

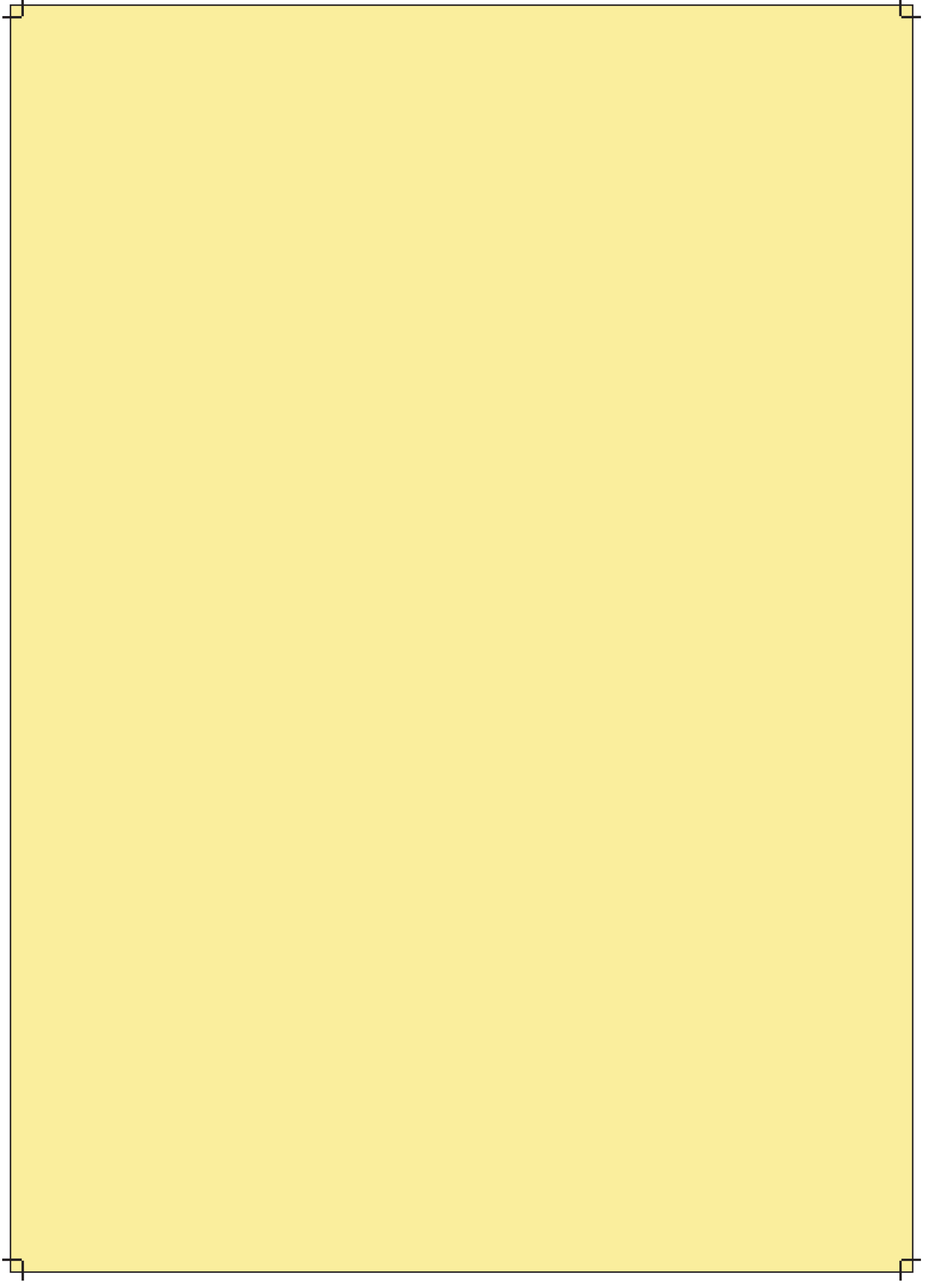


*Empowered lives.  
Resilient nations.*

# HIV and the LAW in India

A SCAN OF LAWS THAT  
CREATE THE FRAMEWORK

2016



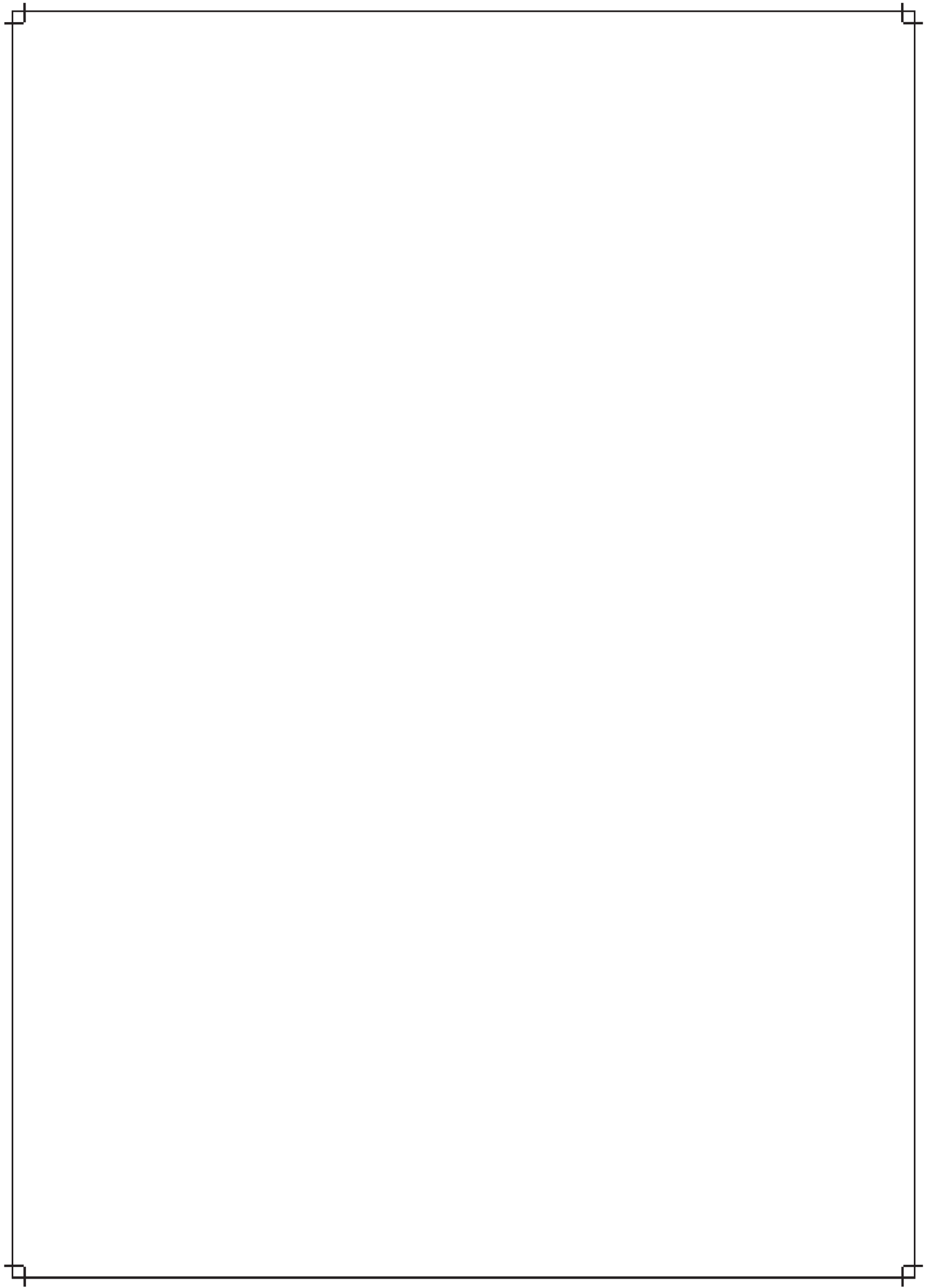


*Empowered lives.  
Resilient nations.*

# HIV and the LAW in India

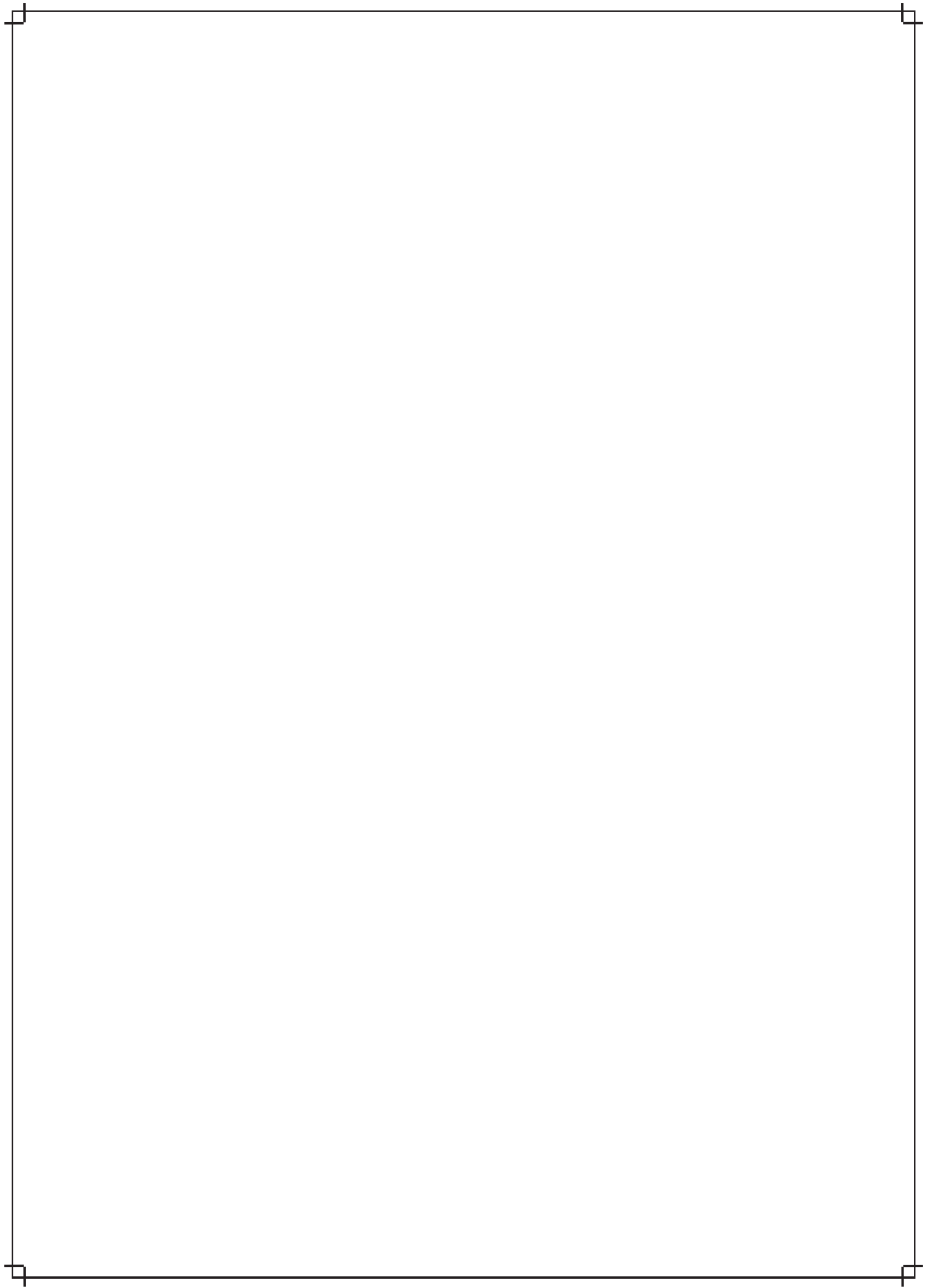
A SCAN OF LAWS THAT  
CREATE THE FRAMEWORK

# 2016



HIV/AIDS and Human Rights  
"Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS  
Respect for the rights of people living with HIV/AIDS drives an effective response"

The UNGASS Declaration of Commitment on HIV/AIDS  
"Global Crisis — Global Action"  
June 2001

