDS (PLWHAs). During 1985-90, a large number of countries adopted the AIDS Legislation. The main objective of these laws were to prevent and control AIDS. Primarily the trends in law-making were related to:

a) Classification of HIV/AIDS

b) Compulsory notification - (obligatory reporting of all cases to the authorities).

c) Protection of confidentiality about the identity of the infected persons.

d) Compulsory HIV-testing on specific population categories, e.g., aliens entering the country, "high-risk groups" - commercial sex workers, drug addicts, professional blood donors and homo sexuals.

e) Access to information and education about HIV/AIDS.

f) Prevention of discrimination against infected persons and emphasizing their human rights.

g) Providing compensation and welfare schemes to health workers infected by HIV-positive while working among the infected persons.

h) Cleaning of blood supply.

In law-making procedure related to PLHAs, each country has taken a different approach to the issue of HIV/AIDS. Some have taken the penal (coercive) approach, some have followed the pragmatic (facilitative) approach, while few others adopted the

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[246] Gracias, Thomas (1997) AIDS Law and Social work, Rawat publications New Delhi.

rehabilitative (compensatory) approach. Different perceptions of HIV/AIDS as a disease, a catastrophe, a divine curse, etc. have also influenced the enactment of laws.

In order to find a remedy to the discrimination faced by the PLHAs, many countries have enacted laws to guarantee equality and provide protection against discrimination. International guidelines on HIV/AIDS and human rights recommends that "States should enact or strengthen antidiscrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors." The goal of these laws is to achieve equality for PLHAs.[247]

LEGAL PROVISIONS IN INDIAN MEDICAL COUNCIL ACT, 1956

The Code of Ethics referred to by the Supreme Court in the case of Mr.X v.Hospital Z[248] is statutorised in the form of the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002. These regulations govern the conduct of medical practice by doctors in India. They outline the duty of physicians in maintaining confidentiality and states that a physician shall not disclose confidential information of the patient except if required by a court, in cases of notifiable disease or where there is a serious and identified risk to specific person or community. The regulations also state that such disclosure should be done by the physician in a manner that he/she would like another to act toward one of his/her own family in like circumstances.[249]Therefore, while the regulations are sensitive to the manner in which disclosure should be made, they do not provide specific procedures for disclosure and fail to consider the need to balance the public interests of confidentiality of the individual against disclosure to others.

The Indian Medical Council lays down specific duties that have to be observed by the doctors towards HIV/AIDS patients. These are enumerated below:

- Duty to take care and to take informed consent from the patient.
- Duty to disclose information & risks to the patient.

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[247] UNAIDS (2001) HTV AIDS & Human Rights - Young people in action United nation Educational, Scientific and cultural organization sector of Social and Human Security. Mioullis 757321.
[248] [1998]8 SCC 296.
[249] Regulation 2.2,Chapter 2 and Regulation 5.2,Chapter 5,Indian Medical Council(Professional Conduct,Etiquette and Ethics)Regulations,2002.

- Provide information about options available & benefits.
- Duty to warn against risks.
- To admit patients in emergency without consent.
- The physician should not abandon his duty for fear of contracting the disease himself.

India is also committed to 'Ending the AIDS' epidemic as a public health threat by 2030 in line with Sustainable Development Goals (SDG). The Government of India has reaffirmed this commitment at the United Nations General Assembly in June 2016 during the High level Meeting (HLM) on AIDS, as well as at other platforms such as BRICS. According to the National Strategic Plan for HIV/AIDS and STI (2017 – 2024), by 2020, the focus of the national programme is to achieve the following fast track targets:

(i) 75% reduction in new HIV infections,

(ii) 90-90-90: 90% of those who are HIV positive in the country know their status, 90% of those who know their status are on treatment and 90% of those who are on treatment experience effective viral load suppression,

(iii) Elimination of mother-to-child transmission of HIV and Syphilis, and

(iv) Elimination of stigma and discrimination

LEGAL PROVISIONS IN IMMORAL TRAFFICKING PREVENTION ACT, 1986

In India, the Immoral Trafficking Prevention Act, 1986, tackles sex work. The Act allows for routine medical examination for HIV / AIDS diagnosis to be carried out. It has made arrangements for compulsory testing.

The other legislation, policies, and agencies which protect HIV/AIDS patients are:

1. Goa, Daman and Diu Public Health Act, 1985.
2. Drugs and Cosmetic Act, 1940.
3. National AIDS Control Organization (NACO), Department of AIDS Control, Policies, and Guidelines.
4. Indian Penal Code, 1860.
5. Juvenile Justice (Care and Protection of Children) Act, 2015.
6. Maharashtra Protection of Commercial Sex Workers, Bill, 1994.
7. Medical Termination of Pregnancy Act, 1971.

8. Narcotic Drugs and Psychotropic Substances Act, 1985.

Antiviral Therapy Guidelines for HIV infected Adults and Adolescents, including Post-exposure, are given as below:

- Condom Promotion by SACS - Operational Guidelines
- Data Sharing Guidelines
- Guidelines for HIV Care and Treatment in Infants and Children, Nov 2006
- Guidelines for HIV Testing, March 2007
- Guidelines for Network of Indian Institutions for HIV/AIDS Research (NIHAR)
- Guidelines for Prevention and Management of Common Opportunistic Infections
- Guidelines for Setting up Blood Storage Centres
- Link Worker Scheme(LWS) Operational Guidelines
- NACO Ethical Guidelines for Operational Research
- NACO IEC Operational Guidelines
- NACO Research Fellowship-Scheme Under NACP-III
- National Guidelines on Prevention, Management & Control of Reproductive Tract Infection
- National Guidelines on Prevention, Management & Control of RTI including STI
- National Policy on HIV/AIDS and the World of Work
- Procurement Manual for National AIDS Control Programme (NACP-III)
- Standards for Blood Banks and Blood Transfusion Services
- Surveillance Operational Guidelines
- Targeted Intervention for Migrants – Operational Guidelines
- Targeted Interventions for High-Risk Groups (HRGs)
- Targeted Interventions for Truckers – Operational Guidelines
- Voluntary Blood Donation – An Operational Guidelines
- National AIDS Control and Prevention Policy (NACPP)
- National Blood Policy (NIHFW)
- National AIDS Control Programme (NIHFW)
- National AIDS Prevention and Control Policy
- Suppression of Immoral Traffic in Women and Girls Act, 1956

- Young Persons (Harmful Publications) Act, 1956
- National AIDS Prevention and Control Policy
- The Indian Employers' Statement of Commitment on HIV/AIDS
- Joint Statement of Commitment on HIV/AIDS of the Central Trade Unions in India
- ILO Code of Practice on HIV/AIDS and the World of Work
- State AIDS Control Societies
- National Human Rights Commission

PRESENT LEGAL PROVISIONS IN INDIA:

The Parliament has passed a new legislation, The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017[250] which prevents discrimination against HIV positive people"In 2014, Ghulam Nabi Azad, then Minister of Health and Family Welfare, introduced the Bill, whose explanatory statement laid out the purpose of the legislation as" To address the stigma faced by HIV and AIDS infected people ... to improve the current National AIDS Prevention Policy by taking legal accountability." The objective clause also stated for the recognition of the need to safeguard the rights of people who are infected with HIV/AIDS, particularly women and children by the existing establishments, both public and private.[251]

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017[252] is an Act of Parliament. The Act contains 50 sections which is divided into 14 chapters. The main object of the Act is to provide for the prevention and control of the spread of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and for the protection of human rights of persons affected by the said virus and syndrome. The HIV/AIDS Prevention Act originated from a draft bill submitted by Lawyers Collective, a non-governmental organization, to the National AIDS Control Organisation (NACO) in 2006. The Bill was introduced by senior Congress leader Ghulam Nabi Azad in 2014, was passed by the Rajya Sabha on March 22, 2017, and on April 12, 2017, it was passed by the Lok Sabha. It received the assent of the President on April 20, 2017 and was published in

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[250]https://nhp.gov.in/nhpfiles/hivaidsact.pdf
[251]http://www.prsindia.org/billtrack/the-humanimmunodeficiency-virus-and-acquired-immune deficiency-syndrome-prevention-and-control-bill-2014-3126/
[252] No.16 of 2017.

the official gazette of India for general information. The Bill was initially introduced in Parliament by the UPA government, the amendments to the HIV and AIDS (Prevention and Control) Bill, 2014 were revived by the NDA government. This legislation can be considered as a long awaited and welcome move on the part of the Government for the protection of human rights of persons affected by virus and syndrome. It is important to see that the health ministry was under pressure from various sections of society to enforce the HIV and AIDS Act. The Delhi High Court also pulled up the Centre over not notifying the Act despite the statute receiving Presidential assent in April 2017. Hearing a PIL that sought immediate notification of the legislation, a bench of Chief Justice Rajendra Menon and Justice C. Hari Shankar on August 13, 2018 had asked the Union health ministry, “You make a law and are not notifying it. Why?"

