Population Review

Volume 45, Number 2, 2006

Type: Report pp.72-84

HIV and Law in India: Need for an Act of Parliament to Protect the Vulnerable and Related Issues

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Introduction

This essay focuses on HIV law. First it presents the broad scenario of HIV/AIDS in India and its possible social and economic impacts. Then it describes the HIV policy in India and its limitations. At the end it deals with some legal controversies on the matter and gives suggestions to be considered in enacting the HIV law. It argues that the HIV laws must aim at protecting both people living with HIV/AIDS (PLHA) and those at risk, from stigma and discrimination. The law must, however, be supported by a fight against misconceptions, greater sensitivity to religion and culture, and strengthening of health facilities.

HIV situation in India

In terms of numbers, India is now the first country in the world with a maximum number of HIV positive persons that surpasses Africa where the HIV/AIDS epidemic has proved to be the most serious public health failure. As per the *2006 Report of the Global AIDS Epidemic*, in India the prevalence rate among the adults, 15 – 49 years, is between 0.5 to 1.5 percent. From the global standards this is not a high rate as such, but the matter of concern is that this rate has constantly been rising for last several years. All those concerned, the planners, academicians and activists think that this is the time to act. If the AIDS virus is not checked in time it may lead to catastrophic results for the society and economy.

Historically speaking, the year 2006 marked a 20 year presence in India of the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The first serological evidence of infection was found among the female sex workers in Tamil Nadu in 1986 although it is believed that the HIV first appeared in India among the intravenous drug users in the northeast states. Initially the cases of HIV/AIDS were reported from commercial sex workers in Mumbai and Chennai and intravenous drug users in Manipur State (NACO, 2003). Now the infection has spread to all parts of the country and to all groups; it is no longer confined to high risk groups. The Sentinel Surveillance conducted during August-October, 2003 revealed that the prevalence rate of HIV had crossed the one percent level in the urban areas of seven states. This means that if urgent steps are not taken at this stage the number of HIV positive people may grow exponentially and develop into a serious public health problem. Less than two decades ago the African countries were in the same situation in which India finds itself today.

India has a large population and even a decimal change in the rates and ratios produces significant changes in numbers. According to the UNAIDS, *2006 Report on the Global AIDS Epidemic*, the estimated number of people living with HIV is 5.7 million. The interval estimate is from 3.4 million to 9.4 million. Thus from a few thousands in 1990s the number of people with HIV/AIDS has gone up to 57 lakh (Radhika, 2006). According to the UNAIDS estimates again between 2.7 lakh to 6.8 lakh people (with a point estimate of more than four lakh) died of HIV AIDS last year (IBNLive.com., 2006). HIV is increasing faster than any other disease in India and there are estimates that 40 percent of all deaths due to infectious diseases in India in 2033 will be from AIDS only (Over, et al. 2004).

In India data on HIV are obtained from sexually transmitted diseases (STD), ante natal care (ANC) and injecting drug users (IDU) sites. For some places, namely, Goa, Mumbai and Tamil Nadu, MSM sites are also observed. There are some interesting trends. Andhra Pradesh, Goa, Karnataka and Maharashtra including Mumbai are the States/UTs where STD surveillance centres produce the prevalence rate above 10 percent. Although at most places, particularly where HIV prevalence had been high in the past, the rates are declining, the virus is spreading from high risk groups to the general population. Also in some groups the rate is still quite high. For example, in Tamil Nadu STD clinics based prevalence rate is less than 10 percent now but the IDU rate is nearly 40 percent. Similar is the case in Manipur where STD clinics based rate is less than 10 percent but the IDUS based prevalence rate is 22.00 percent.