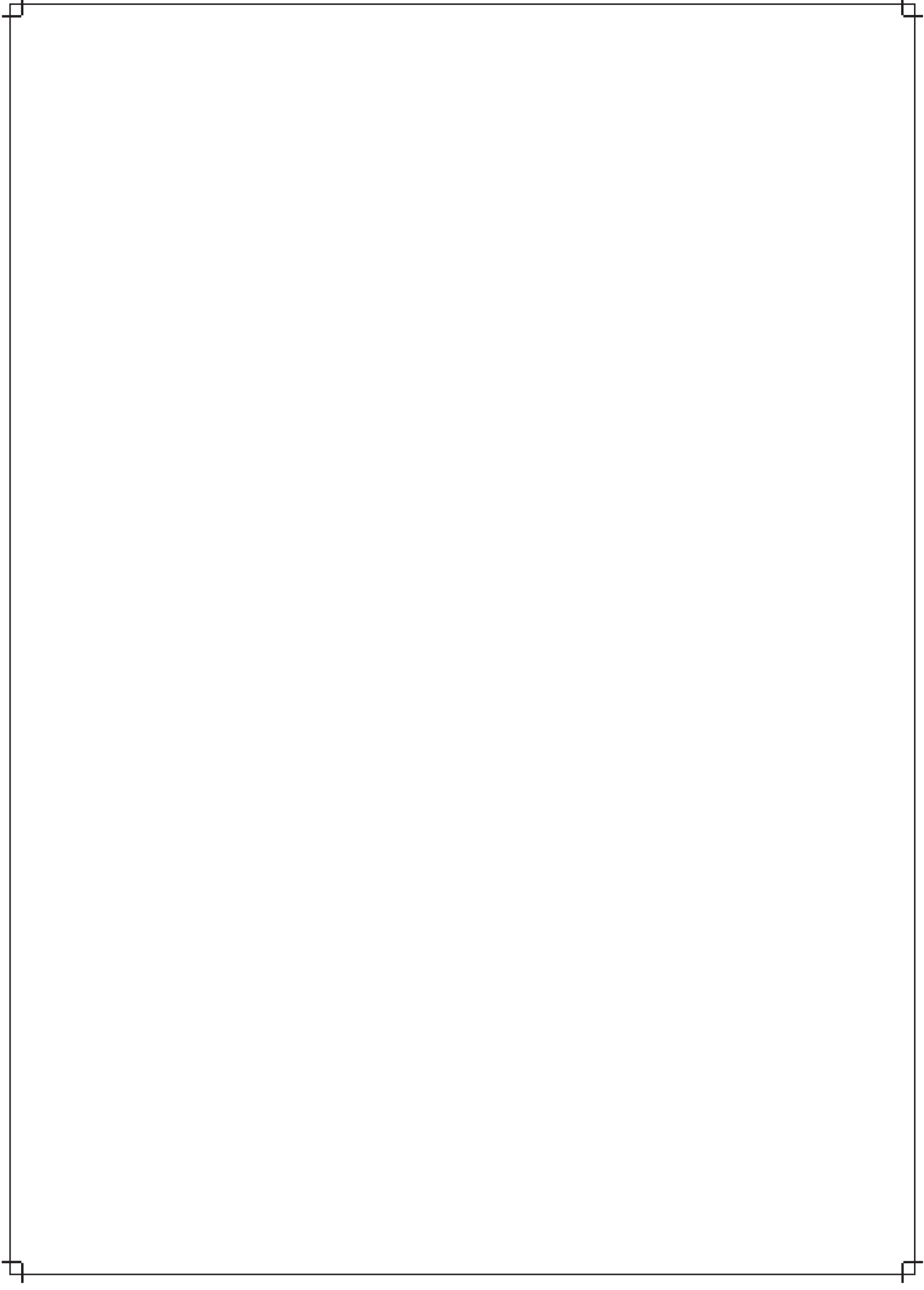


# CONTENT

|   |    |
|---|----|
| • Introduction.....   | 1  |
| • Legal protections for PLHIV<br>and affected communities.....              | 3  |
| International obligations.....  | 3  |
| • HIV, fundamental rights<br>and the indian constitution.....               | 6  |
| International Guidelines on HIV and Human Rights.....                       | 7  |
| Right to Life.....  | 8  |
| Right to Liberty and Security of the Person.....                            | 8  |
| The Equal Remuneration Act, (ERA) 1976.....                                 | 8  |
| The Rights of Persons with Disabilities Bill, 2014.....                     | 8  |
| • The HIV/AIDS Bill, 2007.....  | 9  |
| • India and Jurisprudence.....  | 13 |
| • Discrimination.....   | 15 |
| Discrimination based on HIV status.....                                     | 16 |
| Discrimination through isolation.....                                       | 16 |
| • Consent & confidentiality.....  | 17 |
| The Issue of Consent.....   | 18 |
| • The Issue of Mandatory Testing, HIV<br>and marginalized populations.....  | 21 |
| Testing for HIV/STIs/RTIs.....  | 21 |
| Testing for Children and Young Persons.....                                 | 21 |
| Testing for sex workers.....  | 21 |
| Testing for Prisoners.....  | 22 |
| Disclosure of HIV status.....   | 22 |
| • HIV and the Right to Life and Health.....                                 | 23 |
| Access to treatment: trips agreement.....                                   | 25 |
| Moving Forward: Recent Decisions on Patents<br>and Access to Medicines..... | 27 |
| • PLHIV and Insurance.....  | 28 |
| • Discrimination based on sexual orientation.....                           | 31 |
| • Recommendations and suggestions .....                                     | 39 |
| Legal measures.....   | 39 |
| Police reforms.....   | 40 |

|   |    |
|---|----|
| Reforming the medical establishment.....                              | 41 |
| Interventions by civil society.....                                   | 41 |
| • Cases that have been taken to various Redressal Mechanisms.....     | 41 |
| • The Supreme Court Judgment - NALSA v Union of India .....           | 44 |
| • Rights of Transgender Persons Bill 2016 .....                       | 46 |
| MOSJE Expert Committee .....  | 47 |
| • Laws that penalise and or illegalise vulnerable groups.....         | 52 |
| Criminalisation of marginalized populations.....                      | 52 |
| Sex work.....   | 52 |
| People who use drugs.....   | 56 |
| WOMEN living with and affected by HIV and AIDS.....                   | 66 |
| • Equality and Non-Discrimination.....                                | 69 |
| The Protection of Women from Domestic Violence Act (PWDVA), 2005..... | 70 |
| The Criminal Law (Amendment) Ordinance, 2013.....                     | 70 |
| Inheritance and property.....   | 72 |
| Maintenance and Alimony .....   | 73 |
| The Marriage Law (Amendment) Act, 2010.....                           | 73 |
| • Children.....   | 74 |
| • Notable current interventions.....                                  | 82 |
| • Sustainable Development Goals - SDGs.....                           | 86 |





# INTRODUCTION

We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General ... as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner Declaration of Commitment on HIV/AIDS "Global Crisis — Global Action" June 2001

At the historic United Nations Millennium Declaration in 2000, the global community acknowledged the importance of an effective response to HIV by placing it in the context of a broader development agenda. The Declaration of Commitment in 2001, followed by the Political Declarations in 2006 and 2011 adopted at the United Nations General Assembly witnessed the further commitment of Member States to the global AIDS response<sup>1</sup>.

The declaration of commitment on HIV/AIDS from the UNGASS<sup>2</sup>, like other UN conference documents, was the work of governments, intergovernmental agencies such as UNAIDS, and civil society organizations. Yet the special session was in many ways unprecedented. Although HIV/AIDS had been the subject of consideration by a number of UN bodies<sup>3</sup>, this was the first time that HIV/AIDS was specifically addressed by the general assembly as a topic of global and urgent concern<sup>4</sup>.

In the United Nations General Assembly Declaration of Commitment

on HIV, 2001, the Government of India recognized that, "...the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS<sup>5</sup>..."

India has been addressing HIV through the various phases of the National AIDS Control Programme (NACP). The goals of the fourth phase of NACP are aligned with the Government of India's 12th Five-Year Plan goals of inclusive growth and development for long term sustainability. Accordingly, the goals are to accelerate the reversal of the HIV epidemic and integrate the response over the current five-year phase.

Coordinated by UNAIDS, and guided by the UN Country Team, the Joint UN Team on AIDS in India brings together different UN agencies and UNAIDS co-sponsors, in support of the

---

1. <http://www.un.org.in/und/task-teams/hiv-aids#>  
2. United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. Resolution A/Res/S-26/2, 27 June 2001 ([www.unaids.org/UNGASS/docs/AIDSDeclaration\\_en.pdf](http://www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf)).  
3. See, especially, Commission on Human Rights resolutions 2001/51 on the protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and 2001/33 on access to medication in the context of pandemics such as HIV/AIDS  
4. <http://hrp.law.harvard.edu/wp-content/uploads/2013/03/ungass-declaration.pdf>  
5. <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

“Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society — national, community, family and individual;”

Declaration of Commitment on HIV/AIDS  
Global Crisis Global Action June 2001

Government; civil society; and community efforts. Coordinated by UNAIDS, and guided by the UN Country Team, the Joint UN Team on AIDS in India brings together different UN agencies and UNAIDS co-sponsors, in support of the Government; civil society; and community efforts<sup>6</sup>.

Over a decade later as the Indian Government's HIV programme continues to evolve, human rights and laws and policies reflecting these principles remain the focus of the response to the epidemic in India. This approach recognizes that the rights of those living with HIV as well as those affected by HIV like family members, employers, etc. and those most at risk to HIV like sex workers, drug users, the LGBTI community, women and children must be protected and enforced for an effective response to the HIV epidemic.

Discrimination against people living with affected by or at risk of HIV can often be rooted in unequal laws or legal protections within national laws. Often laws penalize sex workers, drug users and the LGBTI community disrupting HIV services that the government itself provides. In 2008 the AIDS in Asia Commission submitted its in-depth report on the HIV epidemic in Asia to the UN Secretary General. Finding that the epidemic in Asia is unlike the one in Africa, the Commission laid stress on addressing the

factors that inhibit or disrupt HIV prevention, treatment, care and support services to marginalized groups, women and children and identified the need for an 'enabling environment' based on the legal system.

“This paper highlights the enabling environment” in India. There has been extensive analysis of the gaps in the Indian legal system in relation to HIV and a critical process of legal reform is ongoing through the HIV Bill the amendments to which were approved by the Union Cabinet on 5th October, 2016.

In the mean time, public interest groups and networks of people living with HIV have actively engaged with the justice system and have achieved some critical legal successes promoting and protecting human rights in the context of HIV. For marginalised communities living in the shadow of criminalisation, the progress towards rights has been slower though with some critical successes such as the reading down of Section 377 of the Indian Penal Code which was known as India's anti-sodomy law.

There are always direct and indirect references to laws creating barriers to an effective HIV response, particularly in the case of criminalization. Where case laws and judgments are insufficient, good practices and policies are created, learnt from, studied and replicated.

---

6. <http://www.un.org.in/und/task-teams/hiv-aids#>

# LEGAL PROTECTIONS FOR PLHIV AND AFFECTED COMMUNITIES

## Article 1.

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.

## Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

## Article 3.

Everyone has the right to life, liberty and security of person.  
The Universal Declaration of Human Rights

## International obligations

India joined the United Nations on October 30th 1945 and is party to several international agreements and conventions, which contain detailed provisions on the rights to life, equality, non-discrimination, health and privacy. These provisions are particularly relevant in the context of protection of PLHIV and key affected communities.

## The Universal Declaration of Human Rights (UDHR), 1948

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights. Drafted by representatives with different legal and cultural backgrounds from all regions of the world, the declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 General Assembly resolution 217(III) A<sup>7</sup> as a common standard of achievements for all peoples and all nations. It sets out, for the first time, fundamental human rights to be universally protected<sup>8</sup>. India has been a party to the UDHR since its inception in 1948. The rights that it speaks

of influenced the formulation of India's Constitution.

The UDHR, a declaration that became the cornerstone of international human rights law stipulates that "all humans are born free and equal in dignity and rights" (Article 1). It also puts forward the principles of equality before the law without discrimination (Article 7) and the right to life, liberty and security (Article 3) as well as the right to privacy (Article 12). Translated into hundreds of languages and dialects from Abkhaz to Zulu, the UDHR set a world record in 2009 for being the most translated document in the world<sup>9</sup>.

## The International Covenant on Civil and Political Rights (ICCPR)<sup>10</sup>

The International Covenant on Civil and Political Rights (ICCPR) is a multilateral treaty adopted by the United Nations General Assembly on 16 December 1966, and has been in force from 23 March 1976. It commits its state parties to respect the civil and political rights of individuals, including the right to life, freedom of religion, freedom

7. [http://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/217\(III\)](http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/217(III))

8. <http://www.un.org/en/universal-declaration-human-rights/#>

9. <http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx#>

10. . Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49

“No single phrase in recent human history has been more privileged to bear the mission and burden of human destiny than the phrase “Human Rights”. The reason behind it is that “the millions of men, women, youth and children around the world will be born, live and die and never know they are owners of human rights. ”

Ivanka Corti, Former Chair, CEDAW.

of speech, freedom of assembly, etc and as of April 2014, the Covenant has 74 signatories and 168 parties<sup>11</sup>. At the core of the Convention is the non-discrimination guarantee.

India ratified the ICCPR in 1979 which obligates its states parties to respect the civil and political rights of citizens. Relevant here are the guarantees to ensure the right to life (Article 6); the right to liberty (Articles 9 and 12); the right to freedom from inhuman and degrading punishment (Article 7); the right to legal recourse (Article 2) and the right to freedom of expression (Article 19).

#### Non-discrimination: (Article 26)

“All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

#### Right to privacy: (Article 17)

“No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence...” The HRC has stipulated that, “competent public authorities should only be able to

call for such information relating to an individual's private life the knowledge of which is essential in the interests of society...” This is relevant in terms of the protection of confidentiality with regards to HIV status and has direct bearing on healthcare and employment policies, laws and practices.

#### The International Covenant on Economic, Social and Cultural Rights (ICESCR)<sup>12</sup>

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a multilateral treaty adopted by the United Nations General Assembly on 16 December 1966, and in force from 3 January 1976. It commits its parties to work toward the granting of economic, social, and cultural rights (ESCR) to the Non-Self-Governing and Trust Territories and individuals, including labour rights and the right to health, the right to education, and the right to an adequate standard of living. As of 2015, the Covenant has 164 parties<sup>13</sup>. The International Covenant on Civil and Political rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) require the respective States parties to guarantee the enjoyment of all rights without discrimination of any kind. Both also have specific provisions for the “equal right” of men and women in the enjoyment of all rights<sup>14</sup>.

11. [https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-4&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en)

12. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with article 27.

13. [https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-3&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en)

14. <http://socialprotection-humanrights.org/framework/principles/equality-and-non-discrimination/>

India ratified the ICESCR in 1979. This Convention contains many rights that are pertinent in the context of HIV and AIDS including the right to work (Articles 6 & 7), the right to social protection (Article 9) and the right to education (Article 13). In addition, the Convention guarantees the right to health and it is worth looking at this in more detail.

#### The right to health: (Article 12)

"The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This right has been interpreted as "an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."

#### The Committee on Economic, Social and Cultural Rights (CESCR)

CESCR has stipulated that the right to health includes certain freedoms and entitlements some of which are legally enforceable such as the provision on non-discrimination. Specific issues that have been addressed by the committee are particularly relevant

to PLHIV and marginalized groups. The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups has been defined as a 'core obligation' of states. The CESCR has stated that the Covenant "proscribes any discrimination in access to health care ... on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation... which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health<sup>15</sup>."

The CESCR has observed that the obligation on states regarding treatment, prevention and control of diseases "requires the establishment of prevention and education programmes for behaviour related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health."