As a result of this Public Interest Litigation (PIL) filed at the Delhi High Court, a notification was released by the Ministry of Health and Family Welfare, Government of India, to bring into force on 10 September 2017 the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017."In exercise of the powers conferred by sub-section 3 of Section 1 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, the Central Government hereby appoints the 10th day of September 2018, as the date on which the provisions of the said Act shall come into force," the notification read. The Act penalises the dissemination of hate against people affected by HIV / AIDS, assures the right of minors affected by HIV / AIDS to a shared home, protects the non-disclosure of HIV / AIDS status in the absence of a court order, and mandates informed consent to report positive identification for HIV / AIDS, among other items. The Act on some legal language issues, however, has been opposed by civil society groups and people impacted by HIV/AIDS, as it requires the state to provide emergency care 'as far as possible' to HIV/AIDS people affected. In the draught bill sent to NACO, this factor was missing.India officially became the first country in South Asia to statutorily ban discrimination against people diagnosed with HIV / AIDS following its enactment. The Act became effective post the Supreme Court judgment in *Navtej Singh Johar and ors. v. Union of India*[253] decriminalizing homosexuality in India. In 2018, the Joint United Nations Agency on AIDS reported that new HIV infections dropped from 1, 20,000 in 2010 to 88,000 in 2017 in India, AIDS-related

[253] W.P.(Crl.)No.76 of 2016.

deaths from 1,60,000 to 69,000 and people living with HIV from 2,300,000 to 2,100,000 in the same time period. However, the decline rate was only 27 per-cent compared to NACO's target of 75 per-cent reduction by 2020 from 2010 levels. In 2017, NACO reported that there are 2.14 million HIV affected persons in India.

BACKGROUND AND HISTORY OF THE ACT

In July 2000, the United Nations Security Council adopted Resolution 1308 calling for "urgent and exceptional actions" to mitigate threats posed by HIV/AIDS infection. The Act was introduced since India is a signatory to the United Nations Declaration of Commitment on Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, 2001.

The process of drafting a law to prevent and monitor the spread of HIV / AIDS in India, while safeguarding the rights of persons affected by HIV / AIDS, started in 2002, when a draft bill was submitted to the National AIDS Control Organization in 2006 by Lawyers Collective, a non-governmental organisation. With six elements of the National AIDS Control Programme (NACP)-III combined with the National Rural Health Mission (NRHM), the convergence of HIV / AIDS interventions and primary health care services began in 2010.These included Integrated Counselling and Testing Centre's (ICTC); prevention of parent-to-child transmission; blood safety; sexually transmitted infections services; condom programming; and antiretroviral treatment (ART); the integration of HIV/AIDS interventions under the broader healthcare system continued with the NACP-IV.

In 2012, an independent United Nations expert committee report stated that regressive laws were impediments to developments in the area of HIV / AIDS, while a Global Commission Report noted that the lack of access to health services for people infected by HIV / AIDS helped further spread the disease. A United Nations report also noted that at the end of 2013, India had the third highest number of people living with HIV / AIDS in the world, standing at 2.1 million people infected, accounting for around 4 out of 10 people living with HIV / AIDS.

On 17 February 2014, in the Rajya Sabha, the then Minister of Health and Family Welfare, Ghulam Nabi Azad, presented the HIV / AIDS Prevention Bill (No. III), 2014. Among other items, the primary goals of the Bill is to discourage and monitor the

dissemination of HIV / AIDS, ban discrimination against persons afflicted with HIV / AIDS, and offer adequate care for those persons. The Bill was referred to the Standing Committee on Ministry of Health and Family Welfare on 26 February 2014, and the committee submitted its report on 29 April 2015. In July 2016, the Bill got a boost when the government made some amendments to the Bill in response to issues posed by the society and state governments impacted by HIV / AIDS. It was passed on 11 April 2017 by the Lok Sabha and on 21 March 2017 by the Rajya Sabha. Jagat Prakash Nadda, the then Minister for Health and Family Welfare, affirmed the government's commitment to provide HIV / AIDS affected individuals with medical care. The Bill obtained assent from then President Pranab Mukherjee on 20 April 2017 and was notified in the Gazette of India on 10 September 2018, thus falling into effect.

India had vowed to follow goals and meet its sustainable development aim earlier in 2016 at the United Nations by quickly measuring progress towards ending the HIV / AIDS outbreak by 2030. It increased the financing of HIV / AIDS services by supplying the government with two-thirds of the NACP-IV allocation from its domestic allocation.

Further, on 6 September 2018, the Supreme Court delivered its judgment in *Navtej Singh Johar and ors. v. Union of India*[254] decriminalising homosexuality in India, by reading down Section 377 of the Indian Penal Code. It also overruled the 2013 judgment in *Suresh Kumar Koushal v. Naz Foundation* [255]and upheld the 2009 Delhi High Court judgment *Naz Foundation v. Govt. of NCT of Delhi.*[256] This Act came into force soon after this historic decision of the Supreme Court of India and thus it can make a huge positive impact on the LGBTQ Community, who form a significant chunk of HIV/AIDS affected population in the country. The coming into force of the Act, to a great extend helps in eliminating the social stigma surrounding them.

STATUTORY PROVISIONS

The Act protects the interests of HIV-positive and HIV-affected individuals. The provisions of the Act resolve HIV-related discrimination, improve the current programme through legal accountability, and establish formal mechanisms for

[254] W.P (Crl.) No. 76 of 2016
[255] Civil Appeal No.10972 of 2013
[256] 160 Delhi Law Times 277.

complaint investigation and grievance redress.[257]The main features of the Act as contained in the said notification are as below.

The Act seeks to prevent and control the spread of HIV and AIDS, prohibits discrimination against persons with HIV and AIDS. The Act lists various grounds on which discrimination against HIV positive persons and those living with them is prohibited.[258] These include the denial, termination, discontinuation or unfair treatment with regard to:

(i) employment,
(ii) educational establishments,
(iii) health care services,
(iv) residing or renting property,
(v) standing for public or private office, and
(vi) provision of insurance (unless based on actuarial studies).

The requirement for HIV testing as a pre-requisite for obtaining employment or accessing health care or education is also prohibited. The law also prohibits any form of expression that is deemed as inciting hatred against people infected with HIV/AIDS.

Every person infected or affected by HIV under the age of 18 has the right to live in a shared household and to enjoy the household's facilities. The Act also forbids any person from sharing information or advocating feelings of hate towards people who are HIV positive and those who live with them. In compliance with the provisions of the Act , a person between the ages of 12 and 18 who has adequate maturity to understand and handle the affairs of his family affected by HIV or AIDS shall be qualified to act as a guardian of another sibling under the age of 18 years in matters relating to admission to educational institutions, operating bank accounts, property management, care and treatment.As per the provisions of the Act, every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services.

In this case , the law making process involved a comprehensive consultative process with civil society and other HIV stakeholders. An anti-discrimination provision to cover violations by the private sector and specific provisions to ensure informed consent

[257] Link of the notification: http://egazette.nic.in/WriteReadData/2018/189234.pdf
[258] Section 3 of the HIV and AIDS (PREVENTION AND CONTROL)ACT,2017.

while seeking HIV-related testing and treatment and confidentiality of HIV status are some of the unique aspects of the Act, as it was eventually passed.

However, the law contains significant loopholes which dilutes the very purpose of the Act. First, it does not recognise the heightened susceptibility to HIV that some people face, which should have been resolved by applying anti-discrimination guarantees to these groups, offering a legislative instrument for access to health, jobs, schooling, and other fields, by sex workers, transgender people, men who have sex with men, and people who use drugs, while still serving public health. Yet, at least the legislation does protect these criminalised communities from punishment when they access or are provided HIV-related services and commodities, which could otherwise be tantamount to a crime. Another drawback of the law is the diluted obligation of the State to provide antiretroviral treatment to those in need. The legislation also provides options to redress grievances, which are localised, less formal and intimidating, and more accessible than courts, thereby recognising that implementation and actualization of rights is critical to the success of the law, and efforts to control HIV.

In the annals of human health, the emergence and spread of HIV / AIDS was a disaster, but a unique occurrence. It was devastating that many millions died before life-sustaining care was made available due to the outbreak, and the disaster is much more acute in many respects today because, for different reasons, millions now in need of such care do not receive or afford[259].

It was significant because the outbreak had spawned a brand of patient advocacy previously unheard, along with great sorrow, loss, and helplessness. It was this activism that made politicians, lawmakers, health bureaucrats, and practitioners aware that alienation and stigma would only fuel the spread of HIV by pushing "underground" activity and sexual and other HIV-related human behaviour. The advocacy of people affected by HIV also brought true meaning to the expression, "nothing for us without

[259] Dutta A, Barker C, Kallarakal A. The HIV treatment gap: estimates of the financial resources needed versus available for scale-up of antiretroviral therapy in 97 countries from 2015 to 2020. PLoS Med. 2015 Nov 24 [cited 2017 Oct 31];12(11):e1001907; discussion e1001907. doi: 10.1371/journal.pmed.1001907. eCollection 2015 Nov. Available from: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001907

us," which led to stellar responses to HIV regulation in many parts of the world through their vigorous involvement in policy decisions and programme implementation[260].