Impact of HIV

Since the prevalence rate in India has not been high, systematic studies on the direct and indirect costs to society are lacking, but several such studies are available in the African context. They show that with HIV/AIDS the state has to spend a lot of money to create awareness, to provide counselling and testing facilities, and to provide treatment. Nearly 80 percent of the funds for financing AIDS control programme in India come from the government sector—with one-fifth coming from government revenue and four-fifth from World Bank credit (Over et al., 2004). The other 20 percent of the financial requirements are met from bilateral donors from USA (USAID), UK (DFIO) and Canada (CIDA). There are indirect costs too. Since HIV affects the adults, particularly younger adults, it has lot of economic and social repercussions. Further, HIV not only leads to 'economic death' of the individual, it directly affects productivity, shortens life, depresses fertility, leads to increased orphanage, illiteracy, poverty and legal and political problems.

The obvious impacts of HIV are: significant decline in agricultural and industrial output; reduced productivity; increased cost of production; contraction of real GDP; reduced exports; reduced labour supply; increased cost for imports and chronic shortage of foreign currency leading to shortage of basic commodities; and a large number of starvation deaths. Moreover, spread of HIV raises need for increased expenditure on health care, death benefits, training and recruitment. It leads to loss of revenue through loss of productivity due to funeral attendance, sick-leave, time spent on training, loss of skilled worker productivity (Policy Project: 2006). This necessitates that the state and society should commit to stop the spread of the virus. Of course, the economic impact of HIV depends on prevalence rates in the work force, cost of benefits (medical care, terminal benefits), cost of training of new employees, existing HIV/AIDS prevention/care interventions in public sector and within the company, and possibility of cost-sharing options with private medical insurers and public health sector.

Economic cost to individual and society is, however, just one part of the story. The other part is that HIV infected or those perceived to be at risk are stigmatized. This not only affects their

quality of life directly, it also creates obstacle in prevention of its spread. On 16 July 2006 *Sunday Times Kanpur*, the most popular paper of the north India, published on the front page:

> *An HIV positive couple jumped into the Ganga near Jajmau in Shuklaganj in Unnao district on Saturday.The suicide note later recovered revealed that they took the extreme step to save their family from the likely 'curse' of the disease.*
> *The couple – identified as Govind Raidas (25) and Sunita of Sikri village of Hardoi district – were identified by some boatmen who tried to save them, but to no avail. Police also recovered a pocket diary from the person of Govind which carried a suicide note wherein it was stated that the two were suffering from AIDS and hence were ending their life on their own accord. The police subsequently informed the members of Govind's family, who also confirmed his positive status. But they were not aware about Sunita, nor did she ever go for confirmatory test. Talking to TOI on phone from Hardoi, Govind's neighbour Ashwani said that the former was the eldest among three brothers and two sisters and worked as an auto driver in Mumbai and Ludhiana. He was married to Sunita of Beniganj in Kursi police circle of Hardoi in 2000. She used to stay with Govind's parents*.

Mahendra et al. (2006) found that although Health Care Workers (HCWs) generally denied that their hospital refused admission and/or treatment to patients because of their known or suspected HIV status, caregivers and patients reported that the access to and quality of in-patient care in New Delhi hospitals depended on a patient's HIV status. Experiences with and fears about such treatment were enough to deter some patients from seeking care and caused other patients to conceal their HIV-status from HCWs. Ironically, this is happening in Delhi, the capital city of India.

A recent study of 43 PLHA attending the treatment and follow-up services at the Vasai Regional AIDS Control Society in Mumbai documented stigma and discrimination against HIV positive people (Mulye et al., 2005). Stigma implies devaluation. Stigmatized persons are targets of prejudice (attitudes), stereotypes (cognition as beliefs, knowledge and expectations of social groups) and discrimination. Such persons are reduced in people's minds from a whole and usual persons to the tainted, discounted ones (Swim and Hyers, 2001). Stigma is relational in nature Goffman (1963), that is, it is an attribute that is deeply discrediting within a particular social interaction. Thus a stigma involves the public's attitude toward a person or group of persons who possesses an attribute that falls short of societal expectations in a given social context. Caste, community, ethnicity, religion, physical ability, appearance, anything can become a basis of stigma. Prostitutes, drug addicts, truckers, show people, full time gamblers, homosexuals, migrants and urban poor are often stigmatized. Since the disease in not understood by people, there are many misconceptions about HIV/AIDS.