The right to be free from non-consensual medical treatment and the right to have personal medical data remain confidential is also deemed to be a part of the right to health. These are considered to be cornerstones of a public health response with regard to protecting the rights of PLHIV and their

---

15. <http://socialprotection-humanrights.org/wp-content/uploads/2015/06/CESCR-General-Comment-19.pdf>

families and enhancing prevention efforts by encouraging people to voluntarily test themselves.

#### The ILO Convention No. 111 on Discrimination (Employment and Occupation)

India ratified this convention in 1960. This stipulates that each member State, "undertakes to declare and pursue a national policy designed to promote... equality of opportunity and treatment in respect of employment and occupation, with a view to eliminate any discrimination in respect there of. "Discrimination is defined in this document as" any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation."

It is important to note that India's legal framework is dualist and as such International laws related to rights cannot be transformed and applied in the country unless there is appropriate domestic legislation. None of the international conventions or treaties have been transformed into domestic law in India but Courts have called upon them in several cases when discussing fundamental rights.

#### HIV, fundamental rights and the Indian constitution

The human rights framework in India is governed by the Constitution of India<sup>16</sup> and the Protection of Human Rights Act, 1993.<sup>17</sup> However, the human rights framework in India is not just informed by the two International Covenants ICCPR and ICSECR but also others like the CRC and CEDAW to which it is signatory. These treaties are binding under international law and signatories are required to enforce these treaties. Under the Indian legal system, these treaties do not automatically become part of the domestic law and are brought in either through the enactment of domestic law or where there is no law or a gap in the law, where Indian courts read provisions of these treaties into domestic law.

The Indian Constitution follows the traditional dichotomy of human rights and recognizes political and civil rights as 'fundamental rights' while economic and social rights are recognised as 'directive principles of state policy.' The fundamental rights found in Part III of the Constitution are enforceable against the State in a court of law and pose a negative covenant on the State not to infringe these rights. The directive principles of state policy on the other hand are meant to inform government action and are not

"WE, THE PEOPLE OF INDIA, having solemnly resolved to constitute India into a SOVEREIGN SOCIALIST SECULAR DEMOCRATIC REPUBLIC and to secure to all its citizens: JUSTICE, social, economic and political; LIBERTY of thought, expression, belief, faith and worship; EQUALITY of status and of opportunity; and to promote among them all FRATERNITY assuring the dignity of the individual..."

Preamble

The Constitution of India

16. <http://lawmin.nic.in/olwing/coi/coi-english/coi-indexenglish.htm>

17. [http://nhrc.nic.in/documents/Publications/TheProtectionofHumanRightsAct1993\\_Eng.pdf](http://nhrc.nic.in/documents/Publications/TheProtectionofHumanRightsAct1993_Eng.pdf)

enforceable in a court of law. These rights provide a positive covenant for the State to confer or create conditions for the exercise of these rights. However, social and economic rights have attained an equal standing with civil and political rights and the Supreme Court has attempted to bridge the gap between the two sets of rights by reading components of the latter into the former. Thus, the right to life, a fundamental right, now includes the right to health and education.

These fundamental rights form the basis for the claiming of rights in the HIV context. As noted by the [International Guidelines on HIV and Human Rights](#)<sup>18</sup> :

“(a) The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards;

(b) Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people become

infected and those living with HIV and their families can better cope with HIV and AIDS;

(c) A rights-based, effective response to the HIV epidemic involves establishing appropriate governmental institutional responsibilities, implementing law reform and support services and promoting a supportive environment for groups vulnerable to HIV and for those living with HIV;

(d) In the context of HIV, international human rights norms and pragmatic public health goals require States to consider measures that may be considered controversial, particularly regarding the status of women and children, sex workers, injecting drug users and men having sex with men. It is, however, the responsibility of all States to identify how they can best meet their human rights obligations and protect public health within their specific political, cultural and religious contexts;

(e) Although States have primary responsibility for implementing strategies that protect human rights and public health, United Nations bodies, agencies and International Guidelines on HIV/AIDS and Human Rights programmes, regional inter governmental bodies and non-governmental organizations, including networks of people living with HIV, play critical roles in this regard.”<sup>19</sup>

---

18. <http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx>

19. <http://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf>



The enabling environment in India in the HIV context is thus defined by the Indian Constitution and is seen in the fundamental rights available to every person regardless of their HIV status, sexual orientation or gender identity. It can be seen in:

#### Right to life:

Article 21 of the Indian Constitution guarantees that "no person shall be deprived of his life or personal liberty except according to the procedure established by law." Article 21 casts an obligation on the State to safeguard the life and liberty of every person. The interpretation of this Article by the Indian Supreme Court has led to its invocation almost as a residuary right. Consequently, the Supreme Court has expanded the meaning and content of this right beyond the mere "animal" needs of a human being to cover the right to health, education, information and various other rights that exist as Directive Principles of State Policy that have now been recognised as part of the right to life.

#### Right to liberty and security of the person:

Article 21 of the Constitution guarantees not only the right to life but also the right to personal liberty of all its citizens.

#### The Equal Remuneration Act, (ERA) 1976

mandates that employers must equally remunerate men and

women for the same work. This Act specifically addresses inequity and discrimination within the workplace but only in terms of gender based discrimination in wages. Whilst this is not directly applicable to PLHIV, legal activists have pointed out that this law is useful in terms of "determining responsibility for discrimination by companies and corporations"<sup>20</sup> and "confirms the commitment and intent of the State to right the wrongs of discrimination."<sup>21</sup> This sort of legislation brings private corporations under the purview of the state with regard to constitutionally guaranteed rights.

#### The Rights of Persons with Disabilities Bill, 2014

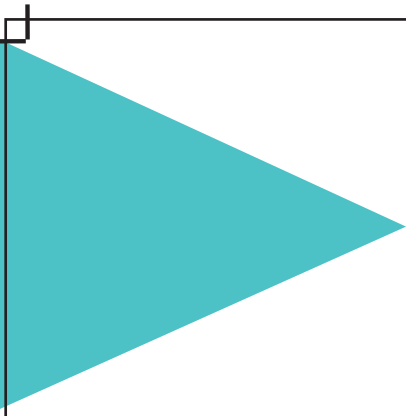
was introduced in the Rajya Sabha<sup>22</sup> in February 2014<sup>23</sup>. India ratified the UN Convention on the Rights of Persons with Disabilities (Disability Convention) in October 2007. The new Bill was drafted by the Ministry of Disability Affairs after several multi-stakeholder consultations, with the aim of bringing the law in line with India's obligations under the convention. Unfortunately, the current version of the Bill under consideration is a diluted version without many of the particularly useful provisions including the critical point that obligations under the Bill were to be applicable to all "workplaces, educational institutions, hospitals and health care providers, government services, private organisations/

20. The Lawyers Collective, *Legislating an Epidemic: HIV/AIDS in India* (New Delhi Universal Law Publishing, 2003).

21. Ibid. ERA outlines what constitutes a punishable offence and prescribes punishments including fines and prison terms, thereby providing an example of an anti-discrimination piece of legislation that has teeth.

22. This is the Upper House of Parliament in India. A Bill must be passed by both houses and signed by the President before it can become an Act of Law.

23. The new Bill repeals the current law, *The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995*. This law attempts to give effect to Article 14 of the Constitution in terms of equal opportunity. Whilst the PDA does attempt to alleviate the position of people with disabilities by addressing non-discrimination of disabled persons in government employment and public transport, it does not deal with the private sector at all.



bodies/ societies.”<sup>24</sup> The current bill only refers to establishments that are aided, funded or owned by the Government. Bringing private bodies and organisations under the purview of non-discrimination laws is a critical part of protecting the rights of people with disabilities or indeed PLHIV.

Across the world, activists have been advocating for the inclusion of PLHIV within disability laws on the basis that the stigma and discrimination experienced by PLHIV is similar to that experienced by people with disabilities. Many countries including Germany, Norway, the United States, the United Kingdom and Canada have now extended their disability laws to include PLHIV<sup>25</sup>. However, it should be noted that PLHIV and AIDS rights activists have not always supported this idea and have had concerns that being perceived as disabled will increase stigma and discrimination against them and heighten the perception that they are unable to perform certain roles and do certain jobs.<sup>26</sup>

#### The HIV/AIDS bill, 2007<sup>27</sup>

HIV and AIDS (Prevention and Control) Bill, 2014 is a unique joint initiative of the government and civil society saw its introduction in the Parliament. Drafted by the Lawyers Collective HIV/ AIDS Unit (LCHAU) after rigorous consultations across the country, this bill seeks to provide

for “the prevention and control of the HIV epidemic in India, the protection and promotion of human rights in relation to HIV/ AIDS” and for the establishment of relevant authorities “to promote such rights and promote prevention, awareness, care, support and treatment programmes to control the spread of HIV.”<sup>28</sup>

Building on the various rights enshrined in the Constitution, the bill specifically includes the recognition of the rights to Equality, Autonomy, Privacy, Health, Safe Working Environment and Information. Some features of the bill include:

Prohibition of Discrimination: Chapter II of the HIV/AIDS bill specifically prohibits discrimination related to HIV/AIDS in public and private spheres. Under the bill, no person may be discriminated against in employment, education, health care, travel, housing, insurance, etc., based on their HIV-related status. Informed consent for testing Treatment and research: In Chapter III, the bill lays out the requirements for specific, free and informed consent for HIV-related testing, treatment and research. The bill leaves little room for ambiguity here, defining informed consent as “consent given, specific to a proposed intervention, without any force, undue influence, fraud, threat,

24. “Nalsar slams leaked Disability Rights Bill 2013 that makes ‘mincemeat’ of rights & may pass for political points”, available at <http://www.legallyindia.com/201402054315/Constitutional-law/nalsar-calls-to-scrap-disability-rights-bill>

25. For a detailed discussion on this issue and the potential links between HIV and disability within human rights law, please see Elliot, R. Utyasheva, L. and Elisse Zack, “HIV, Disability And Discrimination: Making The Links In International And Domestic Human Rights Law”, *Journal of the International AIDS Society*, 2009, <http://www.jiasociety.org/content/12/1/29>

26. Ibid.

27. <http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf>

28. Ibid, Preamble, p. 3.

obtained after disclosing to the person giving consent adequate information including risks and benefits of, and alternatives to, the proposed intervention in a language and manner understood by such person.”<sup>31</sup>

**Disclosure of Information:** Chapter IV guarantees the confidentiality of HIV-related information (including the HIV status of a person) and outlines the few exceptions for disclosure. Importantly, whilst dealing with “partner notification” and the “duty to prevent transmission”, the Bill also recognises the vulnerability of women and specifies that the duty to notify partners is waived in the case of women who fear violence and loss of their homes in the event of notification.

**Right to Access Treatment:** Chapter V, within the context of the right to health, provides for access to comprehensive HIV-related “treatment care and support facilities, goods, measures, services and information, including centres providing voluntary testing and counselling services...and free of cost treatment for HIV/AIDS for all persons”.<sup>32</sup>

**Risk Reduction:** Chapter VII specifically addresses harm reduction strategies (such as the provision of clean needles, promotion of safer sex practices or provision of information and

condoms to sex workers), protecting them from civil and criminal liability and law enforcement harassment.

**Information, Education and Communication (IEC):** Chapter IX deals with IEC, recognising that information is the key to any successful prevention programme and places a duty on the State to promote positive and evidence based messages that look at prevention as well as care, support and rights. The information provided should be “age-appropriate, gender sensitive, non-stigmatising, non-discriminatory”<sup>33</sup> and should promote gender equality. It also suggests that particular attention be focused on women and young persons and IEC be made specific to their needs.

**Implementation and Grievance Redressal:** Chapters XI and XII address and conceptualise innovative implementation mechanisms, including an institutional grievance redressal machinery, Health Ombuds in each district and HIV/AIDS authorities that will take over from the National AIDS Control Organisation (NACO) and State AIDS Prevention and Control Societies (SACS) with an independent and accountable structure and expanded policy and programme base. The Bill also specifies special court procedures

---

31. The HIV/AIDS Bill 2007, Chapter 1 Art.2 (g).

32. Ibid., Chapter 5 Art.2.

33. Ibid., Chapter IX, Art. 24 (1).

including quick trials and creative redressal. Thus a case related to discrimination could see a court awarding damages and directing the person who discriminated to undergo sensitisation and training and do community service.

Special Provisions: Chapter XIV is a comprehensive overview of special provisions taking into account nuanced needs that may exist for particular groups in particular circumstances. For instance, it specifically recognises certain rights for women, children and persons in the care and custody of the State who find themselves more vulnerable to HIV and are disproportionately affected by the epidemic. Prisoners are provided with specific access to risk reduction strategies, counselling and health care services.<sup>34</sup> This chapter also addresses some underlying causes of the vulnerability of women to HIV, providing for the registration of marriages, the provision of maintenance and the right of residence for HIV-positive women<sup>35</sup>; The right of pregnant women to proper counselling, to enable them to decide treatment options, as well as a prohibition on forced abortion or sterilisation is also laid out.<sup>36</sup>

Critically, Chapter XIV addresses the link between sexual violence and HIV and directs the State to set up sexual assault crisis centres

where survivors of sexual assault may access services such as counselling, treatment and management of sexually transmitted infections (STIs), including HIV and AIDS, and referrals.<sup>37</sup>

The Standing Committee on Health and Family Welfare through its Chairperson Mr. Brajesh Pathak submitted its report on the Human Immuno deficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Bill, 2014 on April 29, 2015. The Committee endorsed the Bill, but made certain recommendations. Major recommendations of the Committee are outlined below<sup>38</sup> :

Framing of guidelines: The Bill provides for the framing of guidelines on certain provisions such as data protection, testing, and diagnosis. The Committee recommended that all guidelines to be framed under the bill should be framed such that the provisions of the bill are implemented effectively. The Committee also recommended that these guidelines be framed and be made available before the date of implementation of the proposed law.