This advocacy led to the introduction of a "rights-based" inclusionary approach that enabled persons, especially the most vulnerable, to access health and related services, and was demonstrably seen as the most successful approach to empowering people to defend themselves and those with whom they had sex or exchanged drugs with health-seeking behaviour.[261] Such an approach required multi-pronged efforts: skilful counselling services for people seeking HIV related services; widespread messaging to provide preventive information and commodities (such as condoms, and appropriate gear for healthcare workers to protect themselves); laws and policies that empowered those affected or vulnerable to HIV (often deeply stigmatised people such as sex workers, transgender people, drug users, men who have sex with men, and people living with HIV) so that they were encouraged to access vital information and services instead of being shunned by society and criminalised by the law; and, significant investment in improving health delivery and provision of treatment when it finally arrived.

It was this “rights-based” approach that the global community adopted as the international response to HIV, after some trial and error with punitive and coercive policies and mindsets that only made an already elusive virus spread more stealthily in dangerous ways. As part of the community of nations, India too adopted this approach through a national HIV/AIDS control programme – an effort of government together with civil society and NGOs (often at odds, sometimes in unison, but always with the common aim to quell the epidemic)[262]

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[260] For an illustration of activism in India see http://www.thehindu.com/news/cities/mumbai/the-shining-legacy-ofdominic- dsouza/article18449535.ece. Activist experiences from the United States and South Africa can be found at https://www.theatlantic.com/health/archive/2011/12/before-occupy-how-aids-activists-seized-control-of-thefda-in-1988/249302/ and https://quod.lib.umich.edu/p/passages/4761530.0010.011/–tac-in-the-history-of-rights-basedpatient-driven-hivaids?rgn=main;view=fulltext

[261] For an early description of the rights-based approach to HIV/AIDS see, Gostin, Lawrence, “A Tribute to Jonathan Mann: Health and Human Rights in the AIDS Pandemic”, 26 J.L. Med. & Ethics 256-258 (1998) available from http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1746&context=facpub.

[262] International agreement on the HIV/AIDS response and human rights imperatives for the same were first reflected in the UNGASS Declaration of Commitment on HIV/AIDS, 2001. Available from: http://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf. This has been succeeded periodically by the UN Political Declaration on HIV/AIDS, 2006 (http://www.unaids.org/sites/default/files/sub_landing/files/20060615_hlm_politicaldeclaration_ares60262_en_0.pdf), 2011 (http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-

Although late by many years, India has now reached a point in time when a substantial, and for the most part, epochal legislation was passed in writing to crystallise the "rights-based" approach to HIV[263].The journey of the making of the law has itself been remarkable, and it represents thoroughly the values of inclusion and inclusiveness in its making and forming. As the bill continued to be formulated in the early 2000s, those most affected by such a bill were all part of widespread controversies across the globe: those afflicted with HIV, who are stigmatised by society, those most vulnerable to the disease, and those suffering from HIV in their lives, etc. Indeed, in the spirit of union, the making of this legislation originated from a non-partisan plea by Indian legislators in 2003, endorsed by all of the then major political parties. And, in the spirit of a national HIV response that was multi-pronged and multi-sectoral, the request was made to the non-profit organization named Lawyers Collective HIV/AIDS Unit (LC) to devise and submit draft legislation. LC negotiated that it would submit the draft only after consulting with the vibrant, active and vastly experienced civil society that had engaged with HIV in India over many years. Thus began a two-year long process of comparative law research on legislative efforts elsewhere, which led to the publication of Legislating an epidemic: HIV/AIDS in India[264] and consultation with hundreds of stakeholders in India, before the draft law was submitted to the National AIDS Control Organisation (NACO), Ministry of Health, in 2005.[265]

CRITICAL ANALYSIS OF THE ACT

The law that has been recently passed – the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 ("HIV Act")[266] – does indeed bear resemblance to that draft of 2005[267]. Salutary provisions in

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RES-65-277_en.pdf) and 2016 (http://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS).

[263] Ministry of Law and Justice, Government of India. The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 New Delhi: MoLJ; 2017[cited 2017 Oct 24]. Available from: http://naco.gov.in/hivaids-act-2017.

[264] The Lawyers Collective. Legislating an epidemic: HIV/AIDS in India. New Delhi: Universal Law Publishing; 2007.

[265]An overview of the process is available from http://www.lawyerscollective.org/files/ENGLISH%20(July%202007)%20FINAL%20COPY.pdf and http://www.lawyerscollective.org/our-initiatives/hiv-and-law

[266] Ministry of Law and Justice, Government of India. The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 New Delhi: MoLJ; 2017[cited 2017 Oct 24]. Available from: http://naco.gov.in/hivaids-act-2017

[267] The original draft that was submitted to the government in 2005 is available from http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf.

the draft have been retained. Primary among these is Section 3, which, for the first time in India, forbids discrimination across the board. Until now, the right to be treated as equal in the eyes of the law and to have a claim against an act of discrimination, has been guaranteed by Articles 14, 15, and 16 of the Indian Constitution. This protection could only be enforced against the "State" viz government entities as defined by Article 12 of the Constitution of India, 1950[268]. For the first time in Indian law, the HIV Act extends the protection of non-discrimination against private actors too, inasmuch as the discrimination due to HIV status occurs against people living with HIV and their kin in the contexts of employment, healthcare, education, mobility, accommodation, insurance coverage, use of public services/facilities, custodial settings, and in standing for public office.[269] Discrimination has been a much too frequent experience for people living with HIV, and the aim of this provision is to deter it in these aspects of public activity.[270]Indeed, the assurance of nondiscrimination to people living with HIV can contribute in enhancing not just the individual's life but can also mitigate the stigma that surrounds HIV and AIDS, thereby contributing to a strengthened response that addresses underlying determinants of HIV vulnerability, and serves public health needs.

Although Section 3 is a significant protection for people living with HIV, one crucial aspect of this anti-discrimination provision has been left out of the original draft that was submitted to NACO after widespread consultation. Sex workers, transgender people, people who use drugs, men who have sex with men, people vulnerable to HIV have been removed from its security sphere. The original draft prohibited discrimination on "HIV related grounds", which included "HIV status, actual or perceived", "actual or perceived exposure to HIV", or conduct that "perpetuates … systemic disadvantage … against a category of persons…" This language was intended to cover people vulnerable to HIV. The rationale of this earlier version was that those highly disenfranchised, stigmatised and criminalised persons should be encouraged to pursue health-enhancing services by promoting a favourable and encouraging social

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[268] Article 12 of the Constitution of India states, "In this part, unless the context otherwise requires, the State includes the Government and Parliament of India and the Government and the Legislature of each of the States and all local or other authorities within the territory of India or under the control of the Government of India."

[269] See Section 3 of the HIV AND AIDS(PREVENTION AND CONTROL) ACT,2017

[270] World Health Organisation, Joint United Nations Programme on HIV/AIDS. Guidance Note. Reduction of HIV related Stigma and Discrimination, 2014. Geneva: UNAIDS; 2014 [cited 2017 Oct 24]. Available from: http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

atmosphere that would make them non-discriminatory access to healthcare, jobs, schooling and other facilities and opportunities. Such framing of legislation, resulting from rights-based foundations, was not only the best thing to do to achieve a fair society, but it would also have fulfilled public policy goals by bringing people from the periphery to access health care, which would in turn become more and more responsive over time to their contexts and desires. Indeed, India's new Mental Healthcare Act guarantees nondiscrimination on the grounds of sexual orientation,[271]which begs the question why it was thought fit to remove the application of non-discrimination to those vulnerable to HIV, including homosexual men in the HIV Act. Failure to acknowledge the need to resolve these marginalizations further increases the alienation that disenfranchised individuals experience towards mainstream services and opportunities, invisibilizes their lives, and encourages HIV to fester in hidden, neglected contexts.Imagine a world in which the mandate of the law required institutions to treat sex workers with dignity and equality. Over time, insensitive hospitals would be forced to become responsive to sex workers' needs, and hostile venues would become hospitable safety nets where health concerns would be fully addressed, and HIV could be nipped in the bud. Such a scenario would have been given great impetus if the HIV Act had extended its anti-discrimination protection to those known to be historically vulnerable to HIV.

Additionally, this loophole in the HIV Act presents a dynamic and potentially technically dubious scenario in which, for example, a sex worker who is refused private health care coverage due to her occupation will have no legal status to appeal that exclusion, while a sex worker who is HIV-positive will have immunity under the statute.

The HIV Act also sets clear standards of informed consent and confidentiality, with another first in Indian law, to be maintained between patients and health workers in relation to HIV status. Legislative gravity has now been given to what were previously standards developed through judgments and common law or in the Code of Ethics Regulations of the Medical Council of India. Indeed, regardless of the health condition that a person may have, such standards can and should be adapted and applied across

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[271] Ministry of Law and Justice, Government of India. Section 18(2), Mental Healthcare Act, 2017, Section 18(2). New Delhi: MoLJ; 2017 [cited 2017 Oct 24]. Available from: http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf

the health sector.In recognition of the autonomy of the individual, the law lays down the principle that informed consent is a requisite for HIV testing and treatment, and that it needs to include pre- and post-test counselling services.[272] Although the law leaves much of the methodological detail to obtain informed consent to be formulated through guidelines, it stipulates well-accepted legal principles that exempt the requirement for informed consent including when required to follow court orders, for epidemiological reasons, and in cases of blood, tissue, and organ donation[273].