Using the social representations approach it may be said that anchoring and objectification lead to associating HIV with certain groups with visible characteristics, such as commercial sex workers, dancing communities and migrants to big cities. Rarely people know that the person with the disease is not always responsible for having the illness: there are many who were infected due to unsafe health practices in hospitals and nursing homes. There is little knowledge of the fact that after the first stage of flue like symptoms, glandular fever and rashes etc. (Acute Stage or Stage I) lasting for four to eight weeks there is a stage (Stage II) in which the person has a healthy immune system with no symptoms. The stage may last for 10 – 12 years even without any medication. After this only the person goes into the asymptomatic immuno-suppressed stage (Stage III) and catches opportunistic infections which can be easily controlled. It is only during the last stage that one develops Acquired Immune Deficiency Syndrome (AIDS), characterized by a suppressed immune system that can result in death from infection. Even at this stage, where

available, Highly Active Anti-retroviral Therapy (HAART) can recover the immune system and an infected person may live a longer and better life.

There is a dearth of literature on how PLHA, a highly stigmatized group, respond to stigma. In many cases they have no pre-test or post-test counselling and have a rather poor knowledge of the modes of transmission. Mulye et al. (2005) showed that in Mumbai only 53.5 percent PLHA knew about sexual transmission, 23.3 percent about blood transmission and 14.0 percent about unusable needles. Yet, one thing is sure: stigma discourages people from knowing their HIV status and acting in a manner that prevents its spread to others.

Global Issues in HIV Law

In June 2001, the Heads of States and Representatives of Governments met at the United Nations General Assembly Special Session dedicated to HIV/AIDS. At the meeting, they issued the Declaration of Commitment on HIV/AIDS. The Declaration remains a powerful tool that is helping to guide and secure action, commitment, support and resources for the AIDS response. The United Nations General Assembly recognized that the AIDS epidemic had caused untold suffering and death worldwide. The UN Special Session served to remind the world that there was hope and that with sufficient will and resources communities and countries could change the epidemic's deadly course.

In principle there are two approaches to combat HIV/AIDS: *the public health approach* and *the human rights approach*. The public health approach, normally used when the prevalence of the epidemic has crossed an acceptable level (say 30 percent), asks for targeting, testing and follow-up investigation. On the other hand, the human rights approach looks at the affliction in the human rights framework. All countries, including the USA and those African countries where the prevalence rate is very high, have decided to opt for the human rights approach. India, too, has embraced the same approach. This approach emphasizes:

- Exclusion on any person solely on the basis of HIV status and without regard to his or her actual health is unfair and discriminatory (Jennings, 2000). The idea is best expressed in the judgment in "The Case of 'A' v South Africa Airways".
- People with HIV/AIDS (PLHA) are one of the most vulnerable groups in our society and the law must protect them from denial of their fundamental rights, including economic rights.
- PLHA cannot be refused treatment in a hospital.
- There are many prejudices and stereotyping against PLHA. The state should combat erroneous perceptions and stigma about HIV. Thus state must also save PLHA from the stigma prevalent against HIV.
- The impact of discrimination on HIV positive people, particularly in the context of employment, is devastating.
- Most HIV positive people (in the second stage of the HIV) are immuno-competent and can function as a normal person in all respects and can perform all the economic roles as efficiently as HIV negative persons.

HIV is linked with many aspects of the social structure. Vulnerable people in society—like women and children—must be saved from the infection. There are many discordant couples in which an infected partner has a high viral load that increases the chance of infection to the non-infected partner (Gray et al., 2001). The uninfected partner (usually the wife in India) must be protected. The author has come across cases in Allahabad district (in state of Uttar Pradesh in India) in which the infected husband who knew about his HIV status did not share the information with wife and eventually passed on the infection to her.