Provision of diagnostic facilities for HIV: The Bill requires that the central government should provide anti-retroviral therapy and opportunistic infection

---


34. Ibid., Chapter XIV, Art. 75.

35. Ibid., Art. 70, 71.

36. Ibid., Art. 73.

37. Ibid., Art.74.

38. <http://www.prsindia.org/uploads/media/HIV/SCR%20summary-%20HIV%20and%20AIDS.pdf>



management to HIV positive people, as far as possible. The Committee recommended that the bill also mandate the provision of diagnostic facilities for people living with HIV (PLHIV) by the central government.<sup>39</sup> More than years after it was first introduced in Parliament the Government has revived the HIV/AIDS (Prevention and Control) Bill, 2014, which makes antiretroviral treatment a legal right of HIV/AIDS patients. A Group of Ministers (GoM) met on 06 July 2016, to iron out the issues as pointed out by a parliamentary standing committee, concerning the HIV/AIDS Bill.<sup>40</sup>

---

39. <http://www.prsindia.org/uploads/media/HIV/SCR%20summary-%20HIV%20and%20AIDS.pdf>

40. <http://indianexpress.com/article/india/india-news-india/hiv-aids-prevention-and-control-bill-antiretroviral-treatment-nda-govt-2898168/>



# INDIA AND JURISPRUDENCE

Through various decisions, the Supreme Court of India has discussed and expanded the scope of personal liberties by stating that liberty is also necessary to secure such conditions that are essential for the full development of human personality.

#### Right to Equality and to be free from all forms of discrimination:

Article 14 of the Indian Constitution guarantees that the State shall not deny any person equality before the law or the equal protection of the laws within the territory of India. Article 15 expressly prohibits the State from discriminating against any citizen on grounds only of religion, race, caste, sex, place of birth, or any of them. Article 15 also embodies the principle of positive discrimination and permits the State to make special provisions for women and children as well as for the advancement of socially and educationally backward classes of citizens and for Scheduled castes and tribes. While this provision permits the State to employ measures of positive discrimination, it does not mandate it to do so, leaving the decision to the State rather than making it an obligation of the State. Supreme Court and High Court judgments have determined the scope of the right to equality in relation to sex, sexual orientation and HIV.

#### Right to Privacy:

The right to privacy has been recognised as, "implicit in the right to life and liberty guaranteed to the citizens of this country by Article 21. It is a right to be left alone. A citizen has a right to safeguard the privacy of his own, his family, marriage, procreation, motherhood, child bearing and education among other matters." The Supreme Court has stated that, right to privacy must encompass and protect the personal intimacies of the home, the family, marriage, motherhood, procreation and child rearing. The court further stated that rights and freedoms of citizens are set forth in the Constitution in order to guarantee that the individual, his personality and those things stamped with his personality shall be free from official interference except where a reasonable basis for intrusion exists. Two key areas where the right to privacy has been invoked that are of relevance to this paper relate to the right to marry of PLHIV and the fundamental rights of the LGBTQ community.

#### Right to information and education:

Through an amendment in 2002, Article 21A of the Indian Constitution was introduced mandating that the Government provide free and compulsory education for all children from the age of six to the age of fourteen.

Although, the Supreme Court has not addressed issues regarding the standard or content of education that the State is obliged to provide, as these matters are left to the discretion of the State. The right to receive accurate information is seen more as contemporaneous of the freedom of speech and expression as well as the right to education. The right to receive and impart information as well as to be educated and entertained is incorporated in Article 19(1)(a).

#### Right to marry and found a family:

While few Indian court decisions have discussed the right to marry under Indian law, in a case related to a person living with HIV, the Indian Supreme Court strayed into discussions on this matter. In *Mr. "X" v. Hospital "Z"*,<sup>41</sup> the Supreme Court discussed the nature of marriage and of the "right to marry" and examined the right of confidentiality in the context of marriage and stated that,

1. "Patients suffering from 'AIDS' deserve full sympathy and are entitled to all respect as human beings. Jobs cannot be denied to them.

2. Although the doctor-patient confidentiality is an important and part of the medical ethics incorporated by the then Medical Council Act, a patient's right to confidentiality was not enforceable in a situation where the patient is HIV positive, if he

stood the risk of spreading it to his prospective spouse.

3. Since HIV is fatal and the life of the spouse has to be saved, the right to privacy of the patient is not absolute in this situation and may be restricted. There was nothing wrong, therefore, in Hospital informing the prospective spouse of Mr. X's HIV status.

4. Since acts likely to spread communicable diseases are a crime, the failure of the hospital to inform the spouse of the disease would make them participant criminals

5. Since Indian matrimonial laws provide venereal disease as a ground for divorce, a person suffering from a VD had no right to get married till she is fully cured and such a right must be treated as a 'suspended right.'<sup>42</sup>

An application against this judgement was filed before the Supreme Court to review and clarify the issues it had raised and in *Mr. X v Hospital Z* (AIR 2003 SC 664, (2003) 1 SCC 500) – the Court held that all observations relating to marriage in *Mr. X v Hospital Z* 1998, were not warranted as they were not issues before the court. However, the Supreme Court's pronouncements regarding the role of hospitals to make disclosure of HIV status in Mr. X's judgment remain as they were made regarding an issue before it in the case. Therefore, it held that the Supreme Court's judgment in *Mr. X v Hospital Z* to the extent that it suspended the

41. *Mr. X v. Hospital Z* (1998) 8 SCC 296, AIR 1998 SCW 3662 — Supreme Court of India

42. <http://www.lawyerscollective.org/hiv-and-law/judgements-a-orders.html>

right of people living with HIV/AIDS to marry is no longer good law and restored the right of an HIV + person to marry. However, it further held that this does not take away from the duty of those who know their HIV+ status to obtain informed consent from their prospective spouse prior to marriage.<sup>43</sup>

#### Right to the highest attainable standard of health:

The Directive Principles of State Policy require that the Indian State protect the health and strength of the people. The Supreme Court has held that the fundamental right of life and personal liberty enshrined in Article 21 includes within it the right to live with human dignity and hence minimum requirements, such as good health, must exist in order to enable a person to live with human dignity. The right to health is now recognised as inherent in the right to life. The Supreme Court has over the years specified the components of this right and has accordingly upheld the right to health of workmen, children, of the mentally ill as well as the right to emergency treatment. The Supreme Court while discussing the right of persons to emergency healthcare has said that the failure of a government hospital to provide timely medical treatment to a person in need of such treatment results in the violation of his right to life guaranteed under Article 21.

#### Discrimination

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at (PLHIV) and AIDS. In 35% of countries with available data, over 50% of men and women report having discriminatory attitudes towards people living with HIV.<sup>44</sup> The consequences of stigma and discrimination are wide-ranging. Some people are shunned by family, peers and the wider community, while others face poor treatment in healthcare and educational settings, erosion of their rights, and psychological damage. These all limit access to HIV testing, treatment and other HIV services.<sup>45</sup>

The People Living with HIV Stigma Index indicates that roughly one in every eight people living with HIV is being denied health services because of stigma and discrimination.<sup>46</sup> The People Living with HIV Stigma Index provides a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. In the initiative, the process is just as important as the product. It aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma - a key obstacle to HIV treatment, prevention, care and support.<sup>47</sup> Discrimination is a predominant and cross cutting theme in any examination of HIV, law and human rights. The legal framework must

43. <http://www.lawyerscollective.org/hiv-and-law/judgements-a-orders.html>

44. UNAIDS (2015) 'On the Fast-Track to end AIDS by 2030: Focus on location and population'; [http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1\\_68xur2l](http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1_68xur2l)

45. Stangl, A.L. et al (2013) 'A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come?' JIAS 16(Supplement 2):18734 ; Katz, I.T. et al (2013) 'Impact of HIV-related stigma on treatment adherence: systematic review and metasynthesis' JIAS 16(Supplement 2):18640; [http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1\\_68xur2l](http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1_68xur2l)

46. UNAIDS (2015) 'On the Fast-Track to end AIDS by 2030: Focus on location and population'; [http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1\\_68xur2l](http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination#footnote1_68xur2l)

47. <http://www.stigmaindex.org/>



not only prohibit discrimination based on various grounds, it must also not perpetuate discrimination and inequality. The right to equality, is enshrined in Articles 14 and 15 of the Indian Constitution.

The National AIDS Prevention and Control Policy 2000 (NAPCP), recognised that, "discrimination against People Living With HIV/AIDS denies them access to treatment, services and support and hinders effective responses. "The subsequent NAPCPs accordingly aimed to strengthen anti-discrimination 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.

#### Discrimination based on hiv status

Promoting, respecting and protecting human rights are fundamental to human development and ending AIDS as a public health threat by 2030. As such, any attempt to fast-track the HIV response must use rights-based approaches and tackle the widespread and deep-seated stigma, discrimination and other human rights violations faced by people living with HIV and key populations that are at higher risk of HIV infection.<sup>48</sup>

Cases related to discrimination based on HIV status have been filed in several courts and judicial platforms across India – they

include the district courts, the High Courts and the Supreme Court of India as well as forums and tribunals. When dealing with cases of people affected or infected by HIV and/or AIDS, the courts held that where a person is fit to perform his or her duties and does not pose a substantial risk of transmission of HIV to others be it in a social setting, healthcare or in the workplace, their rights cannot not be denied based on the person's HIV status.

Discrimination related to HIV occurs in multiple settings – employment, healthcare, education , insurance, etc. While court decisions have prohibited discrimination by the government, people living with or affected by HIV have little avenue for redress for discrimination in the private sector.

#### Discrimination through isolation

Lucy D'Souza vs. State of Goa<sup>49</sup> was one of the first litigations on the issue of HIV/AIDS in India. Section 53(1) (vii) of the Goa Public Health Act, 1987, empowered the government to isolate a person suffering with AIDS. The act did not specify a particular period of isolation or where it should take place, but that isolation was acceptable for such person, and at such institution or ward as may be prescribed. Thus wide powers were given to the government to take away the liberty of the individual on grounds that a person was suffering from AIDS.

48. [http://www.unaids.org/sites/default/files/media\\_asset/WAD2015\\_report\\_en\\_part01.pdf](http://www.unaids.org/sites/default/files/media_asset/WAD2015_report_en_part01.pdf)

49. Lucy D'Souza v. State of Goa, AIR 1990 Bom 355

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

Justice Michael Kirby of the Australian High Court

The late Dominic D’Souza had gone to donate blood where he was found to be HIV positive and as a result was quarantined in a TB hospital. The Goa, Daman and Diu Public Health Act, 1985 authorised the State of Goa to mandatorily test anyone for HIV and isolate persons found to be HIV positive and on such conditions for such period as may be prescribed. The provision was challenged before the Goa Bench of the Bombay High Court by Dominic’s mother, Lucy D’Souza, on the ground that it violated the fundamental rights of her son, guaranteed under Articles 14 (right to equality), 19(1) (d) (right to move freely throughout the country) and 21 (right to life) of the Constitution.

The court held that the matter essentially fell in the realm of policy and this decision was taken by those who were in charge of advancing public health and who were equipped with the requisite know-how. Further, while recognizing the harmful effects of isolation of people living with HIV, the court held that in case of a conflict between individual liberty and public health, considerations of public health would prevail.<sup>50</sup> It was also considered that the isolation might lead to people not coming forward and people not coming forward and going underground if they are suffering from HIV/AIDS. Thus they will not be able to take proper treatment.

#### Denial of treatment

In December 2010, the Delhi High Court gave immediate directions to a Delhi hospital to provide blood and treatment to a poor, HIV-positive pregnant woman who needed blood transfusion before her delivery. In this case the hospital had asked her husband, also HIV-positive, to procure the blood as well as a universal precaution kit despite the fact that he had repeatedly explained his inability to afford these items. The Human Rights Law Network filed a case with the Delhi High Court on behalf of the husband upon hearing which the Court ordered the hospital to provide the requisite care.<sup>51</sup>

#### Consent & confidentiality

For (PLHIV), voluntary and confidential HIV testing is considered the gateway to treatment and other HIV-related services. With the majority of people living with HIV unaware of their HIV status, scaling up testing has been a constant refrain of both national and international programmes. In addition, the HIV epidemic has demonstrated the importance of ensuring that HIV testing is voluntary and confidential from a public health perspective as well. This is essential for not only HIV testing, but also for testing for STIs and RTIs amongst women, adolescent children, young persons, vulnerable communities, etc. The object of informed consent and counselling

50. <http://www.lawyerscollective.org/hiv-and-law/judgements-a-orders.html>

51. <http://hrln.org/hrln/hiv-aids/pils-a-cases/629-hiv-ve-pregnant-woman-denied-treatment.html>

for HIV and such communicable diseases is to help persons under going a test to take a voluntary informed decision based on knowledge and understanding the implications of a positive and a negative test, and to make a choiceto either consent to undertaking the test or refuse to undertake it.

#### The issue of consent

The International Guidelines on HIV and Human Rights state that that there is no public health rationale for mandatory testing and that respect for the right to physical integrity requires that "testing be voluntary and that no testing be carried out without informed consent."<sup>52</sup> Research has shown that "testing for HIV can... have profound consequences for the individual, consequences that are significant in human rights and public health terms. The issues of consent and autonomy have accordingly assumed considerable importance in the HIV/AIDs context"<sup>53</sup>

The issue of consent for testing or treatment is a critical one for any medical condition being linked to respect for the individual's autonomy and bodily integrity and protecting both patient and physician. The patient needs to understand and have faith in the treatment being offered and this is particularly important with relation to HIV for which strict adherence to the treatment regime is usually a long term requirement.

Research indicates that mandatory screening policies have detrimental effects on HIV prevention efforts, causing people from key populations to avoid health authorities so that they are not identified and forcibly tested. Apart from this, informed consent is particularly critical in the case of testing for HIV due to the resounding implications of a positive result on every aspect of the individual's life. Informed consent should include appropriate counselling services that help people arrive at a voluntary decision with full understanding of the medical and social implications of a positive result.<sup>54</sup>

Article 21 of the Constitution of India guarantees the right to life and personal liberty. The principle of autonomy has been enshrined within this right, which also includes the right to live with human dignity. Though it may seem removed from the topic, contract law in India also deals with the principle of consent. The Indian Contract Act, 1872 stipulates that all agreements are contracts made by the free consent of parties, and "two or more persons are said to consent when they agree upon the same thing in the same sense".<sup>55</sup> Consent is free if it is not obtained by coercion, undue influence, fraud, misrepresentation or mistake.<sup>56</sup>

In India, mandatory HIV testing policies were, as in the case of other countries, mooted at the

---

52. Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, International Guidelines on HIV/AIDS and Human Rights, 2006, Para 135.