Giving priority to the right to privacy, the HIV Act protects any person's compelled disclosure of HIV status unless necessary by court order and allows competent individuals who are in a fiduciary role to preserve the secrecy of HIV status unless informed consent is obtained for such disclosure.[274] As is the case for other laws relating to public health, such exceptions to non-disclosure are also given, particularly in court cases and legal proceedings, for circumstances of shared confidentiality between healthcare staff in the best interests of the patient, for partner notice as set out in Section 9 in appropriate cases, and for statistical monitoring where disclosure is made.[275] Indeed, all rights come with responsibilities; in free societies the assurance of rights is the rule, while curbing them remains the exception. As the Supreme Court of India recently pointed out while upholding the paramount nature of the fundamental right to privacy, “Natural rights are not bestowed by the State. They inhere in human beings because they are human”.[276] Privacy and confidentiality are of that kind, but under very special circumstances, they can be restricted. This is what the HIV Act helps in balancing the law with the requirement to report in some situations to preserve anonymity of HIV status. Confidentiality is not only contained in the Act as a corollary of the right to privacy, but also as a sound public health measure. After all, individuals would stop entering a health system if it were not promised, which might subject them to social opprobrium by reporting their HIV status without law-drawn restrictions. Section 9 of the HIV Act includes a comprehensive procedure for partner notification with built-in protections to ensure that a balance is maintained between a person living

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[272] See Section 5 of the HIV AND AIDS (PREVENTION AND CONTROL)ACT,2017.
[273] Ibid at Section 6.
[274] Ibid at Section 8.
[275] Ibid
[276] Justice KS Puttaswamy (Retd.) v Union of India, Supreme Court of India, Writ Petition (Civil) No. 494 of 2012. Available from:
http://supremecourtofindia.nic.in/supremecourt/2012/35071/35071_2012_Judgement_24-Aug-2017.pdf

with HIV to protect anonymity of status, and a partner who may be at risk of being transmitted HIV.[277] The Section requires only the doctor or counsellor of the individual to make such disclosure to a partner after being satisfied that the partner is at serious risk of transmission, that the person would not tell the partner despite being instructed to do so, that the person has been notified of the decision to alert the partner, and that the partner is notified in person after having counselling. An exception to partner notification is made even when it satisfies these conditions – when a healthcare provider reasonably apprehends that the person living with HIV is a woman who will be subject to violence, abandonment or other severe actions by her partner.[278]

The often-ill-informed controversy revolving around the criminalisation of HIV transmission is directly related to the problem of confidentiality and partner warning. Those in support of criminalization claim that the only harsh weapon that can prevent people dealing with HIV from moving it to others is criminal law. They may not understand that the vast majority of HIV transmission happens unknowingly, or that it is mostly women who are first screened and later accused of transmitting by breastfeeding to their husbands or their children.[279] As the Global Commission on HIV and the law pointed out in its seminal 2013 report, "Risks, rights and health", "Criminalisation is justified under one condition only: where individuals maliciously and intentionally transmit or expose others with the express purpose of causing harm… existing laws – against assault, homicide and causing bodily harm, or allowing intervention where a person is spreading communicable diseases – suffice to prosecute people in those exceptional cases".[280] It is this very approach that the HIV Act has taken, in recognition of Section 270 of the Indian Penal Code, which penalises a person who knowingly, intentionally, or maliciously spreads a life threatening disease.[281] Given the existence of this general law, Section 10 of the HIV Act instead stipulates the duty to prevent HIV transmission by a person who is HIV-positive, has undergone counselling, and is knowledgeable about the nature of HIV and its transmission. This

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[277] Section 9 of the HIV AND AIDS (PREVENTION AND CONTROL) ACT,2017.
[278] Id.
[279] Cameron E, Burris S, Clayton M. HIV is a virus, not a crime: ten reasons against criminal statutes and criminal prosecutions. J Int AIDS Soc. 2008 Dec 1 [cited 2017 Oct 24];11:7. doi: 10.1186/1758-2652-11-7. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2635346/
[280] Global Commission on HIV and the Law. Risks, rights and health, 2012 [cited 2017 Oct 24]: p.24. Available from: https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf
[281] Section 270 of the Indian Penal Code, 1860.

duty includes taking risk reduction measures with or self-disclosure to a partner[282]. The object of this provision is to apply a responsibility to take care of an informed HIV-positive person – of their sexual or needle-sharing partners, to mitigate the rash and malevolent behaviour envisaged by the penal code.

In these times of concerns around State surveillance linked to the Aadhaar scheme,[283] the HIV Act requires all institutions keeping records of HIV-related information to adopt data protection measures in accordance with guidelines to be devised in this regard.[284]Adequate precedent on robust data protection measures of health records exists globally, which will hopefully form the template for devising guidelines under the HIV Act.[285]

The HIV Act is also laudably related to the issues of informed consent, confidentiality and non-discrimination and maintains vital protections that offer health staff a much-needed right to a healthy working atmosphere.[286] Section 19 stipulates that institutions providing healthcare services and other venues which carry a significant risk of occupational exposure to HIV shall ensure universal precautions and post-exposure prophylaxis to all workers who may be occupationally exposed to HIV and train and educate them on their use and availability.

Section 14 of the HIV Act includes an element that has attracted some attention and criticism. fThis clause disappointingly qualifies the State's duty to provide 'as far as possible' antiretroviral therapy, inter alia, while the drat Bill submitted to NACO required free provision of antiretroviral therapy on the basis of the right of every citizen to the highest practicable quality of health under the International Covenant on Physical , Social and Cultural Rights.[287] The watering down this obligation seems to be a means for the State to escape liability for those living with HIV for supplying vital drugs. This is especially risky since the discontinuation or inconsistency of antiretroviral therapy

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[282] Section 10 of the HIV AND AIDS(PREVENTION AND CONTROL)ACT, 2017

[283] Dreze J. Dissent and Aadhaar. The Indian Express, May 8, 2017 [cited 2017 Oct 24]. Available from: http://indianexpress.com/article/opinion/columns/dissent-and-aadhaar-4645231/

[284] Section 11 of the HIV AND AIDS (PREVENTION AND CONTROL) ACT,2017

[285] See, for example, the UK's Data Protection Act 1998, and the Access to Medical Reports Act 1988 Available from: http://www.aidsmap.com/Access-to-medical-records/page/1505571/#item1505575

[286] Section 19 of the HIV AND AIDS (PREVENTION AND CONTROL)ACT, 2017.

[287] The International Covenant on Economic, Social and Cultural Rights is a foundational human rights document that the vast majority of countries are signatory too, including India. Article 12 (1) requires States to recognise "… the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

can contribute to drug resistance and serious health complications.[288] In addition, treatment-as-prevention research has shown conclusively that the consistent use of antiretroviral therapy will decrease the viral load to such a marginal degree that transmission to a sexual partner by a person living with HIV is prevented.[289]

Most of the State Governments have not yet made rules for the implementation of this Act, thereby denying the rights of the HIV/AIDS affected persons and continue making them the victims of discrimination. It is only after rules are made by the concerned State Governments, we will be able to know how far the State Governments have imbibed the very essence of this federal law which prevents discrimination, had been made to benefit the HIV/AIDS affected people.

Finally, a law that provides substantive rights is likely to be futile in actualising those rights (and in this case, contributing to HIV control efforts) if it is not endowed with rigorous obligations and systems to ensure effective implementation. Institutions of a certain size are required to set up grievance redress mechanisms with complaints officers,[290] and state governments are expected to appoint and vest powers and obligations under the law with an ombudsman.[291] The determination of the tenure and other powers of the Ombudsman will be determined by the State Governments involved, is likely to be dependent on the whims and fancies of the governing party in the State, and therefore is likely to be misused, which in turn is a significant setback to the 2017 legislation on Prevention and Control of AIDS. The rules by which how complaints are registered, rules regarding keeping of records and maintaining anonymity in case of legal proceedings are also under the purview of concerned State Governments.

Chapter VII of the HIV and AIDS (Prevention and Control) Act, 2017 containing Sections 15, 16 and 17 are provisions regarding welfare measures by the Central and State Government. Section 15(1) lays down that the Central Government as well as every State Government shall take measures to facilitate better access to welfare

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[288] US Department of Health and Human Services. Guidelines for the use of antiretroviral agents in adults and adolescents living with HIV; 2015 [cited 2017 Oct 24]. Available from: https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/18/discontinuation-orinterruption- of-antiretroviral-therapy

[289] US Centers for Disease Control and Prevention. HIV Treatment as Prevention [cited 2017 Oct 24]. Available from: https://www.cdc.gov/hiv/risk/art/

[290] Section 21 of the HIV AND AIDS (PREVENTION AND CONTROL)ACT,2017.

[291] Ibid at Chapter 10.

schemes to persons infected or affected by HIV or AIDS. Under Clause (2) to Section 15 the Central Government and State Governments shall frame schemes to address the needs of all protected persons. More than one and a half years after coming into force of the Act, no schemes have been framed by the Central or State Governments.