HIV Policy in India

HIV policy has to deal with complex individual behaviour. In an overwhelming majority of cases it is associated with sexual behaviour, the most intimate aspect of human behaviour, poorly understood and barely subject to external control. NACO suggests that in India the predominant mode of transmission of infection in AIDS patients is through heterosexual contact (85.7%), followed by injecting drug use (2.2%), blood transfusion and blood product infusion (2.6%), perinatal transmission (2.7%) and other causes (6.8%). It may be noted that in the last decade the percentage transmission due to blood transfusion and blood product contact has fallen significantly (Over et al., 2004). Thus an effective intervention strategy for HIV/AIDS requires a sound understanding of attitudes towards sex, expectations of sexual behaviour at the place of destination among the rural-urban migrants, sexual norms, sexual practices (including forced sex among the vulnerable girls working in mining, quarrying, agriculture, forestry and other informal activities), and gender norms which make the women and children particularly vulnerable or empowered.

As soon as the first HIV/AIDS case was discovered in India, a high-powered National AIDS Committee was constituted in 1986 and a National AIDS Control Programme was launched a year later. Initially the programme focused on generation of public awareness through a mass communication programme, introduction of blood screening for transfusion purposes, and conducting surveillance activities in the epicentres of the epidemic. In 1992 the government formulated a multi-sectoral strategy for the prevention and control of AIDS in India. The government policy was implemented through the National AIDS Control Organisation at the national level and State AIDS Cells/Societies at the State/UT levels. The programme concentrated on programme management, surveillance and research, information, education and communication including social mobilisation through non-government organizations (NGOs), control of sexually transmitted diseases (STD), condom programming, blood safety, and reduction of impact. (Embassy of India, 2006).

HIV/AIDS programme is a public health programme for which Ministry of Health and Family Welfare is responsible. The government of India established National Aids Control Organization for surveillance, information, education and communication, control of STDs, setting norms for target interventions, and research and information dissemination. The government has already implemented various programmes and developed norms for blood safety and involving state level agencies in the programme.

There have been several changes in programme design. National AIDS Control Programme (NACP) was launched first time in year 1992. In the first phase of the programme i.e., NACP (1992 – 1999), it focused on capacity building in managerial and technical aspects of the programme in all states and union territories, setting up of training centres for personnel involved in management, and strengthening the STD clinics. NACP II, which ran from 1999 to 2006, shifted to building awareness, seeking change in behaviour through interventions, setting up annual sentinel surveillance, detection of HIV/AIDS cases, evidence based planning and support for people living with HIV/AIDS. During this period greater efforts were made to involve high risk groups such as sex workers, truck drivers and injecting drug users. For the programme to act in a decentralized manner State AIDS Societies (SACs) were formed at the state level. NACP II had a goal to keep seroprevalence below:

- 5% of the adult population in high prevalence states
- 3% of the adult population in the moderate prevalence state
- 1% of the adult population in the low prevalence states

In April 2002, the Union Cabinet launched the National AIDS Prevention and Control Policy (NAPCP). It states that 15 years after the epidemic started, it has spread from urban to rural areas and from individuals practicing high risk behaviour to the general population. It recognizes that there is a wide gap between reported and estimated cases and that there is virtually no part of the country that remains unaffected by the epidemic. It states that for an effective response, development and human rights need to be addressed through a multi-sectoral collaboration. The NAPCP prioritizes human rights protection as an objective and not merely a strategy. Other objectives include reduction of the impact of the epidemic, bringing about a zero transmission rate by 2007, bringing about an enabling socio-economic environment for prevention and control, decentralisation of the programme and working towards a horizontal integration of the HIV/AIDS response with other national programmes relating to health.