53. Lawyers Collective, 2003, p. 22.

54. Ibid.

55. See: The Indian Contract Act, 1872 (ACT No. 9 OF 1872), Article 13 [25th April, 1872].

56. Ibid, Article 14: "Free Consent defined".

beginning of the epidemic. The National AIDS Prevention and Control Policy (NAPCP) recognises the counter productive nature of mandatory testing and notes that the State “feels that there is no public health rationale for mandatory testing of a person for HIV/AIDS.”

In 1995, the National HIV Testing Policy was formulated to lay down protocols for testing to monitor the trend of HIV infection, to test blood or organs or tissues for ensuring safety to the recipient, to identify individuals with HIV infection for diagnoses and voluntary testing purposes and for research. Mandatory screening for HIV is recommended only for blood transfusion safety and for screening donors of semen, organs, or tissues to prevent transmission to the recipient of the biological products. In these circumstances, the tests cannot be linked to the identity of the individual.

As seen above, the Indian private sector remains virtually uncontrolled while adopting discriminatory practices such as mandatory testing for employment and access to services, particularly health care. There is a plethora of international case law:

Specifically in relation to the doctor-patient relationship, in 2002, the Medical Council of India [MCI] framed the Indian Medical Council

(Professional conduct, Etiquette and Ethics) Regulations, 2002 codifying professional and ethical duties of medical doctors. The MCI regulations address consent to medical interventions in the limited areas of surgery, assisted reproductive technology and research. The Regulations do not address consent for testing and treatment for which the Supreme Court has now laid down requirements.

#### The Issue of confidentiality

The International Guidelines on Human Rights and HIV stipulate that the duty of States to protect the right to privacy “includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent, that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual”<sup>57</sup>

The right to confidentiality, while not explicitly covered under Indian law, is derived from Article 21 of the Constitution, interpreted by the Supreme Court to include the right to privacy and therefore to confidentiality. In a general context, it recognises the right of every person to take part in activities or have information that he/she needs not disclose to anyone else.

---

57. Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, International Guidelines on HIV/AIDS and Human Rights, 2006, Para 121.

“Prima facie, this conduct of respondent ...is wholly illegal and demonstrates lack of sensitivity. It appears to violate the fundamental right under Article 21 of the Constitution of India, which ensures the right to life with dignity to every citizen. It also breaches the privacy and confidentiality of the petitioner, which was required to be maintained in relation to her medical condition.”

Ms. X V Union of India and Ors  
W.P.(C) 691/2012, Delhi High Court

In the context of HIV, “the maintenance of confidentiality of an individual’s health status is one of the cornerstones of a rights-based legal and public health response to HIV/AIDS.”<sup>58</sup> This is necessary given the inevitable discrimination and ostracism associated with public disclosure of one’s HIV status. A public health approach recognises that people will avoid a health care system that violates their confidentiality and leads to their stigmatisation. This has the effect of hiding the epidemic, making prevention and control efforts ineffectual.

While the right to confidentiality is perceived as critical in terms of encouraging KPHR to avail of HIV testing, counselling and treatment services, it is not an absolute right. Courts around the world have deemed it necessary to strive towards a balance between the public interest of maintaining confidentiality versus the public interest in disclosure of the information. The law has addressed situations where disclosure of the HIV status of the individual may be necessary regardless of consent being obtained. These include situations within which:

- “notification to public authorities is required by law;
- disclosure is necessary in the public interest, or for the administration of justice (in a court proceeding where HIV status is a material fact), or for the benefit and treatment of the patient (to a

healthcare worker directly involved in the treatment)

- disclosure is necessary to protect an identifiable person who is in foreseeable danger (partner notification).<sup>59</sup>

In July 2011, the Center for Legal Aid and Rights through its counsel filed a writ Ms. X v Union of India and others<sup>60</sup> in the Delhi High Court, the petitioner was admitted in the Hospital for some complications in her gallstone. A placard was put above her bed saying “Sero Positive Bio Hazard”. A legal notice was sent to the Hospital, in 2011 and no response was received. Thereafter, a write petition was filed before the Delhi High Court in 2012. The court condemned the breach of confidentiality and stated that it is the duty of the health care provider not to disclose any medical status of the patient. The court also directed the Union Government to circulate a notification to all hospitals stating that such disclosure of medical status amounts to breach of confidentiality.

Taking into account that no such mandatory policies or guidelines were present or being used, the court directed the respondents including NACO, to draft guidelines on confidentiality in consultation with CLAR; this was drafted in December 2014 and submitted to the Hon’ble court. As there were specific gaps in the guidelines drawn up, they were

58. <http://www.hivaidsonline.in/index.php/HIV-Human-Rights/legal-issues-that-arise-in-the-hiv-context.html>

59. Ibid.

60. Ms. X V Union of India and Ors; W.P.(C) 691/2012, Delhi High Court

identified and CLAR on behalf of Petitioner submitted additional clarifications to the guidelines in April 2015. The Union Government has now to incorporate the comments given by CLAR and submit the guidelines to the Court. The matter is pending for further order.

### The Issue of Mandatory Testing, HIV and marginalized populations

#### Testing for HIV/STIS/RTIS

Only one law in India specifically refers to testing for HIV. The Goa Public Health Act, 1985 provides for the management of infectious diseases, including those made notifiable by the Government. This includes mandatory testing and segregation of persons found suffering from infectious diseases under certain circumstances. Under this Act, forcible testing and quarantining of persons testing positive for HIV was undertaken. Though the Bombay High Court in the late 1980s and early 1990s, upheld the restriction in the movements of people infected with HIV as reasonable and permissible, The Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 has a provision that assumes significance in the debate on routine HIV testing in health settings is Regulation 3.1 that dissuades physicians from conducting “unnecessary consultations.” The regulation states that

“However in case of serious illness and in doubtful or difficult conditions, the physicians should request consultation, but under any circumstances such consultation should be justifiable and in the interest of the patient only and not for any other consideration. Consulting pathologists/radiologists or asking for any other diagnostic Lab investigation should be done judiciously and not in a routine manner.” Though the MCI guidelines do not recommend routine testing of HIV, it does take place to some extent, especially before admission to a hospital and before surgery.

#### Testing for children and young persons

The Juvenile Justice (Care and Protection of Children) Act, 2000 (JJ Act) provides the legal framework for children who are in conflict with the law or who are vulnerable and in need of State assistance. Among the requirements of State and institutional authorities under the JJ Act is the medical examination of children at the time of admission to institutions.

#### Testing for sex workers

The legal framework relating to sex workers in India is covered by laws relating to trafficking. Under the Immoral Traffic (Prevention) Act, 1956 (ITPA)<sup>61</sup> sex work itself is not criminalized but activities surrounding sex work are. ITPA empowers law enforcement officers to conduct “raid and

---

61. <http://wcd.nic.in/sites/default/files/640ls.pdf>

rescue” operations and includes powers for the medical examination of rescued sex workers including testing for STIs. There have been several cases where this provision of ITPA has been used to mandatorily test sex workers for HIV.

In 1997, in a case titled *Public at Large v. State of Maharashtra and others*, the Bombay High Court in a series of orders<sup>62</sup> had directed the raid and rescue of sex workers in Bombay and their mandatory HIV testing. Several interventions by groups brought the problem of mandatory testing to the notice of the Court including the National HIV Testing Policy which did not recommend mandatory HIV testing for sex workers. Still the Court noted that the number of sex workers who had tested positive for HIV was alarming and at a minimum the government should start AIDS awareness programmes.

In *M. Vijaya vs Chairman and Managing Director, Singareni Collieries Co. Ltd.*, (AIR 2001 AP 502)<sup>63</sup>, in 2001, the Andhra Pradesh High Court dealt at length with the matter of HIV testing and found that ITPA did indeed allow for the mandatory HIV testing of sex workers. Court observed, “There is an apparent conflict between the right to privacy of a person suspected of HIV not to submit himself forcibly for medical examination and the

power and duty of the State to identify HIV-infected persons for the purpose of stopping further transmission of the virus. In the interests of the general public, it is necessary for the State to identify HIV-positive cases and any action taken in that regard cannot be termed as unconstitutional”.

#### Testing for prisoners

Under the Prisons Act in India, a prisoner is required to be examined medically as soon as he is admitted to a prison and a record of the prisoner’s health is to be maintained in a register. Women prisoners can only be examined by the matron under the general or special powers of the Medical Officer. It may be noted that confidentiality of prisoner’s status or even consent for that matter is hardly considered important or a necessity to be taken.

#### Disclosure of hiv status

As confidentiality rests on the balance of public and private interests as noted above, courts have recognised situations where doctors may disclose a person’s status. Well known exceptions include where disclosure is allowed or mandated by a statutory law or a court order or as noted above in the case of the disclosure of a person’s HIV status to a partner who may be at risk of HIV transmission.

The MCI regulations do not provide sufficient guidance for medical

62. 997 (4) BomCR 171; also see <https://indiankanoon.org/doc/1755280/>

63. I (2002) ACC 32, 2002 ACJ 32, 2001 (5) ALD 522, 2001 (5) ALT 154

professionals either. While the duty of confidentiality is recognised, the Regulations also direct medical professionals to share medical records with legal authorities without specifying the circumstances under which such information can be shared. They also encourage doctors to discuss the medical condition of a patient with family and friends. For women particularly such sharing of information can result in violence and abandonment. Partner notification remains one of the most contentious and fraught areas in HIV.

#### HIV and the right to life and health

The Indian Supreme Court has held that failure on the part of a Government to provide timely medical treatment to a patient amounts to a violation of the right to life.<sup>64</sup> Public Interest Litigations (PIL) filed by NGOs have also been responsible for significant progress in this regard. A PIL filed in 1999 by the Lawyers Collective through Sankalp Rehabilitation Trust sought specifically to address barriers that prevented the access of PLHIV to healthcare services, especially discrimination in hospitals. In 2003, HRLN filed a petition on behalf of the Voluntary Health Association of Punjab (VHAP) calling upon the government to provide free ARV drugs to HIV positive persons.<sup>65</sup>

Resultantly, treatment was accepted

as part of government policy. This petition seeks the recognition and implementation of the right to health and treatment of positive persons as a part of their Right to Life under Article 21 of the Indian Constitution.

In 2008, the Supreme Court passed an order endorsing 14 points addressing these issues. The order included:

- Ensuring the non-discrimination of people with HIV in healthcare settings;
- Rapid upscale of antiretroviral therapy (ART) centres and Link ART centres;
- Increasing the number of CD4 machines and ensuring their maintenance in a timely and efficient manner;
- Ensuring adequate infrastructure in ART centres—adequate seating space, clean toilets and safe drinking water;
- Creation of a grievance redressal mechanism by the institution, consisting of a complaint box in every ART centre and the appointment of Nodal Officers to review the complaints, as well as a State Level Grievance Redressal Mechanism;
- Provision of free treatment for opportunistic infections;
- Ensuring availability of universal precautions and post-exposure prophylaxis for healthcare providers in public hospitals.

The Network of Maharashtra People with HIV had filed a petition in public interest in March 2009 in the Bombay High Court

64. Paschim Bengal Khet Mazdoor Society v. State of West Bengal, AIR 1996 SC 242.

65. <http://www.hrln.org/hrln/hiv-aids/pils-a-cases/205-docket-voluntary-health-association-of-punjab-vhap-vs-the-union-of-india-and-others.html>



against the Ministry of Health & Family Welfare of the Union of India, the National AIDS Control Organisation (NACO), Maharashtra State AIDS Control Society, Sir JJ Hospital and the Ministry of Health of the State of Maharashtra on the issue of provision of free second line treatment to HIV positive persons who were not responding to first line antiretroviral therapy (ART). The petitioners demanded that the respondents be directed to ensure that all those in need of second line ART on the basis of clinical evaluation be provided with such treatment free of cost irrespective of geographical location, registration with an ART centre, time-span on first-line ART or any other condition. The petitioners stated that despite the initial phase of the pilot programme for provision of second line ART being completed, there were stringent restrictions as to who can obtain the treatment at centres and that those restrictions were not based on medical need but on arbitrary cut-offs including length of time on first line treatment, residential address of the patient etc.

The Network of Maharashtra People with HIV had conducted a fact-finding study amongst people registered at ART centres in Pune for whom first line treatment was no longer working. Details of eight such extremely critical persons, some of whom had a CD count as low as 14, were provided in the petition with their consent. The petition also pointed

out the shocking revelation that people who are eligible for second line treatment were being made to sign waivers to the effect that whilst they understand that first line ART was not working on their bodies, they could not afford second line ART and would hence like to continue with the first line treatment. These patients did not understand what they had signed and the implications of such a waiver upon their treatment.

The Government of India had begun providing first line treatment to people living with HIV/AIDs since 2004. However, resistance to first line ART had developed gradually as a result of which many persons were not responding to the treatment. After a campaign by several advocacy groups across India, the Government started a pilot programme in 2008 in two hospitals (Sir JJ Hospital in Mumbai and Tambaram Sanatorium near Chennai) for dispensation of second line ART. Under the programme anyone not living in the state was not eligible to receive the treatment regardless of medical need. It was further announced that from December 2008, the Government would bring eight more centres across India under the second line treatment pilot project. However, at the time of filing of the petition, some of these centres neither have drugs nor the facilities for testing and provision of the treatment. In an affidavit filed by NACO in the Supreme Court in

October 2008 in a related matter, it was stated that the technical resource group at NACO had, on the basis of the prevailing scenario, recommended that second line ART be provided in a phased manner starting with a pilot project at two centres and that during the pilot project, patients who had been on ART at those centres for at least six months be considered for treatment.

By an order dated August 13, 2009, the High Court recorded that the competent authority of the respondents had decided to provide free of cost appropriate treatment including second line and any other treatment as may be advised to the petitioners and any other patient with HIV.