Inorder to understand the statutory compliance of the aforementioned Act, an attempt was made by the researcher by selecting Kerala as an illustrative State and an RTI was sought to the Public Information Officer, Kerala State AIDS Control Society(KSACS) under The Right to Information Act,2005.The data obtained for the period of 2018-2020 from the RTI dated 19.08.2020 reveals the following facts and figures:[292]

1. As per AAP 2019-20,various programmes were conducted under various Divisions like:
    - Basic Services Division: HIV Counselling & Testing Services are provided through Integrated Counselling and Testing Centres (ICTC) in Government and private Health Institutions.
    - Care & Support Services: Treatment and other care and support services for HIV infected and affected people are carried out through Anti Retroviral Treatment Centres (ART) m 10 Government hospitals.
    - STI Programme: Services like counselling, testing and treatment for Sexually Transmitted Infections are provided through STI Centres in Government hospitals.
    - Blood Transfusion Services: Responsible for the functioning of the Blood Banks in the state, to ensure blood safety and prevention of HIV through blood transfusion.
    - Targeted Intervention (TI) Programme: Through TI projects, KSACS provide services to the High Risk Groups (HRGs) including Female Sex workers (FSW), Men having Sex with Men (MSM), Transgenders (TG), Injecting Drug Users (IDU), Migrants and Long Distance Truckers.
    - Lab Services: Ensure the quality of Lab services that are working in all the Service centres of KSACS.

[292] 0536/2020/Admin II/KSACS dated 19.08.2020.

- IEC & Mainstreaming Division: Awareness activities through Mass media, Mid media, Outdoor media, Social Media and Mainstreaming with other line departments in the state and Youth oriented programmes in Schools and colleges.

2. 1184 new people were tested positive for HIV in Kerala.
3. KSACS comes within the purview of Section 2(f) of the HIV & AIDS Act, 2017 and data protection measures are complied under Section 11 of the Act.
4. Following are the welfare schemes for PLHIVS:
    - Inclusion of PLHIV in the RSBY CHIS PLUS scheme.
    - Snehapoorvam Special Scheme for Infected Children with the support of Kerala Social Security Mission.
    - Inclusion of all PLHIVs in the BPL list.
    - Free Pap smear Test for all women PLHIV.
    - Treatment Care Team supported by Kerala Social Security Mission.
    - Financial Assistance to PLHIV.
    - Nutritional Support by District Panchayat.
    - LIFE MISSION PROJECT- Free home for homeless PLHIV.
5. 1082 total registrations at the ART and 940 patients receiving ART.
6. No complaints regarding the protection of property of children affected by HIV/AIDS under Section 16(1) were received.
7. HIV and AIDS related information, education and communication programmes for High Risk Groups, especially Female Sex Workers, Men having Sex with Men, Transgenders are the gender sensitive programmes formulated under Section 17 of the Act.
8. Complaints Officer as stipulated under Section 21 is NOT appointed so far. Only draft rules are forwarded to the Government.
9. An Ombudsman as stipulated under Section 23(1) is NOT appointed so far. Only draft rules are forwarded to the Government.
10. As on 31 July 2020, there are a total number of 45 HIV infected persons in Prisons in the State, of which 18 persons are under active care.
11. In order to carry out the provisions of the Act, NO rules are so far made by the Government. Only draft rules are submitted to the Government.

    Thus, the information reveals that the provisions of this Act has not been fully complied by the State of Kerala, though Kerala is one among the developed states in the country.

WAY FORWARD

Indeed, the HIV Act is a constructive, progressive, social legislative initiative that can lead to the successful control of the HIV outbreak in communities of people that are disadvantaged and vulnerable, where it tends to fester. After undue delay, it has come to pass, and can only bear fruit if it is accompanied by financial and human capital that ensure its successful and humane execution. In addition, the HIV Act is hoped to act as a roadmap to wider health reforms to include healthcare rights and obligations, make health services and workers more accountable and fully realise the right to health for all Indians.

In view of the protection of persons affected by HIV and the elimination of discrimination against persons affected by HIV and their family members, the adoption of the Act is a step in the right direction. Treatment of anti-retroviral therapy is also a civil right under the terms of this Act for a person affected with HIV / AIDS. However, only infected persons are shielded from prejudiced actions and behaviours by the provisions of this Act. It is also essential to follow a systemic approach to fight bigotry against the infected and the disabled effectively and to create safe spaces for them.

With the legalisation of gay marriages, enforcement of this Act in spirit is the need of the hour. LGBTQ people are more vulnerable to AIDS and HIV. With the Supreme Court striking down Section 377 of the Indian Penal Code, 1860, and the HIV and AIDS Act also coming into effect, the LGBTQ community's social stigma will eventually end. They will have more rights and more persons will come forward with ease for medical treatment.

In 2016 , India had 80,000 new HIV infections and 62,000 AIDS-related deaths, according to UNAIDS. In 2016, there were 2.1 million people diagnosed with HIV, of which only 49% had access to antiretroviral care. The report from UNAIDS also indicates that men who have sex with men have an HIV prevalence of 4.3%, while the prevalence of HIV in transgender people is 7.2%.

The HIV/AIDS (PREVENTION AND CONTROL) ACT, 2017 is certainly a positive and much awaited development but it is equally important that the provisions of the Act must help those who are affected by HIV/AIDS. The failure to guarantee treatment and potentially flawed enforcement measures also goes against the very purpose of the Act.

Without the guarantee of treatment, HIV will once again become a death sentence. Treatment must be the absolute priority, so that we can be healthy and live. Section 14 of the Act dilutes the impact of the law.

Another significant setback of the Act being that the obligation for all state governments to establish an ombudsman to prosecute breaches of the Act is a major weakness in upholding the provisions of the Act as for the ombudsman, it is neither a full-time role nor the person needed to have some judicial training. Another issue regarding the appointment of Ombudsman is the question that from where will the state government, particularly if it is small and financially weak, get the funds to set up and maintain such a post. These are significant loopholes and when state governments implement federal laws, they make their own rules and these rules can easily water down the requirement for an ombudsman. It is also crucial on the part of the State Governments to frame rules for appointment of ombudsman in such a manner which ensures that the ombudsman provide immediate relief in case of emergency and in life threatening conditions. Even in other cases of discrimination, the Ombudsman must pass orders in a speedy and diligent manner.

There are recorded cases in many States where HIV affected people suffer as State fails to appoint ombudsman notwithstanding the compulsory provision under Section 23 of the HIV and AIDS (Prevention and Control) Act, 2017 to name one or more ombudsman to bring legal responsibility, and to devise a system to inquire into the grievances of people living with HIV / AIDS. But it has been over two years since the Act is formulated, that the Maharashtra Government has failed to implement it. Since no appointments are made so far, the patients living with HIV/AIDS are forced to approach police for justice, which often takes a longer time. The State of Kerala also has not appointed an Ombudsman so far. It was revealed through an information obtained from an RTI dated 19.07.2020 filed by the researcher. The main object of the Act is to render speedy justice to persons suffering from HIV/AIDS. But sadly, most of the States have not yet implemented it.

That said, nonetheless, the law is welcome because at least it gives people some recourse, some protection. Apart from all these flaws this Act is expected to strengthen the rights of lesbian, gay, bisexual, transgender and queer (LGBTQ+) community as it constitutes a significant chunk of HIV and AIDS inflicted population in India. With the

Supreme Court striking down Section 377 of the Indian Penal Code, 1860 and the HIV and AIDS Act also coming in force, the social stigma on the LGBTQ community will gradually go away. They will have more rights and we can expect more people will come forward for medical treatment with ease.

The need of the hour is an amendment to Section 14 (1) of the Act which states, "The measures to be taken by the Central or State Governments under Section 13 shall include measures for providing, as far as possible, diagnostic facilities relating to HIV or AIDS, Anti-retroviral Therapy and Opportunistic Infection management to people living with HIV or AIDS." The phrase "as far as possible" must be removed from the Act as it can be used as an escape route by the State Governments which do not want to fulfill their responsibility.

Although the enactment of legislation on this topic has already been considerably postponed, the feasibility of the legislation depends to a large degree on the timely implementation and successful adoption by the State Governments of the laws.

CHAPTER 6

CONCLUSION AND SUGGESTIONS

"The world must do more, much more on every front in the fight against AIDS. Of course, it means dramatically expanding our prevention efforts, but the most striking inequity is our failure to provide the lifesaving treatment to the millions of people who need it most. The single most important step we must now take is to provide access to treatment throughout the developing world. There is no excuse for delay. We must start now. If we discard the people who are dying from AIDS, then we can no longer call sourselves decent people."