Interestingly, while talking about strategies to deal with HIV, NAPCP included reinforcing traditional Indian values amongst youth and other impressionable groups along with the following standard items: awareness generation; participation of NGOs and community based organizations (CBOs); control of STDs; use of condoms as preventive measure; treatment; surveillance; injecting drug use; HIV testing; counselling, care and support for people living with HIV/AIDS; blood safety; research and development of medications; indigenous systems of medicine; international co-operation with bilateral agencies and other governments. The NAPCP recognises that the protection of the human rights of people living with HIV/AIDS and of those more vulnerable to HIV is essential to arrest the further growth of the virus. It draws attention to the violations of human rights of people living with HIV/AIDS and advocates review and reform of the criminal laws (in order to ensure that they are not used against vulnerable groups) and evolving anti-discrimination laws. It also advocates access to legal services and the creation of a supportive environment for women and children. Issues of specific attention include the right to privacy, ethics of research and access to services and information on rights. A related development is the development of strategy of harm minimisation and needle exchange prescribed for interventions with injecting drug users (Lawyers Collective, 2006). It is articulated that to implement the policy involvement of different departments of the government, decentralisation and collaboration with NGOs, especially for the purpose of targeted interventions, would be useful.

The NAPCP also reviews the role of private sector which caters to the needs of three-fourth of its population and aims at building an effective public-private-partnership (PPP). It suggests that through appropriate legislations it must be ensured that testing facilities in private health care comply with ethical guidelines and there are no violations of rights.

For the PLHA beyond a specified viral load there is a need for medicines and treatment. The NAPCP recognises the need for providing anti-retroviral treatment (ART) to people. The policy recognizes that the government is presently not providing ART due to prohibitive costs and that the government should make the necessary changes in excise and customs duties on the ARTs to make them more affordable to people.

NACP III, starting in 2006, places importance on district level surveillance and care which means that testing and ART facilities should be provided at the district level. It also stresses the need for strengthening infrastructure and links HIV/AIDS programme with the Eleventh Five Year Plan, 2007 – 11. In addition, it focuses on target interventions among the three core groups: commercial sex workers (CSWs), intravenous drug users (IVDUs) and males having sex with males (MSMs). It initiates a complex consultative process including state specific and nation wide consultations with state authorities, and national and international experts and NGOs.

The Government of India is currently procuring and delivering Anti- Retroviral Therapies (ARTs) through the public health system. They are delivered free of cost to the end consumers, at selected government hospitals. According to Sujata Rao (2006), Director General, NACO, 36,494 were receiving ART. Yet looking at the size of the problem this achievement is far from satisfactory and greater efforts and resources are required to reach the afflicted. So far only a

small proportion of people living with AIDS are getting ART. In one study among the PLHA at settings where they were receiving counselling and treatment it was found that only 19 percent respondents were using ART (Over et al., 2004). Lack of knowledge, lack of availability of facilities in the vicinity, lack of affordability by the common Indians are some factors behind this. Many PLHAs in the late stages of HIV suffer from opportunistic infections and contact doctor for fever, diarrhoea and lymphadenopathy without knowing their HIV status. The second line of treatment is utterly deficit. Efforts are on to develop a vaccine for HIV (NACO, 2006) with the help of Government of India, NACO, Indian Council of Medical Research (ICMR), and International Aids Vaccine Initiative (IAVI).

The HIV policy in India has several limitations. Some are as follows: lack of effective coordination with health programme; lack of vision regarding how to provide ARTs to the poor spread over lakhs of villages; lack of dialogue with the culture and tradition; lack of communication with the employers; and lack of integration with the development programmes. It is well recognized that an information campaign is the main answer to HIV (Villin and Mesle, 2006). Yet the role of health facilities is still very important. On papers in India STD control in general and HIV/AIDS in particular are integrated into primary health care with the understanding that their integration with primary health care ensures sustainability of the efforts, and the programme linkages between institutional, community and home levels. In actuality a sub-optimally functioning health infrastructure has no place for HIV/AIDS work. If a syndromic approach to STD diagnosis is actually practiced in the area of STD prevention and control, it will be quite effective as it does not require laboratory tests, and treatment for opportunistic infections can be given at the first contact with health services. Further, the activists working in low prevalence states complain of creating an artificial division between high, moderate and low prevalence states by the government of India. They say that people in different states are connected through mobility but due to this division the HIV work in low prevalence districts has suffered heavily. Finally, the NACP's emphasis on core groups (e.g., CSWs) has ignored the needs of the bridge population (e.g., the 'protectors' and 'husbands' of CSWs).