#### Access to treatment: TRIPS agreement

Access to treatment in the form of life-saving drugs is obviously critical to PLHIV and the price of HIV/AIDS-related drugs remains a formidable issue that all governments must deal with. An increasing number of HIV-positive people in India urgently require access to antiretroviral drugs (ARVs) which have a proven record of delaying the development of HIV into AIDS by lowering the viral load in the body of PLHIV. Here are some facts:

- As of 2015, 2.1 million Indians are estimated to be living with HIV with a 0.26% HIV prevalence.<sup>66</sup>
- 9.02 lakhs PLHIVs are on ART.<sup>67</sup>

As noted earlier in this report, the Constitution of India guarantees the right to health for every citizen and also declares that the state has the responsibility to improve public health. Various international instruments also speak of the fundamental right to health. General Comment 14 on the right to health (Article 12) in ICESCR suggests that this includes certain "core obligations" including "to provide essential drugs".<sup>68</sup> The UNGASS declaration of commitment, to which India is a signatory, also mandates states parties to "make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment... including the effective use of quality controlled ARV therapy." The Indian Patents Act, 1970, abolished product patent protection in pharmaceuticals in order to ensure that medicines were available to the public at reasonable prices. As a result, triple combination ARVs have been produced by India's generic manufacturers and sold at a fraction of the price being offered by patent-holding multinational pharmaceutical companies. Thank to India's generic ARV drugs, life-saving treatment programmes have been implemented in many countries. For instance, according to Médecins Sans Frontières (MSF), an estimated 70 per cent of the 25,000 AIDS patients treated by them in 27 countries are taking Indian generics<sup>69</sup>, and indeed, India is the world's leading supplier of

66. India HIV Estimation 2015

67. NACO Annual Report 2015-16

68. As cited in Lawyers Collective, 2003, p. 200.

69. Médecins Sans Frontières (MSF), Will the Lifeline of Affordable Medicine to Poor Countries Be Cut? Consequences of Medicines Patenting in India, February 2010.

safe, effective and affordable generic HIV medicines.<sup>70</sup>

The absence of drug product patents has also allowed Indian generic manufacturers to develop fixed-dose combinations of AIDS drugs, combining several pills originally produced by different companies into one tablet that is easy to take.<sup>71</sup> Considering that AIDS treatment protocols are complicated and many people who need to access them may have little or no education and irregular access to healthcare professionals, this simplification of treatment regimens has been crucial to the scale-up of AIDS treatment programmes in poor countries. India is currently trying to balance these responsibilities with its new obligations under the World Trade Organization's (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement.

In 2004, the President of India issued the Patents (Amendment) Ordinance (amending the Patents Act, 1970), which requires patents to be granted on new medicines as from January 1st 2005, and on medicines for which companies filed a patent application after 1995. TRIPS does not establish a uniform international law but sets out minimum standards of patent protection that must be met by all WTO members. This has led to global concern about the continuing ability of Indian generic companies to supply these

medicines. The Doha Declaration of TRIPS and Public Health tries to address these concerns and explicitly recognises "the gravity of the public health problems afflicting many developing and least-developed countries". Article 4 of the declaration states that the "TRIPS Agreement does not and should not prevent members from taking measures to protect public health" and "can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."<sup>72</sup>

Nevertheless, there are questions about the binding nature of the declaration and many commentators have serious concerns that TRIPS will potentially be "very bad news for Indian patients".<sup>73</sup> As MSF explains, "If the government does not establish measures to bring prices down, the cost of new drugs will remain very high, because patents prevent competition. Estimates suggest prices of new drugs will increase by a mean of 200%. It is also a devastating development for many poor countries that rely on India as a source of affordable quality medicines".<sup>74</sup> The Indian Government has been trying to address these concerns by looking at different "flexibilities available under TRIPS in an attempt to secure the availability, affordability and accessibility of medicines."<sup>75</sup>

70. Chaudhuri, Sudip, Park, Chan, and Gopakumar, K.M., Five Years Into the Product Patent Regime: India's Response, UNDP, 2010.

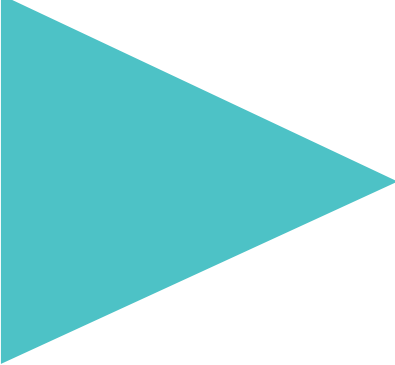
71. MSF, 2010.

72. DOHA WTO MINISTERIAL 2001: TRIPS (WT/MIN(01)/DEC/2 20 November 2001), Declaration on the TRIPS Agreement and Public Health, available at [http://www.wto.org/english/thewto\\_e/minist\\_e/min01\\_e/mindecl\\_trips\\_e.htm](http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm)

73. MSF, 2010, p. 3.

74. Ibid.

75. Chaudhuri et al., 2010.



These include the provision on “compulsory licensing”, which allows countries to overcome patent barriers by issuing licenses for government use that permit the production or importation of generic medicines without the consent of the patent holder.<sup>76</sup> In addition, TRIPS allows member states to provide “limited exceptions to the exclusive rights conferred by a patent...taking into account the legitimate interest of third parties.”<sup>77</sup> In order for countries to utilise these options under TRIPS their own laws must contain provisions relating to this.

In India the Patent Act and subsequent amendments contain 19 sections on compulsory licenses. An additional public health safeguard is the unique “efficacy standard” section 3 (d) of the Indian patent regime. This prohibits the patenting of new forms of existing pharmaceutical substances that do not demonstrate significantly enhanced efficacy with the key purpose of preventing companies from getting subsequent patents for minor improvements to existing drugs before expiry of the original patent.<sup>78</sup>

This provision was challenged by Swiss conglomerate Novartis in the Indian courts on the grounds that it was unconstitutionally vague and arbitrary. However, the Madras High Court ultimately rejected Novartis’ challenge and, as of now, the efficacy provision remains the law.

### Moving forward: recent decisions on patents and access to medicines

In April 2013, the Supreme Court rejected an appeal in *Novartis AG v. Union of India and Others*, against a decision by the Intellectual Property Appellate Board (IPAB) to deny their patent application for the cancer drug Gleevec. The two judge bench said the drug was not different enough from existing products to justify a patent. The decision has been greeted with relief from public health experts who feel that the decision gives “extra legal cover to Indian companies that produce and export low-cost generics.”<sup>79</sup> The President of MSF International also praised the decision stating, “the Supreme Court’s decision now makes patents on the medicines that we desperately need less likely.”<sup>80</sup>

In a historic decision the first compulsory licence (CL) was issued by Controller of Patents on 12 March 2012. The CL was granted in response to an application filed by generic manufacturer Natco Pharma requesting authorisation to make and sell generic versions of the cancer medicine, sofenib tosylate. This meant that a cancer drug that until then cost thousands of dollars a month would be available at 3 % of the cost. It also offered hope to PLHIV that the use of CLs to open up generic competition on

---

76. See Article 31, TRIPS Act.

77. See Article 30, TRIPS Act.

78. Chaudhuri et al., 2010.

79. “Novartis Loses Gleevec Patent Battle in India”, Wall Street Journal, April 2013, available at <http://online.wsj.com/news/articles/>

80. Ibid.

patented medicines and thereby give access to new drugs is a real possibility.

In 2008 the patent for a paediatric syrup version of the HIV drug Nevirapine was denied. Civil society groups had challenged the drug maker Boehringer Ingelheim (BI) over its patent application, which postulated that its new formulation of the existing drug met the efficacy standard because the syrup version allows the drug to be ingested by children living with HIV who were unable to swallow the prior tablet version. The Indian Patent Office denied the patent on the grounds that newer forms must be clinically more beneficial as a drug, not just a new method of delivery. Commentators stated that "this ruling represents a landmark legal precedent in Indian civil society's fight to ensure that India's strict patent law is upheld and patents are not granted frivolously,"<sup>81</sup> and could be especially significant for the remaining 12 patent oppositions pending.<sup>82</sup>

It is difficult to overstate the criticality of Indian drug companies being able to continue to produce low cost drugs in the fight against HIV and AIDS. In 2005, the UN Special Envoys of the UN Secretary General on HIV/AIDS in the Asia Pacific and Africa collaborated for the very first time to write to the Indian

Government, highlighting the importance of generic HIV medicines from India to the achievement of universal access to treatment goals.<sup>83</sup> The special rapporteur on the right to health has pointed out that "States have a legal obligation under the right to health to ensure that production of essential medicines by the private sector does not threaten affordability and accessibility of medicines," and has recommended that states take advantage of flexibilities under TRIPS that allow least developed countries to "to produce medicines locally in the public health interest, irrespective of patents on medicines..."<sup>84</sup>

India is now in a position where it needs to scale up production of drugs for the various stages of AIDS-related illness, ensure that these are provided at the lowest costs possible and ultimately provide an example to the rest of the world on how public health must be prioritised in light of constitutional guarantees regarding the right to health and the right to life.

#### PLHIV and insurance

Insurance companies in India have generally excluded HIV from the purview of most generic insurance products. This has been a major problem for PLHIV for whom the out-of-pocket health care expenses are crippling. Health insurance offers the chance for PLHIV to seek out healthcare from private facilities and ensure

On 11 October, the Insurance Regulatory Development Authority of India (IRDA) set about correcting this to an extent. The IRDA sent out a draft circular provisioning the sale of life insurance and health insurance to persons living with the HIV virus.  
Nov 29, 2013

81. MSF, Pre Grant Opposition Victory in India, available at <http://www.msfaccess.org/our-work/hiv-aids/article/1563>

82. Over the last few years, as a result of patent oppositions by civil society groups and generic companies, the patent application on one HIV combination (lamivudine/zidovudine) was withdrawn by GSK and applications for the salt forms of Tenofovir, and some patent applications related to Darunavir have been rejected in India.

83. Chaudhuri et al., 2010.

84. UN Human Rights Council, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, on access to medicines", May 2013, Para 70, A/HRC/23/42, available at <http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>

that they improve their overall health. Some progress is finally being made in this regard. A Chennai-based insurance company has introduced a group insurance policy for PLHIV; Star Netplus is a unique public/private partnership between Population Services International, Star Health and Allied Insurance Company Limited and Karnataka Network of People Living with HIV/AIDS. The number of policy holders has increased from 258 PLHIV in Karnataka in 2008 to more than 7,000 PLHIV across Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra and Kerala. The annual renewal rate was more than 80% in 2010, indicating the demand for insurance among PLHIV.

The issue of insurance for PLHIV was heard by The Hon'ble Delhi High Court bench comprising Justice D. Mugugesan and Justice V.K. Jain who directed IRDA (Insurance Regulatory Development Authority) to implement the draft guidelines to cover all HIV positive under the ambit of Insurance cover. While directing the respondents the Hon'ble High Court prescribed 8 months time to implement the same by all insurance companies of the country under the supervision of a High Power Committee represented by top IRDA, NACO and Health Ministry officials along with the petitioner. The guidelines were framed by IRDA as a result of a PIL filed by Dr. Rajeev Sharma<sup>85</sup>. Prior to this, most of the

existing insurance policies include an exclusion clause specifically excluding insurance benefits of HIV/AIDS and related treatment. Thus, when an existing policy holder is subsequently diagnosed with HIV/AIDS during the policy period they are denied the benefits of their existing insurance policy. But with the intervention of this PIL (Public Interest Litigation) the IRDA was forced to draft the guidelines to maintain the provisions of Article 14 of the constitution.

The Rajya Sabha's Standing Committee on the Health Ministry, in its comments on the HIV bill<sup>86</sup> has also stated in a report tabled in the House in May 2015, that the committee is of the opinion that "all HIV positive people should be provided insurance cover without any discrimination preferably at normal rate of premium or they may be charged slightly higher rate of premium but in no case exorbitant rate of premium should be charged from HIV positive people for providing insurance cover for both life and health insurance."

Another case to note is Sri Rao Saheb Mahadev Gayakwad v. Life Insurance Corporation of India<sup>87</sup>; 2004<sup>88</sup>; the Petitioners were the brother, wife and children of a deceased man who died from AIDS. The Defendant insurance company refused to honour the deceased's life insurance policy because it claimed he "with held material information regarding his health at the time of seeking insurance."

85. In the matter of: Dr. Rajeev Sharma Vs Union of India & Others.; <http://www.hrln.org/hrln/hiv-aids/pils-a-cases/1243-insurance-cover-for-hiv-positivedelhi-high-court-directed-irda-to-implement-the-draft-guidelines-in-8-months-period.html>

86. [http://www.isidelhi.org.in/hrnews/HR\\_THEMATIC\\_ISSUES/HIV/HIV-2015.pdf](http://www.isidelhi.org.in/hrnews/HR_THEMATIC_ISSUES/HIV/HIV-2015.pdf)

87. AIR 2004 Kant 439; ILR 2004 KAR 3390; 2004 (7) KarLJ 289

88. <http://www.undp.org/content/dam/undp/library/hiv/aids/English/Compendium%20of%20Judgments%20-%20Background%20Material%20BKK%20Judicial%20Dialogue%20FINA%20%20%20.pdf>

The Defendant contended that the deceased was aware that he was living with HIV two months prior to purchasing his life insurance policy, but failed to disclose the fact on his insurance declaration.

The Defendant claimed the deceased had "consulted the National [AIDS] Research Institute" prior to completing the insurance declaration form. It argued that this indicated that the deceased was living with HIV and was in fact aware of his condition. It further noted that it was company policy, when death occurs within three years of the date of the issuance of a policy, to conduct a detailed investigation in order to ascertain the reason for the death and to determine the validity of the information provided in the insurance declaration. The Petitioners asserted that the deceased had neither deliberately suppressed any material fact nor given inaccurate or wrong information to the defendant.