Nelson Mandela[293]

The above statement made by Nelson Mandela in the year 2003 is still relevant for the fact that we have failed as a nation in providing access to treatment to the millions of HIV/AIDS affected people in the country. AIDS is a global disease. However, patented treatment for AIDS are affordable for patients in rich countries have not been widely available to the people in poor countries. First of all, there must be an appreciation that while AIDS is an infectious disease, it can be generally prevented. This means that public education and preventive measures such as free condom distribution and needle exchange programs are capable of slowing the spread of the disease. AIDS is also a sexually transmitted disease. India is a country where there are many myths and taboos related to sex and AIDS and the sexual taboo hamper India's fight against AIDS. Public health data shows that there is a clear correlation between a lack of social acceptance and legal security, independent of social status, and a higher incidence of HIV and sexually transmitted diseases, psychological stress, opioid addiction, crime and mental illness. Decades of global experience have shown that attempts to detect HIV and other sexually transmitted viruses are impeded by the criminalization of homosexuality. In addition, criminalization leads to greater distress among those afflicted with HIV and the risk of death because it establishes institutional and socioeconomic obstacles to access to healthcare. It is thus important to mention in this context the five-judge Constitution bench decision decriminalizing homosexuality in *Navtej Singh Johar & Ors. v. Union of India.*[294]In this notable judgment, Justice D Y Chandrachud, told

[293] July 15, 2003, at the International AIDS Society Conference in Paris.
[294] W. P. (Crl.) No. 76 of 2016

lawyers that public acceptance of people in gay relationships will help meet health concerns and control the spread of HIV. Saying that all suppression is wrong, Justice Chandrachud added, “Same sex couples living in denial with no access to medical care were more prone to contracting and spreading sexually-transmitted diseases." UNAIDS also welcomed the decision of the Supreme Court of India to annul key provisions of Section 377 of the Indian Penal Code which criminalized sexual relations between lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Criminalization hinders people from receiving and using HIV detection, monitoring and recovery programmes and raises their risk of contracting HIV. In India, the prevalence of HIV among homosexual people and other men who have sex with men is 2.7 percent and 3.1 percent among transgender people, compared to the national HIV prevalence of just 0.26 percent among all adults. Around three out of ten homosexual people and four out of ten transgender people in India who are living with HIV do not know their HIV status. Many LGBTI people living with HIV may not have access to HIV care, the UNAIDS Press Statement issued on 6 September, 2018 read.[295]

In addressing the AIDS problem, we must take a multi-pronged approach by including not just the homosexual community but also heterosexual sections of society. We have to make sure that the persons who need it most have access to information, confidential testing and prescription. The Prevention, treatment and human rights must be part of every holistic plan for AIDS. In any approach to fit the circumstances in various parts of the globe, these three criteria must be followed. Variations in community norms, affected populations, rates of transmission, legal systems, economic capital and human capital suggest that HIV / AIDS needs to be taken into account in particular circumstances. In the absence of access to care, a sense of futility in finding testing may be generated, which in turn will lead to the spread of the disease.

It is necessary to expand and improve the embraced National HIV / AIDS Policy. The strategy's aims are to decrease the prevalence of HIV; to improve access to treatment and to enhance health conditions for people living with HIV; and to minimise inequalities associated with HIV. A limited range of intervention measures must be defined by the plan that can coordinate strategies through federal, state, municipal, and tribal government levels and have the greatest effect on the domestic HIV outbreak.

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[295]https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2018/september/201809
6_India_section377

A CONCEPTUAL FRAMEWORK

A difficult mixture of biomedical, behavioural and socio-cultural influences impacts sexual transmission of HIV infection. In defining possible goals for which synergistic collections of strategies may be constructed, a simpler conceptual structure can be beneficial. Determinants of sexual HIV transmission operate at least at three stages that interact reciprocally, ranging from microbiological and cellular levels to individual and local community levels, to population and global levels.

The biological factors controlling susceptibility to the virus and the likelihood of infection are highly affected by the activities of individuals (and those of their partners), local sexual networks and regional health care services at the individual and community level. The frequency and type of sexual interaction between infected and uninfected partners is dictated by sexual behaviour and networks. Health-seeking activities and health programmes assess the chance that people may have access to appropriate facilities to include HIV testing, prevention and care, as well as co-infection therapy, and other STIs. Thus, these variables can influence biomedical factors such as HIV viral load and patterns of resistance or prevalence of co-infection. Intra-vaginal cleansing and other practices may also affect HIV transmission risk by altering host defences against HIV and/or co-infections.[296]

Finally, behavioural and biomedical variables are, in turn, influenced at the population and global levels by a large variety of fundamental determinants, including socio-cultural, economic, political, technological, epidemiological and demographic influences. This distal determinants incorporate the activities and biomedical parameters that control the likelihood of HIV transmission in dynamic ways to impact them and can in turn be influenced by these parameters.

This conceptual structure helps to distinguish important links in the sexual propagation of HIV's causal chain. For preventive measures, each connexion offers a possible target.

ANTIRETROVIRAL TREATMENT FOR HIV PREVENTION

The roll-out of antiretroviral treatment (ART) in low and middle income countries has been successful in reducing mortality and improving the quality of life among people living with HIV/AIDS. Existing evidence shows that ART is effective in protecting

[296] Intravaginal practices, vaginal infections and HIV acquisition: systematic review and meta-analysis. Hilber AM, Francis SC, Chersich M, Scott P, Redmond S, Bender N, Miotti P, Temmerman M, Low N PLoS One. 2010 Feb 9; 5(2):e9119.

uninfected individuals following exposure to HIV infection. Current guidelines recommend use of a full 28-day triple ART regimen for occupational exposure as well as non-occupational exposure if there is a substantial risk of HIV transmission from a known HIV-infected person or a person whose HIV status is unknown. Besides, ART may be used to protect individuals known to be HIV uninfected prior to exposure to the virus.

Universal voluntary HIV testing followed by immediate treatment of all infected individuals, irrespective of their CD4 (Cluster of Differentiation 4)[297] counts, has been proposed as a new strategy for HIV prevention. This Universal Test and Treat (UTT) strategy aims to reduce infectiousness at a population level, thereby reducing HIV incidence. Implementation of UTT is clearly challenging given that a substantial proportion of those individuals who are currently HIV-infected and eligible for treatment do not receive it.

MALE CIRCUMCISION

The efficacy of male circumcision (MC) in preventing female-to-male transmission has been definitively established in three RCTs (Randomised Controlled Trial) in South Africa, Kenya and Uganda.With some evidence of a protective effect from observational studies but no useful RCT evidence, the results on male-to - female transmission are less evident because the only study was terminated early as numbers were inadequate to provide appropriate power. Similarly, there is ambiguous empirical evidence of defence for males who have sex with men (MSM), including those who primarily participate in insertive anal intercourse, and no RCTs have been reported. It still remains unknown to what degree the defensive effect against female-to - male transmission is induced by impacts on ulcerative STIs.After more than 20 years of HIV prevention research, it is striking that only male circumcision has been proven to be an effective preventative intervention in multiple randomised trials.Although much has been learnt from the increasing number of flat trials, it is surprising to have a relatively poor percentage of trials with positive outcomes. Clearly, before planning future treatments and experiments, we must consider what experiences we can draw from these experiments, and if there are things we can do better.

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[297] It is a glycoprotein found on the surface of immune cells such as T helper cells, monocytes, macrophages, and dendritic cells.

It is also important to note that the primary guidelines emphasised by global public health organisations such as the WHO are to avoid AIDS in high-risk communities. The implementation of pre-exposure prophylaxis or PrEP, which promotes the use of anti-retrovirals as an alternative tool for HIV prevention, was one of those guidelines. The WHO noted that the lack of preventive regulation and inadequate expertise and awareness of health professionals on identity and sexual health lead to a reduction in access to health care for MSM and Transgender communities..

A new guidance for the care of high-risk groups was published by the WHO in 2015 and it was noted that rates of HIV infection in men who have sex with men remain high almost everywhere. In Asia, the WHO has recommended that health groups need to concentrate on MSM, transgender women, sex workers and their male partners as the top three demographic groups to step up HIV prevention. Health programmes, including HIV preventive resources such as condoms, PrEP, HIV testing centres and HIV treatment and care, among others, need to be given to these communities.

Another main objective of this research was to inform about the current status of HIV infected persons. The fact sheet of Global HIV & AIDS statistics of the year 2019 was published by UNAIDS[298] and the same is reproduced below for a better understanding of the global HIV/AIDS figures.

GLOBAL HIV STATISTICS

- 24.5 million [21.6 million–25.5 million] people were accessing antiretroviral therapy.[299]
- 37.9 million [32.7 million–44.0 million] people globally were living with HIV.[300]
- 1.7 million [1.4 million–2.3 million] people became newly infected with HIV.[301]
- 770 000 [570 000–1.1 million] people died from AIDS-related illnesses.[302]
- 74.9 million [58.3 million–98.1 million] people have become infected with HIV since the start of the epidemic.[303]

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[298] https://www.unaids.org/en/resources/fact-sheet
[299] End of June 2019.
[300] End of 2018
[301] End of 2018.
[302] Ibid.
[303] Ibid.

- 32.0 million [23.6 million–43.8 million] people have died from AIDS-related illnesses since the start of the epidemic.[304]

People living with HIV

- In 2018, there were 37.9 million [32.7 million–44.0 million] people living with HIV.
  - 36.2 million [31.3 million–42.0 million] adults.
  - 1.7 million [1.3 million–2.2 million] children (<15 years).
- 79% [67–92%] of all people living with HIV knew their HIV status.
- About 8.1 million people did not know that they were living with HIV.