WHO also strongly advocates that all primary health care workers be trained in the syndromic approach to STD management. Attempts have not been made to educate and involve employers and religious leaders in the programme. In a poor country employers cannot obviously afford to provide for the medical bills of HIV positive people which may at times be higher than their salaries. The law may provide for some kind of subsidies to employers for providing testing and treatment facilities without disclosing the identity of the HIV positive persons.

Legal Approach in India

As said earlier, the law in India uses human rights approach towards PLHA. The guiding principle is that the discrimination, stigmatization and rights violations that PLHA face necessitate a judicial response. The urgent need to tackle HIV/AIDS has created an opportunity to reform shortcomings of the system. This has led to a string of judgments from the courts. Below are some significant judgments on HIV/AIDS passed by Indian Courts (Lawyers Collective, 2006).

- MX v. ZY *AIR 1997 Bom 406 -- Bombay High Court* (Right to Employment)
- Mr. X v. Hospital Z *(1998) 8 SCC 296 -- Supreme Court of India* (Right to Marry)
- A , C & Ors. v. Union of India & Ors. *(1999) -- Bombay High Court* (Right to Marry)
- Shri Subodh Sarma & Anr. v. State of Assam & ors. *(2000) -- Gauhati High Court*
- P v. Union of India *(2001) -- Kolkata High Court* (Negligence in blood transfusion)
- Chhotulal Shambahi Salve v. State Of Gujarat *(2001) -- Gujarat High Court* (Right to Employment)

- Mr. Badan Singh v. Union of India & Anr. *(2002) -- Delhi High Court* (Right to Employment)
- Mr. X v. Hospital Z *(2002)* Supreme Court Of India (Right to Marry)
- X v. Bank of India (2002) - Bombay High Court (Right to Employment)
- G v. New India Assurance Co. Ltd. (2004) Bombay High Court (Right to Employment)
- RR v. Superintendent of Police & others (2005) - Karnataka Administrative Tribunal (Right to Employment)
- Supreme Court of India (Section 377 of the Indian Penal Code, 1860)
- Sanmitra Trust & Ekta Self help Group V. State of Maharashtra (dancer's right to life)

The above judgments are based on the HIV related norms set up by the international organizations, the legal decisions and guidelines given by the courts in other countries, scientific facts and the directions given by NACO, in India. The most important considerations before the decision makers are voluntary nature of test, non-discrimination and strict confidentiality of results (except in cases in which a woman who is going to marry someone wants to know his HIV status).

To quote from the judgment in the case from RR v. Superintendent of Police & others (2005) - Karnataka Administrative Tribunal (Right to Employment):

> *HIV testing is recommended by the World Health Organisation (WHO) only for selected purposes. These include (1) screening of blood including blood products, and organs and tissues for transplantation; (2) epidemiological surveillance, particularly HIV sentinel surveillance using unlinked anonymous HIV testing methodology where all personal details of the person being tested are removed from the blood samples so that the results of HIV testing cannot be linked with the identity of the person – the specific purposes of testing in these situations are to ensure blood safety or to conduct epidemiological surveillance respectively; (3) diagnosis of symptomatic infection among those clinically suspected of having AIDS; and finally (4) early diagnosis of HIV infection among asymptomatic persons who would like to know their HIV status. In the latter two situations HIV testing is carried out with strict maintenance of confidentially. No situation other than the four listed above warrant HIV testing, and there is no place in national AIDS prevention and control programmes for testing without informed consent. Experience shows that any kind of HIV testing without the full and informed consent of the person concerned is counter-productive as well as wasteful of resources.*

The following is a quote from Shri Subodh Sarma & Anr. v. State of Assam & ors. *(2000)* -- Gauhati High Court.