The question was, did the defendant insurance company Act in a "bona fide" manner when it repudiated the deceased's insurance contract because it believed he had failed to disclose, and in fact was aware, that he was living with HIV at the time the contract was completed? To which the answer was, no. The court first noted that the defendant had only learned of the deceased's consultation with the National AIDS Research

Institute subsequent to the defendant's repudiation of the deceased's insurance contract. The court held that, even if the deceased died of AIDS, it did "not necessarily follow that the person was very much aware that he was suffering" from an HIV-related disease. It stated that the deceased "may or may not" have been aware that he was living with HIV when he consulted the National AIDS Research Institute, but that the consultation in and of itself did not definitively prove awareness. The court held that to justify its repudiation of the contract the defendant was required to show that the deceased had committed fraud and indulged in material suppression. The defendant was thus required to prove that the declaration furnished by the deceased was "factually incorrect to the knowledge of the declarant and for the purpose of misleading the corporation in the sense of obtaining a policy in contemplation of death or with the knowledge that the [deceased was] running a risk against his life." The court held that the evidence presented did not lead to this "irresistible conclusion." It stated that the factual position of the defendant was only that the deceased died of AIDS. However, this did "not necessarily lead to any other factual inference," such as the inference that the deceased was aware of his condition. Thus based on the evidence before the court it was not possible to find that the deceased had committed

The Court also cited General Comment 14 to the ICESCR in defining the right to adequate health as including the right to control one's health and body, including sexual reproductive freedom, the right to be free from interference, and most importantly non-discrimination and equal treatment with regards to accessing health care. Finally, the Court cited numerous other international treaties and agreements to which India is a party that specifically declare a commitment on the part of India to address the needs and rights of groups with a high-risk of contracting HIV/AIDS.

fraud. The court directed the defendant to make a payment on the deceased's policy. It stated, however, that the defendant had an opportunity to "make good its plea of fraud by filing a suit for declaration that the contract [was]... voidable because of practice of fraud on the part of the insured." However, it noted that to prevail on such a claim the defendant must present "cogent evidence."

#### Discrimination based on sexual orientation

The content of the right to equality in relation to sexual orientation came before the Indian courts in the case of Naz Foundation (India) Trust v. Government of NCT of Delhi & others<sup>89</sup> where the Delhi Court was asked to determine whether Section 377 of the Indian Penal Code, India's anti-sodomy law inherited from the British, violated the rights to life, personal liberty, privacy and equality. The challenge to the anti-sodomy law was filed by an organization working with men who have sex with men providing information and tools related to safer sex. The court held that, "...the nature of the provision of Section 377 IPC and its purpose is to criminalise private conduct of consenting adults which causes no harm to anyone else. It has not other purpose than to criminalise conduct which fails to conform with the morals or religious views of a section of society. The discrimination severely affects

the rights and interests of homosexuals and deeply impairs their dignity.

"The Delhi High Court presided over by Chief Justice AP Shah and Justice S Muralidhar held that Section 377 violated the rights of life, privacy, equality and health.

The Court also determined the nature of morality that the Indian government could rely on to justify any law that infringes on these rights. While the Indian government argued that enforcing public morality was a sufficient basis to justify such a law, the court stated that popular morality was distinct from "constitutional morality", stating, "Thus popular morality or public disapproval of certain acts is not a valid justification for restriction of the fundamental rights under Article 21. Popular morality, as distinct from a constitutional morality derived from constitutional values, is based on shifting and subjecting notions of right and wrong. If there is any type of "morality" that can pass the test of compelling state interest, it must be "constitutional" morality and not public morality."

The court struck down Section 377, in so far as it criminalized adult, private, consensual sexual Acts finding that the provision violated the rights to life, liberty privacy and equality. However as this law is also used to prosecute those accused of male child sexual

89. Naz Foundation v. Government of NCT of New Delhi and Others, WP(C) No. 7455/2001

90. CIVIL APPEAL NO.10972 OF 2013, (Arising out of SLP (C) No.15436 of 2009



abuse, the judges allowed the law to continue to exist on the law books asking at the same time for the government to reform India's criminal law on sexual violence.

This decision of the Delhi High Court was challenged before the Supreme court of India by several religious and conservative groups and a decision was reached in December 2013, as Suresh Kumar Koushal v. Naz Foundation<sup>90</sup>, that upheld the validity of Section 377, IPC and set aside the Delhi High Court judgment, which had decriminalized adult consensual sexual acts in private in 2009.

The Naz Foundation (India) Trust, the original petitioner in the constitutional challenge to Section 377, filed a curative petition challenging the Supreme Court decision in Suresh Kumar Koushal v. Naz Foundation (hereinafter 'Koushal') delivered in December, 2013 Highlighting the fundamental principles of 'justice is above all' and 'no party should suffer because of mistake of the court', the petition points out that the present case remains a fit case for the exercise of curative jurisdiction by the Hon'ble Supreme Court. (The curative jurisdiction has been developed by the court itself to deal with extraordinary situations, wherein gross miscarriage of justice or immense public injury has been caused, on account of a decision of the Supreme Court, whose judgments ordinarily are final and are binding in nature.) Pertinently, the

most glaring error in the Supreme Court decision is the failure of the court to notice the effect of the amendment in the offence of rape in Section 375, IPC on Section 377. After the Criminal Law (Amendment) Act, 2013, Section 375 prohibits both penile vaginal and penile-non vaginal sexual acts between man and woman, without consent. By implication, such sexual acts between man and woman, which are consensual, are not criminalized anymore. Therefore, consensual penile non-vaginal acts in a heterosexual context would be out of the ambit of Section 377, otherwise the amendment in Section 375 would become meaningless. Presently, in effect, Section 377 only criminalises all forms of penetrative sex, i.e., penile-anal sex and penile-oral sex, between man and man, which makes it exfacie discriminatory against homosexual men and transgender persons and thus violative of Article 14. The amendments came into force in February, 2013, long after the conclusion of final arguments in March, 2012 but way before the pronouncement of the judgment in December, 2013. The Court ought to have noticed the import of the statutory amendments and their effect on Section 377 and ruled accordingly<sup>91</sup>.

The petition further notes the gross miscarriage of justice that has resulted from the Supreme Court decision in misreading the legislative intention in not amending Section 377 during the

---

91. <http://www.lawyerscollective.org/updates/naz-foundation-files-curative-petition-challenging-supreme-court-judgment-section-377.html>

All States should co-operate with a view to promoting, encouraging and strengthening universal respect for and observance of all human rights and fundamental freedoms for all without any distinction as to race, sex, language or religion.

- Article 6 (1), UN GA Declaration on the Right to Development

criminal law amendments in 2013. At the time of debating changes to the rape law, Section 377 was raised in the Lok Sabha, but the House refrained from discussing it, because the matter was sub-judice. This legislative deference to judicial process cannot be seen as an endorsement of the existing Section 377 and by doing so, the Supreme Court has committed a manifest error of law. The petition also highlights several other instances of patent errors on the face of the record in the judgment, including non-consideration of the main contentions of the curative petitioner and wrong application of law, which have caused manifest injustice, affecting lakhs of homosexual men and transgender persons in India. In light of the significant import of the issues raised in the curative petition, the petition has sought an oral hearing of the petition as well as an interim stay on the Koushal decision<sup>92</sup>.

#### Transgenders in india

The right to development entitles every human being and all peoples "to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized."<sup>93</sup> For transgender persons, this vision is not yet a full reality in any region of the world. International human rights standards recognize the diversity of human kind and explicitly protect the rights of

marginalized groups such as transpeople. States are obliged under international law to respect, protect and fulfil human rights. Yet UN treaty bodies and special procedures are increasingly documenting how States violate trans people's human rights, fail to protect against abuses by third parties and refrain from acting to secure trans people's enjoyment of basic human rights.

The legal, economic and social marginalization of trans people affects every aspect of their lives. Social exclusion is seen in laws that do not acknowledge the existence of trans people, either as a third gender or as people who wish to transition from male to female, or from female to male. Without legal protection, trans people are vulnerable to daily violence and discrimination, with cumulative impacts. Some impacts are visible, such as issues of HIV and health among trans women in many parts of the world. Most impacts are insidious, with trans people, their families and communities left to support each other and struggle for their right.<sup>94</sup>

Whether as Hijras, Aravanis, or all other transgender groups, trans people in India face a variety of issues. So far, the communities have been excluded from effectively participating in social and cultural life; economy; and politics and decision making processes. A primary reason (and consequence) of the exclusion was the lack of (or ambiguity in) legal

92. <http://www.lawyerscollective.org/updates/naz-foundation-files-curative-petition-challenging-supreme-court-judgment-section-377.html>

93. <http://www.un.org/documents/ga/res/41/a41r128.htm> ; A/RES/41/128; 4 December 1986, 97th plenary meeting, Declaration on the Right to Development.

94. Office of the High Commissioner for Human Rights (2012) Born Free and Equal: Sexual Orientation and Gender Identity in International Human Rights Law, p. 10

recognition of the gender status all transgender people. It has been a key barrier that often prevents them in exercising their civil rights in their desired gender.

Gender identity and gender expression are increasingly recognised as grounds of discrimination on which specific protection is required. Indeed, an increasing number of provisions within European and national legislation refer to gender identity and gender expression and apply expressly to trans people. In addition, some national governments have gone a step further and adopted legislation taking into consideration specific situations that are unique to transpeople (e.g. employment protection during gender reassignment). Unfortunately, despite recent progress, institutionalised transphobia and severe human rights breaches against trans people are still the order of the day across the European continent. In this context, the Yogyakarta Principles and other authoritative human rights documents can guide European institutions and national governments in protecting the fundamental rights of trans people and to tackle discrimination based on gender identity and gender expression. Legal and human rights challenges faced by sexual minority groups in India.

Sexual minority groups in India have long suffered from criminalisation, virulent social stigma and harassment. Numerous reports,

accounts, and narratives document a wide range of human rights violations faced by MSM and TGs in India. These violations increase manifold the vulnerability of these groups to HIV. Prevalence of HIV within the MSM and TG sexual minority group is the highest of any population group in India. The consequent stigma, discrimination and criminalisation faced by MSM and TGs are major barriers to HIV prevention, treatment, care and support.

Our research documents some of the persecution and harassment that MSM and TGs have had to face and how the state and national human rights commission in addition to other justice mechanisms have provided access to justice. Abuses against sexual minorities involve both state and non-state violators. When sexual minorities experience violence and discrimination by state institutions and the police themselves, they lose several inter-related rights such as freedom of expression, right to health, and effective legal remedies. As a result, they face intersecting discrimination from legal, medical, law enforcement, judicial, and other domains of everyday life.

This section cites a number of examples of gross violations of human rights in the area of civil and political rights, among the MSM and TG groups. The range of examples demonstrates how this minority group has become the

target of numerous attacks by Government, law enforcement groups, media, and medical agencies. Moreover, not only are MSM and TGs subject to discrimination on grounds of HIV interventions but they are often singled out because they are seen as a 'deviant' section of the population. The NACP-III, Strategy and Implementation Plan states, "It is clear from the experience gained so far that the social marginalisation and disempowerment that characterise [High Risk Groups (HRGs)] are the key vulnerabilities that need to be addressed before any interventions related to HIV/AIDS can be successfully adopted by them."

The Universal Declaration of Human Rights (UDHR) does not expressly mention gender identity but it provides for an open list of protected grounds. (Article 2 states): "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

In 2009, the Committee on Economic, Social and Cultural Rights (CESCR) underlined that: "'Other status' as recognized in article 2, paragraph 2, includes sexual orientation. States parties should ensure that a person's sexual orientation is not a barrier to realizing Covenant rights, for example, in accessing survivor's

pension rights. In addition, gender identity is recognized as among the prohibited grounds of discrimination; for example, persons who are transgender, transsexual or intersex often face serious human rights violations, such as harassment in schools or in the workplace."<sup>95</sup> On 15 June 2011, the Human Rights Council adopted a historic resolution expressing its concern regarding violations of human rights and discrimination based on sexual orientation and gender identity.

Following the instructions of this resolution<sup>96</sup>, the United Nations High Commissioner for Human Rights produced a report entitled *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*.<sup>97</sup> Some thematic instruments within the UN human rights system make express reference to gender identity as well. This is the case of the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW).<sup>98</sup>

Two recommendations<sup>99</sup> have been adopted by the CEDAW Committee in 2010 and both affirmed that "discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as [...] gender identity." This leads to an obligation for state parties to CEDAW to address discrimination against transwomen and to report the progress achieved to the Committee.

95. UN Committee on Economic, Social and Cultural Rights, General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, E/C.12/GC/20

96. UN Human Rights Council, Seventeenth session, Follow-up and implementation of the Vienna Declaration and Programme of Action, Human rights, sexual orientation and gender identity, 15 June 2011, A/HRC/17/L.9/Rev.1

97. UN Human Rights Council, Nineteenth session, Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General Follow-up and implementation of the Vienna Declaration and Programme of Action, Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity: Report of the United Nations High Commissioner for Human Rights, 17 November 2011, A/HRC/19/41

98. Adopted by the United Nations General Assembly in 1979

99. UN Committee on the Elimination of Discrimination against Women, General recommendation No. 27 on older women and protection of their human rights, 16 December 2010, CEDAW/C/GC/27; and General recommendation No. 28 on the Core Obligations of State Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women, 16 December 2010, CEDAW/C/GC/28

There are many recommendations made by civil society groups, experts and community members when looking at the issue of transgender and human rights. The following are from a document titled "Human Rights and Gender Identity: Best Practice Catalogue" published in December 2011<sup>100</sup>.

1. Implementing International Human Rights Standards: Implement international human rights standards without discrimination, and prohibit explicitly discrimination on the ground of gender identity in national non-discrimination legislation. The Yogyakarta Principles on the Application of International Human Rights Law in relation to sexual orientation and gender identity should be used to provide guidance for national implementation in this field.

2. Enacting Hate Crime Legislation: Enact hate crime legislation which affords specific protection for transgender persons against transphobic crimes and incidents.

3. Adopting Expeditious and Transparent Procedures for Change of Name and Sex: Develop expeditious and transparent procedures for changing the name and sex of a transgender person on birth certificates, identity cards, passports, educational certificates and other similar documents.