People living with HIV accessing antiretroviral therapy

- As of end of June 2019, 24.5 million [21.6 million–25.5 million] people were accessing antiretroviral therapy.
- 23.3 million [20.5 million–24.3 million] people living with HIV were accessing antiretroviral therapy in 2018, up from 7.7 million [6.8 million–8.0 million] in 2010.
- In 2018, 62% [47–74%] of all people living with HIV were accessing treatment.
  - 62% [47–75%] of adults aged 15 years and older living with HIV had access to treatment, as did 54% [37–73%] of children aged 0–14 years.
  - 68% [52-82%] of female adults aged 15 years and older had access to treatment however, just 55% [41-68%] of male adults aged 15 years and older had access.
- 82% [62– >95%] of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their child in 2018.

New HIV infections

- New HIV infections have been reduced by 40% since the peak in 1997.
- In 2018, around 1.7 million [1.4 million–2.3 million] were newly infected with HIV, compared to 2.9 million [2.3 million–3.8 million] in 1997.
- Since 2010, new HIV infections have declined by an estimated 16%, from 2.1 million [1.6 million–2.7 million] to 1.7 million [1.4 million–2.3 million] in 2018.
- Since 2010, new HIV infections among children have declined by 41%, from 280 000 [190 000–430 000] in 2010 to 160 000 [110 000–260 000] in 2018.

AIDS-related deaths

[304] Ibid.

- AIDS-related deaths have been reduced by more than 56% since the peak in 2004.
- In 2018, around 770 000 [570 000–1.1 million] people died from AIDS-related illnesses worldwide, compared to 1.7 million [1.3 million–2.4 million] in 2004 and 1.2 million [860 000–1.6 million] in 2010.
- AIDS-related mortality has declined by 33% since 2010.

Women

- Every week, around 6000 young women aged 15–24 years become infected with HIV.
- In sub-Saharan Africa, four in five new infections among adolescents aged 15–19 years are in girls. Young women aged 15–24 years are twice as likely to be living with HIV as men.
- More than one third (35%) of women around the world have experienced physical and/or sexual violence at some time in their lives.
  - In some regions, women who have experienced physical or sexual intimate partner violence are 1.5 times more likely to acquire HIV than women who have not experienced such violence.

Key populations

- Key populations and their sexual partners account for:
  - 54% of new HIV infections globally.
  - More than 95% of new HIV infections in Eastern Europe and Central Asia.
  - 95% of new HIV infections in Middle East and North Africa.
  - 88% of new HIV infections in Western and central Europe and North America.
  - 78% of new HIV infections in Asia and the Pacific.
  - 65% of new HIV infections in Latin America.
  - 64% of new HIV infections in Western and central Africa.
  - 47% of new HIV infections in the Caribbean.
  - 25% of new HIV infections in eastern and southern Africa.
- The risk of acquiring HIV is:
  - 22 times higher among men who have sex with men.
  - 22 times higher among people who inject drugs.
  - 21 times higher for sex workers.
  - 12 times higher for transgender people.

HIV/Tuberculosis (TB)

- For people living with HIV, TB is the leading cause of death, accounting for around one in three deaths due to AIDS.In 2017, an estimated 10.0 million [9.0-11.1million] people developed TB disease, approximately 9% were living with HIV.
- TB preventive treatment is required for people living with HIV without TB symptoms, which lowers the chance of contracting TB and decreases the death rate of TB / HIV by about 40 percent.
- It is estimated that 49 % of people with HIV and tuberculosis are unaware of their co-infection and thus do not receive treatment..

SUGGESTIONS

On completing the research, the researcher feels that, sensitization projects for the police and health employees in the public and private sectors must be started by the government. This should reflect in particular on the need to handle with respect those afflicted by HIV / AIDS and provide them with equal treatment without prejudice. The researcher is also of the opinion that the existing legal frameworks for the prevention and control of HIV and AIDS in India is inadequate and thus failed to protect the human rights of persons so affected by the said disease.

Following are the suggestions which the researcher puts forth on completing the study.

- We need improvements in school curricula that stay outdated and also teach prejudice in classrooms.
- Through public awareness campaigns that focus on creating awareness and acceptance of those affected by HIV / AIDS, we also need targeted stigma reduction.
- We ought to develop programmes that meet the community's mental health needs.
- The medical practice must also share the responsibility to help individuals, families, workplaces and educational and other institutions to understand the problems faced by HIV/AIDS affected groups completely in order to facilitate the creation of a society free from discrimination where HIV/AIDS affected individuals like all other citizens are treated with equal standards of respect and value for human rights.

- We also need to create support networks amongst this community that reduce self-stigma and promote safer sexual practices. The government needs to partner with health and social care organisations to engage with the social networks within the LGBT community, who form a major chunk of HIV/AIDS affected persons.
- The existing legal framework for the protection of HIV/AIDS affected persons is the Human ImmunoDeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Act, 2017, which is inadequate. Certain amendments must be made out in the Act so as to prevent discrimination of PWHA effectively and efficiently.
- The State must ensure free treatment of those afflicted by the virus. The HIV/AIDS Act contains a 'convenient clause' by the State which provides that treatment to the HIV/AIDS affected persons shall be provided by the State 'as far as possible'. This provision goes against the very purpose of the Act.
- Health Insurance coverage and social security must be ensured to PWHAs and to the health service professionals.
- All persons have the right to enjoy the highest attainable standard of health, including the right to access affordable medicines and treatment.
- It is necessary to ensure universal and continuous access to medications for the treatment of OIs, ARVs and required monitoring tests for all PLHAs in order to understand the right to health of PLHAs.
- While expanding access to ARVs, existing schemes such as the Employees State Insurance Scheme must be effectively and appropriately utilized.
- All persons should have ARV access. Private health insurance could also help defray the costs of universal access.
- A health fund could also be set up, with special budgetary allocation for ARV access. This health fund could be made available not only for treatment of HIV but also other diseases that require expensive treatment. This would require an increase in the budgetary allocation for health.
- The State must also strengthen the role of NGO's.
- The decision makers- be it the Court or an Ombudsman under the 2017 Act, must strive to bring about an attitudinal change in patients and their families, health care teams, communities and policy makers.

- The existing legislation has proved inadequate to deal effectively with quacks, hence there is a need to amend the legislation.
- The media would be required to play a constructive role in the dissemination of information and refrain from publishing advertisements and claims by quacks.
- In the HIV/AIDS context, the practice of quackery threatens the very lives of PLHAs. HIV treatment, care and support providers should be equipped to convey effectively to PLHAs the nature of the disease and the importance of following medically indicated treatment regimes.
- The health infrastructure of the country should be improved and incentives provided for the setting up of proper medical colleges and increase the number of qualified physicians.
- An effective mechanism to monitor quality control in the country for blood, blood products, organ donation and HIV testing should be established.
- Regulatory controls of the media should impose privacy protection as well as guidelines for reporting of HIV/AIDS cases and information.
- Media reports, information on HIV/AIDS and media campaigns should be accurate, properly researched and devoid of stigmatization and stereotyping.
- The State Governments must frame, notify and implement the rules as stipulated under the 2017 Act as soon as possible so as to effectively realize the rights of PLHAs and to achieve the objectives of the Act.

BIBILIOGRAPHY

ARTICLES

- Richardson, Jean L., et al. "Physician Attitudes and Experience Regarding the Care of Patients with Acquired Immunodeficiency Syndrome (AIDS) and Related Disorders (ARC)." Medical Care, vol. 25, no. 8, 1987, pp. 675–685. JSTOR
- Fee, Elizabeth, and Manon Parry. "Jonathan Mann, HIV/AIDS, and Human Rights." Journal of Public Health Policy, vol. 29, no. 1, 2008, pp. 54–71. JSTOR
- Siegel, Richard Lewis. "AIDS and Human Rights." Human Rights Quarterly, vol. 18, no. 3, 1996, pp. 612–640. JSTOR
- Enoch, Jamie, and Peter Piot. "Human Rights in the Fourth Decade of the HIV/AIDS Response: An Inspiring Legacy and Urgent Imperative." Health and Human Rights, vol. 19, no. 2, 2017, pp. 117–122. JSTOR
- Mehrotra, Nilika, and Supriya Singh. "Conference Report: Women, HIV/AIDS and Human Rights." Indian Anthropologist, vol. 35, no. 1/2, 2005, pp. 197–207. JSTOR
- Leonard, Arthur S. "AIDS and Employment: Bibliographic Resources." The Labor Lawyer, vol. 3, no. 2, 1987, pp. 299–309. JSTOR
- Jain, Hem C. "AIDS: Need for Policy in the Workplace." Relations Industrielles / Industrial Relations, vol. 44, no. 4, 1989, pp. 850–865. JSTOR
- Farber, Bruce F., and Mark H. Kaplan. "The AIDS Epidemic: Neglected Issues." The Journal of Infectious Diseases, vol. 155, no. 6, 1987, pp. 1097–1099. JSTOR
- Sidorsky, David,'Contemporary Reinterpretations of the Concept of Human Rights', Essays on Human Rights, David Sidorsky(ed.), 1979, reproduced in International Human Rights in Context, p.327.
- Nickel,James, Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights, Berkley :University of California Press: 1987,pp.561-2 cited in, 'Human Rights', 'Internet Encyclopedia of Philosophy', Andrew Fagan at http://www.iep.utm.edu/h/hum-rts.htm#H2.
- Ashok Kumar, Women's Human Rights, Pg.4, 2014.