> *In view of the draw backs pointed out above in implementation of the programme, it would not be uncalled for to issue suitable directions to the respondents to streamline the administration for adhering to the objection set by the NACO. We, therefore, propose to dispose of this writ petition with the following directions to the Respondents:-*
> *1. The guidelines and strategies formulated by the National AIDS Control Organisation (NACO) shall be properly implemented in letter and spirit with due regard to the London Declaration of Aids Prevention dated 28th January, 1988 and the Global strategy formulated by the World Health Organisation.*
> *2. The funds released by the Government of India shall not be diverted to any other Heads of Account except for the purpose of implementation of the programme as per guidelines and strategies formulated by the NACO and the funds withheld so far shall be released for the programme, if not already lapsed.*

3. The State Government shall make enquiry by appropriate agencies as to the irregularities in funding affairs, as alleged, and take appropriate remedial measures, if necessary.
4. The State authorities shall close those Blood Banks which are operating in the State without valid licence and establish a State Transfusion Council to regulate the affairs of the Blood Banks in the State ensuring that all tests mandatorily required to be done as prescribed by the World Health Organisation before transfusion of blood are carried out.
5. AIDS Counselling Centres should be opened at different State Hospitals through out the State, depending upon necessity and steps should be taken for effective functioning of the AIDS Counselling Centre opened at Mahendra Mohan Choudhury Hospital, and trained and qualified persons shall be appointed for AIDS Management Programme to prevent spread of AIDS in State.
6. Appropriate steps should be taken immediately to provide adequate equipments and other facilities in the three Medical Colleges in the State of Assam and trained persons should be posted to participate effectively in the AIDS Management Programme.
7. Effective monitoring system should be evolved to supervise the implementation of the programme including regular audit of accounts subject to the guidelines framed by the NACO in this behalf in addition to regular audits by the Accountant General, Assam.
8. Appropriate orders/directives be issued to ensure that persons suspected to be suffering from AIDS or HIV positive shall not be refused treatment in the hospitals. On such matters coming to the notice appropriate action should be taken against the erring doctors or the members of the staff.
The respondents are directed to take effective steps without loss of time to comply with the directions above. The writ petition accordingly stands disposed of.

The Lawyers Collective HIV/AIDS Unit was set up in 1998 to deal with HIV/AIDS law. It handled the first HIV litigation in the country involving the incarceration of the celebrated HIV+ activist Dominic D'Souza under the Goa Public Health (Amendment) Act, 1986. It also espoused the need for human rights based approach to deal with HIV/AIDS and people living with HIV/AIDS (PLHA), first time. In the 1990's, it set up a full time HIV/AIDS Unit for legal intervention on HIV/AIDS. Lawyers Collective HIV/AIDS Unit has a Head Office that was set up in Mumbai in 1998. It has drafted the HIV/AIDS Bill 2005 that may be taken up in the parliament soon. The various provisions of the bill aim at the following:

- prohibition of discrimination in employment and selection of occupation
- informed consent for HIV testing and treatment
- right to privacy so that no person is compelled to disclose HIV-related information (the healthcare provider may, however, inform the partner of the person)
- state to protect and fulfil the right to the highest attainable standard of physical and mental health
- right to safe working environment
- promotion of strategies for reduction of risk
- social security for the protected persons and their children
- right to information and education for protection of health
- institutional support to implement the provisions of the bill

One significant aspect of the bill is to shift attention from the PLHA to 'protected person' which means a person who is: (i) HIV-positive; or (ii) actually, or perceived to be, associated with an HIV-positive person; or (iii) actually, or perceived to be, at risk of exposure to HIV infection; or (iv) actually, or perceived to be, a member of a group actually or perceived to be,

vulnerable to HIV/AIDS. Also the definition of partner not only includes spouse but also "a person with whom another person has a relationship in the nature of marriage."