- Sen, Amartya,'Human Rights and the Westernizing Illusion', Harvard International Review,20(3),Summer 1998,available at http://www.mtholyoke.edu/acad/intrel/asian%20values/sen.htm
- Banerjee, Vikramjit, 'Human Rights and the Indian Academia: A Need for Civilizational Understanding',(2002)8SCC(Jour)1, available at http://www.ebcindia.com/lawyer/articles/2002v8al.htm.
- A Short History of the Human Rights Movement Early Political, Religious, and Philosophical Sources', Human Rights Web at http://www.hrweb.org/history.html.
- Hodges-Aeberhard, J.: Policy and legal issues relating to HIV/AIDS and the world of work (ILO, Geneva, 1999).
- United Nations employees and their families (Geneva, 1999), p. 29.
- Risa L. Goluboff, The Lost Promise of Civil Rights (2007)
- Jonny Steinberg, Sizwe's Test: A Young Man's Journey Through Africa's Aids Epidemic (2008)
- Human Rights Watch, A Question of Life or Death: Treatment Access for Children Living with HIV in Kenya (Dec. 16, 2008);
- Human Rights Watch, Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia (Dec. 18, 2007).
- Human Rights Watch, Letting Them Fail**:** Government Neglect and the Right to Education for Children Affected by AIDS (2005), available at http:/ / www.hrw.org/en/ reports/2005/10/O/ letting-them-fail.
- Amy Kapczynski, The Access to Knowledge Mobilization and the New Politics of Intellectual Property, 117 YALE L. J. 804, 828 (2008).
- Jonathan M. Mann et al., Health and Human Rights, in Health and Human Rights 17 (Jonathan M. Mann et al. eds., 1999).
- Nanu Poku & Fantu Cheru, The Politics of Poverty and Debt in Africa's AIDS crisis, 15 Int'l Rel. 37, 89-96 (2001).
- UNICEF, 2007, Barriers to Services for Children with HIV Positive Parents, July 2007, p. 1.
- Anant Kumar and Toni Schofield, 'Orphan and Vulnerable Children: health policy interventions in India', Journal of Health and Development, 2008, Vol. 4(1–4).

- Bharat, Shalini, et al, India : HI V and AIDS related Discrimination, Stigmatization and Denial. UNAIDS Best Practices, Key Material. UNAIDS/01.46E (Geneva : UNAIDS, August, 2001).
- Olaide Gbadamosi Esq,(2005) UNESCO, UNAIDS HIV/AIDS Human Rights & Law, Network for Justice Democracy.
- Dutta A, Barker C, Kallarakal A. The HIV treatment gap: estimates of the financial resources needed versus available for scale-up of antiretroviral therapy in 97 countries from 2015 to 2020. PLoS Med. 2015 Nov 24 [cited 2017 Oct 31];12(11):e1001907; discussion e1001907. doc: 10.1371/journal.pmed.1001907. eCollection 2015 Nov. http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001907
- The Lawyers Collective. Legislating an epidemic: HIV/AIDS in India. New Delhi: Universal Law Publishing; 2007.
- Global Commission on HIV and the Law. Risks, rights and health, 2012 [cited 2017 Oct 24]: p.24. Available from: https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf
- US Department of Health and Human Services. Guidelines for the use of antiretroviral agents in adults and adolescents living with HIV; 2015
- Human Rights and Humanitarian Law, Developments in Indian & International Law, Oxford University Press, 2008, South Asia HRs Documentation Centre.

BOOKS

- Dr.Lily Srivastava, Law & Medicine, Universal Law Publishing Co, Edn.1, 2010, Pp 67-70,95-101.
- Justice Hosbet Suresh, All Human Rights Are Fundamental Rights, Universal Law Publishing Co,Edn.2,2010,Pp 53-62,64-73,112-117.
- Prof (Ms)S.K.Verma, Legal Framework For Healthcare In India, Lexis Nexis,Edn.1,2002,Pp 11-25.
- Prof. (Dr).S.V.Joga Rao,Hiv/AIDS & Legal, Ethical & Human Rights Concerns Obtaining Indian Response, NLSIU, 2000, Pp 1-22
- Dr.Nandita Adhikari, Law and Medicine, Central Law Publications, Edn.4, 2015, Pp.270-296.

- Lan Brownlie & Guy.S.Goodwin, Brownlie's Documents on Human Rights, Oxford University Press, Edn.1, 2010, Pp.1144.
- Rama Jois, Justice, M, Ancient Indian Law, Eternal Values in Manu Smriti, Delhi, Universal Law Publishing Co. Pvt. Ltd, 2002 n.70, p.324.
- Holland on Jurisprudence, Edn.13, Chapter VII ,Pg.82.
- Gracias, Thomas (1997) AIDS Law and Social work, Rawat publications, New Delhi.
- Ram Ahuja, Social Problems in India, Rawat Publications, Edn. 3rd, 2014, Reprinted in 2016
- Ashok Kumar, Women's Human Rights Prateeksha Publications, 2014

CONVENTIONS AND TREATIES

- Universal Declaration of Human Rights, 1948.
- Declaration of Commitment on Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, 2001.
- Convention on the Elimination of All Forms of Discrimination against Women, 1979
- Convention on the Rights of the Child, 1989
- The International Covenant on Civil and Political Rights, 1966
- The International Covenant on Economic, Social and Cultural Rights, 1966
- Trade-Related Aspects of Intellectual Property Rights, 1995
- European Convention on Human Rights, 1953

ONLINE RESOURCES

- JSTOR
- WESTLAW
- LEXIS NEXIS
- SCC ONLINE
- MANUPATRA
- HEIN ONLINE

REPORTS

- Report of the Secretary-General on international and domestic measures taken to protect human rights and prevent discrimination in the context of

HIV/AIDS, Commission on Human Rights, Fifty-first session, 1995. E/CN.4/1995/45, paragraphs 12-14.

- Report of the First Consultation on HIV/AIDS and Human Rights (HR/PUB/90/2).
- Report submitted by the ILO to the Commission on Human Rights at its 57th Session on the steps taken by the ILO to promote the application of the International Guidelines on HIV/AIDS and Human Rights. Agenda item 14 (d): Specific groups and individuals: the protection of human rights in the context of HIV/AIDS, Geneva, 11 April 2001.
- Press Note on Poverty Estimates, 2011 – 12, Planning Commission; Report of the Expert Group to Review the Methodology for Estimation of Poverty (2009) Planning Commission.
- Report of the Expert Group Meeting on Women and HIV/AIDS and the Role of National Machinery of the Advancement of Women, convened by the division for the Advancement of Women,Vienna,24-28 September 1990 (EGM/AIDS/1990/1)
- Department of AIDS Control, Ministry of Health and Family Welfare, Government of India, Annual Report 2009-10.
- The Report of the National Commission to Review the Working of the Constitution, March 2002.
- United Nations Programme on HIV and AIDS (UNAIDS), The Gap Report, 17 (2014), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf
- United Nations Programme on HIV and AIDS (UNAIDS), World AIDS Day 2014 Report, http://www.unaids.org/sites/default/files/documents/20141118_FS_WADreport_en.pdf
- National AIDS Control Organisation (NACO), Annual Report 2014-2015, 403
- Social security: Issues, challenges and prospects, Report VI, International Labour Conference, (89th Session), 2001, ILO, Geneva, pp. 5-8.

RESOLUTIONS

- Decisions and resolutions of the Sub-Commission: 1989/17, 1990/118, 1991/109, 1992/108, 1993/31, 1994/29,1995/21, 1996/33, 1997/40.
- Resolutions of the Commission on Human Rights: 1990/65, 1992/56, 1993/53, 1994/49, 1995/44, 1996/43, 1997/33, 1999/49, 2001/33, 2002/32. Reports of the Secretary-General to the Commission on Human Rights: E/CN.4/1995/45, E/CN.4/1996/44.
- Resolutions of the Commission on Human Rights concerning the guidelines 1995/44, 1996/43, 1997/33, 1999/49, E/CN.4/2001/L.69 Reports of the Secretary-General to the Commission on Human Rights: E/CN.4/1997/37, E/CN.4/2001/80.
- Universal Declaration of Human Rights, Article 1, G.A.Resolution 217(III) OF 10 December 1948 at http://www.unhchr.ch/udhr/lang/eng.htm.

STATUTES

- The Constitution of India, 1950
- Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention And Control) Act, 2017
- Equal Employment Act, 1976
- The Patents (Amendment) Act, No. 15(2005) (India)
- Mental Healthcare Act, 2017
- Indian Medical Council Act, 1956
- Immoral Trafficking Prevention Act,1986
- Goa, Daman and Diu Public Health Act, 1985.
- Indian Penal Code, 1860.
- Drugs and Cosmetic Act, 1940.
- Juvenile Justice (Care and Protection of Children) Act, 2015.
- Medical Termination of Pregnancy Act, 1971.
- Narcotic Drugs and Psychotropic Substances Act, 1985.
- Suppression of Immoral Traffic in Women and Girls Act, 1956
- Young Persons (Harmful Publications) Act, 1956

APPENDIX

THE NATIONAL UNIVERSITY OF ADVANCED LEGAL STUDIES

Kalamassery, Kochi – 683 503, Kerala, India

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