Both public sector companies and private business initiatives are coming forward for work place interventions. Indian Railways, Tatas, Mahindras, Larsen & Toubro, Steel Authority of India Limited (SAIL) & Employees' State Insurance Corporation (ESIC) have already commenced several initiatives for their employees, and the populations in their surroundings. Confederation of Indian Industry (CII) is co-ordinating acceleration of the business response to HIV. International organizations such as WHO and ILO have developed framework for policies for work place interventions which would have a significant impact on enacting HIV/AIDS law in India.

Controversial issues

The fight against HIV/AIDS involves dealing with controversial issues such as HIV infected mothers' rights, providing safe alternatives to drug users, and anti-sodomy laws.

In some cases in the USA child welfare agencies have sought to gain custody of children born to HIV-positive mothers for the sole purpose of administering HIV medications to the children. In one New York case, the Family Court ordered the mother to comply with an HIV medication regime for herself as a condition of the children's return to her care. They may undoubtedly be considered the cases of "unwarranted state infringement into the lives of HIV-positive women and their families" (HIV Law Project, 2006) but the infringement over individual mothers' right can be justified in terms of efforts to protect lives of the people in general.

In a recent and controversial move, the National Aids Control Organisation (NACO) is formulating a bill that will seek to legalize a national drug substitution and needle exchange programme under which known addicts would be supplied with clean syringes and drugs like Methadone and Bupernorphin for intravenous use. It is believed that while the clean syringes would help reduce the risk of addicts getting infected with HIV through sharing needles, the two less addictive drugs would help them get over hard substances like heroin and cocaine (AIDS-India, 2006).

In India, anti-sodomy law is another controversial issue. The controversial law, Section 377 of the penal code, makes sodomy or any kind of "carnal intercourse against the order of nature with any man, woman or animal" punishable by up to 10 years in prison. Naz India is seeking an amendment of 377, which would still cover male rapes. There is stigma and discrimination against sex workers, lesbians and males having sex with males (MSMs). Same sex marriages lack legal sanctity though they are a present reality. Other controversial and debatable issues in India are sex education in schools and the presence of condom vending machines in schools. Although state governments have already taken lead in including lessons on HIV in schools but the teachers hesitate to teach them especially in presence of girls. In general, the cultural is not ready to accept vending machines in schools though the people in both rural and urban areas widely acknowledge the presence of sexual activities among adolescents before marriage.

Concluding remarks

In sum, there is a need to protect the 'protected person'. The law must help people with HIV/AIDS and those at risk of getting HIV/AIDS. These people comprise an extremely vulnerable social unit in Indian society. Yet, the overall possible impact of law on society and culture cannot be ignored. The interests of mothers must be balanced with those of children yet to be born. The interests of HIV positive employees must be balanced with those of employers. The interests of drug addicts must be balanced with the larger interests of society and so on. It seems almost certain that the best course of action in the fight against HIV/AIDS is to fight against stigma and discrimination against PLHA. Relatedly, it is critical to provide the public with

accurate information about the disease (and dispel destructive myths) via the mass media and NGOs.

Several commentators have noted that the AIDS epidemic in Africa is less related to heterosexual transmission and more related to the collapse of the state system, unsafe medical practices, unsafe abortions, unsafe injections and unsafe delivery practices (Simonsen et al., 1999). Their feelings may be exaggerated, but the fact remains that 'systems failure' has and continues to be a primary factor in the spread of the HIV pandemic. The Indian story of providing health facilities is not very promising. Commonly, health providers and NGOs blame each other. In a recent study, aided by UNICEF, the author found that failure of ANMs to visit their respective fields, shortage of staff, and lack of quality services in rural areas have been associated with misconceptions about condoms. There is no doubt that there have to be institutions in place to fight HIV, but the institutions have to function.

A commitment to a systems approach is important. The point is that a well drafted law is not enough. It has to be supported by functioning social institutions. A functioning health system is the most important part of it. To fight HIV/AIDS, a law is needed to support PLHA. But to make it effective, an effective communication campaign must be in place to remove misconceptions about the disease, apprehensions of employers and religious groups must be respected, and the health system must be strengthened.

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