4. Abolishing Sterilisation and Other Compulsory Medical Treatment: Abolish sterilisation and other compulsory medical treatment as a

necessary legal requirement to recognise a person's gender identity in laws regulating the process for name and sex change.

5. Making Healthcare and Public Health Insurance Coverage Accessible: Make gender reassignment procedures, such as hormone treatment, surgery and psychological support, accessible for transgender persons, and ensure that they are reimbursed by public health insurance schemes.

6. Dissociating Marital Status from the Gender Recognition Process: Remove any restrictions on the right of transgender persons to remain in an existing marriage following a recognised change of gender.

7. Making Equality a Reality in All Spheres of Life: Prepare and implement policies to combat discrimination and exclusion faced by transgender persons on the labour market, in education and health care.

8. Involving and Consulting the Trans Community: Involve and consult transgender persons and their organisations when developing and implementing policy and legal measures which concern them.

9. Providing Training and Raising Awareness: Address the human rights of transgender persons and discrimination based on gender identity through human rights education and training programmes, as well as awareness-raising campaigns.

10. Providing Training to Specific Professions: Provide training

---

100. "Human Rights and Gender Identity: Best Practice Catalogue" Silvan Agius, Richard Köhler, Sophie Aujean, Julia Ehrh, published by ILGA Europe, TGEU, Belgian Institute for the equality of women and men, December 2011.

to health service professionals, including psychologists, psychiatrists and general practitioners, with regard to the needs and rights of transgender persons and the requirement to respect their dignity.

11. Including Gender Identity in the Scope of Equality Bodies: Include the human rights concerns of transgender persons in the scope of activities of equality bodies and national human rights structures.

12. Collecting Data on the Situation of Trans People: Develop research projects to collect and analyse data on the human rights situation of transgender persons including the discrimination and intolerance they encounter with due regard to the right to privacy of the persons concerned.

June 17, 2011—For the first time, the UN's Human Rights Council in Geneva has adopted a resolution expressing concern at acts of violence and discrimination committed against lesbian, gay, bisexual and transgender people. The text calls on the UN's High Commissioner for Human Rights to prepare a global study outlining discriminatory laws, practices and acts of violence directed at LGBT individuals, with recommendations on how to put an end to such fundamental human rights abuses. The study will be reviewed by the UN Human Rights Council next year. The Resolution<sup>101</sup> was tabled by South Africa and it enjoyed strong support from the United States and a broad coalition

of voting states from all regions of the world. It was adopted in Geneva today by a vote of 23 countries in support, 19 against and 3 abstentions.

On 16th September 2011, the United Nations' High Commissioner for Human Rights, Navanethem "Navi" Pillay, embraced Australia's decision to enable transgender citizens to self identify gender on their passports. In addition to male and female, Australian citizens may also now designate "X" as their gender. Ms. Pillay said that now Australians will "not be required to undergo surgery or hormonal treatment in order to be able to express their gender identity." Growing awareness of the difficulties encountered by transgender people have prompted the international body to examine what countries can do to mitigate those difficulties. Increasingly, Ms. Pillay said, "States around the world are starting to recognize the need to reflect sex and gender diversity. Other States that have taken pioneering steps in recent years to make it easier for transgender and intersex persons to obtain legal recognition of a change of gender, or to indicate a gender other than male or female, include Nepal, Portugal, the United Kingdom and Uruguay."

Ms. Pillay's leadership in addressing LGBT issues internationally has put homophobia and transphobia on the radar of the United Nations human rights concerns. Since she

---

101 <http://globalequality.wordpress.com/2011/06/17/un-adopts-groundbreaking-resolution-affirming-that-lgbt-rights-are-human-rights/>

assumed office in 2008, she has been at the forefront of the fight for equality. In May, she had warned in a video message that although governments have largely condemned sexism, racism and xenophobia, "homophobia and transphobia are too often overlooked." "History shows us the terrible human price of discrimination and prejudice. No one is entitled to treat a group of people as less valuable, less deserving or less worthy of respect, she said.

From United Nations Development Programme (UNDP), Rebeca Grynspan, cited efforts in Latin America, Papua New Guinea and

Senegal where efforts to end discrimination have been initiated. However, she said, "Eighty nations worldwide—more than 40 percent of all countries—still keep laws on the books that criminalize same sex relations." Law alone, she said, "Cannot eliminate discrimination and disempowerment. It must be accompanied by political will, at the highest levels, to challenge intolerance.

#### The Indian legal background and the constitution:

In essence, the Constitution of India is 'sex blind', that is to say, the basic premise of equality before the law and equal protection of the law is based on a Constitutional mandate that the sex of a person is irrelevant save where the Constitution itself requires special provisions to be

made for women (Art. 15(3)). Article 15(1), 15(2) and 16(2) in express terms enjoin discrimination on the ground of sex.

In Part III of the Constitution, the beneficiaries of the rights are identified as 'person' or 'citizen'. In the absence of any specific or implied exclusion or denial of such recognition, by virtue of the fact that a transgender is a human being, all constitutional rights must necessarily flow to a transgender. The 'Transgender' community necessarily falls within the purview of the Constitution of India and thereby they are entitled to all the rights as guaranteed under the same.

Article 5 of the Constitution identifies the persons who are entitled to be citizens of India. None of the conditions specified there in require a determinate sex or gender identity as a pre-condition of acquiring citizenship.

The Citizenship Act, 1955 which provides for the acquisition and determination of Indian Citizenship also does not, expressly or impliedly require a determinate sex or gender identity as a pre-condition for acquiring citizenship.

The definition of person under the General Clauses Act, 1897 is couched in even wider terms. Section 3(42) of the Act of 1897 defines a person to 'include any company or association or body of

In 2006, in response to well-documented patterns of abuse, a distinguished group of international human rights experts met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender identity. The result was the Yogyakarta Principles: a universal guide to human rights which affirm binding international legal standards with which all States must comply. They promise a different future where all people born free and equal in dignity and rights can fulfil that precious birthright.

---

102. This report examines the human rights violations suffered by sexuality minorities in India (with specific reference to Bangalore) under two broad heads, namely the state and society, as two sites from which violence against sexuality minorities is perpetrated. The violations by the state can be further subdivided into violations by the law and by the police. Societal violence is inflicted through the various sites like the family, the medical establishment, workspaces, household spaces, public spaces and popular culture. Both societal and state violence impinge strongly on the individual person's dignity. The report then goes on to document issues of further marginalization among sexuality minorities, namely the position of lesbians, bisexuals and sexuality minorities from low income/non English-speaking backgrounds and hijras.

individuals, whether incorporated or not'. Though Section 13 of the 1897 Act stipulates that words importing the masculine gender shall be taken to include females, this stipulation is itself conditioned by the statutory direction that this is so unless there is anything repugnant in the subject or context. A harmonious reading of the Constitutional provisions set out hereinabove as well as the provisions of the 1955 and 1897 Act would show that in fact there is no conflict or limitation imposed on the concept of 'person' by any of these laws and a Transgender person would undoubtedly fall within the definition of 'person'. An Extract from the Report by Peoples' Union for Civil Liberties, Karnataka, 2001<sup>102</sup>

### Recommendations and suggestions

What became apparent in the course of the study is that discrimination against hijras and kothis is embedded in both state and civil society. The violence that this community faces is not only due to the state but also has deep societal roots. As has been argued in the course of the Report, wider change is premised on changing existing social relations. Any proposal which tries to ensure that the dignity and selfhood of kothis and hijras is respected has to deal with a complex reality in which class, gender and sexuality play a crucial role. Apart from shifts in class relations, change would also crucially hinge upon overturning

the existing regime of both gender and sexuality that enforces its own hierarchies, (e.g. heterosexuality over homo sexuality), exclusions (e.g. hijras as the excluded category) and oppressions. While keeping in mind this wider context, a human rights approach has to deal with the various institutional contexts and think through ways in which change can be brought about. In this context the following proposals are made. These recommendations are also based on the demands made by the hijra kothi community in meetings held with them. Some of the demands made by them require us to reorient our very imagination to conceptualize the nature of violation suffered by them. In this context the demand for recognition of the discrimination suffered by them as a form of untouchability (in terms of access to public spaces, employment, as well as the forms of violence they suffer) needs to be taken seriously.

### Legal measures

1. Every person must have the right to decide their gender expression and identity, including transsexuals, transgenders, transvestites and hijras. They should also have the right to freely express their gender identity. This includes the demand for hijras to be considered female as well as a third sex.

2. Comprehensive civil rights legislation should be enacted to offer hijras and kothis the same



protection and rights now guaranteed to others on the basis of sex, caste, creed and colour. The Constitution should be amended to include sexual orientation/ gender identity as a ground of non discrimination.

3. There should be a special legal protection against this form of discrimination inflicted by both state and civil society which is very akin to the offence of practicing untouchability.

4. Same-sex marriages should be recognized as legal and valid; all legal benefits, including property rights that accrue to heterosexual married people should be made available to same-sex unions.

5. The Immoral Trafficking in Persons Act, 1956 should be repealed. Sex work should be decriminalized, and legal and other kinds of discrimination against kothis and hijras should stop.

6. Section 377 of the IPC and other discriminatory legislations that single out same-sexual acts between consenting adults should be repealed.

7. Section 375 of the IPC should be amended to punish all kinds of sexual violence, including sexual abuse of children. A comprehensive sexual assault law should be enacted applying to all persons irrespective of their sexual orientation and marital status.

8. Civil rights under law such as the right to get a passport, ration card, make a will, inherit property and adopt children. must be available to all regardless of change in gender/sex identities.

9. Reservation in educational institutions such as schools and colleges as well as in government employment.

#### Police reforms

1. The police administration should appoint a standing committee comprising Station House Officers and human rights and social activists to promptly investigate reports of gross abuses by the police against kothis and hijras in public areas and police stations, and the guilty policeman immediately punished.

2. The police administration should adopt transparency in their dealings with hijras and kothis; make available all information relating to procedures and penalties used in detaining kothis and hijras in public places.

3. Protection and safety should be ensured for hijras and kothis to prevent rape in police custody and in jail. Hijras should not be sent into male cells with other men in order to prevent harassment, abuse and rape.

4. The police at all levels should undergo sensitization workshops by human rights groups/queer groups in order to break down their social prejudices and to train them to accord hijras and kothis the same courteous and humane treatment as they should towards the general public.



### Reforming the medical establishment

1. Initiate a debate on whether being transgender should be classified as a gender identity disorder or whether it should be seen as a choice.
2. The Medical Council of India should issue guidelines to ensure that discrimination in medical treatment of hijras and kothis , which would include refusal to treat a person on the basis of their gender identity , is treated as professional misconduct.
3. Reform medical curricula in medical colleges that moves beyond seeing transgenderism as a disease and a deviance.
4. Free SRS services for hijras should be provided in government hospitals.

### Interventions by civil society

1. Human rights and social action organizations should take up the issues of hijras and kothis as a part of their mandate for social change. Socialist and Marxist organizations, Gandhian organizations, environmental organizations, dalit organizations and women's organizations, among others, which have played a key role in initiating social change, should integrate the concerns of hijras and kothis as part of their man-date in sites such as the family, religion and the media which foster extreme forms of intolerance to gender non conformity.
2. A comprehensive sex-education program should be included as part of the school curricula that

- alters the heterosexist bias in education and provides judgement-free information and fosters a liberal outlook with regard to matters of sexuality, including orientation, identity and behaviour of all sexualities.
3. The Press Council of India and other watchdog institutions of various popular media (including film, video and TV) should issue guidelines to ensure sensitive and respectful treatment of these issues.
  4. Setting up of counselling centres to enable families to understand issues of gender non-conformity in their children.
  5. Setting up of short-stay homes for hijras and kothis in crises.

### Cases that have been taken to various Redressal Mechanisms: Maharashtra state human rights commission: access to public spaces and discrimination

Laxmi Narain Tripathi and the Bombay Gymkhana Club Seeking the right to vote for her community and transgenders in the forthcoming state Assembly polls, Laxmi Narayan Tripathi has moved the Maharashtra State Human Rights Commission (SHRC) in Mumbai. Terming the denial to cast vote as "gross violation of Human Rights in the state," Laxmi Narayan Tripathi in her four-page complaint asked the government to extend the fundamental right to eunuchs and transgenders. She mentions in her argument that "There is a gross violation of the human rights of

eunuchs in Maharashtra. We are not provided with ration cards and not permitted to vote,".

In response, the SHRC has issued notices to the Chief Secretary of the State Government with a direction to ensure that departments concerned with ration cards and voter ID cards file their reply to the complaint by November 4.

The commission has also directed the government to suggest in their reply affidavit steps being taken or to be taken with this regard. Earlier, the commission had directed the state government to file its reply by August 24 but it failed to do so following which the time period was extended till November 4.

[West Bengal State Human Rights Commission: Right to gender identity, employment and anti discrimination](#)

[Pinki pramanik and the state of west bengal \(2012\)](#)

Pinky Pramanik was arrested on June 2012 and remanded in judicial custody after her live-in partner filed a police complaint against her. A video clip showing the petitioner in an unclothed state undergoing the gender test during her detention was leaked via the internet.

The petitioner appeared before a panel of the West Bengal State Human Rights Commission. In her submission to the Commission, she alleged discrimination on the basis that the police forced her to

undergo the gender determination test, kept her in a prison cell meant for male inmates, and was escorted to court by male police personnel. The West Bengal Human Rights Commission determined that since the Cyber Crime Cell of the Kolkata Police had started investigation into the circulation of the video, the Commission would not conduct an inquiry.

[Manabi banerjee \(2003\) case filed before the state human rights commission as well as Calcutta high court.](#)

The petitioner is a transgender living as a woman at home, but a man when outside, she was employed as a college professor and lived on campus. The other teachers forced Ms Banerjee to move out of the professors' quarters, called her a hijra, and accused her of child abuse. She approached the West Bengal Human Rights Commission with a complaint against the treatment in the college. The West Bengal Human Rights Commission served a show-cause notice on the college.

[Karnataka state human rights commission: illegal detention, torture, sexual and physical abuse](#)

On 20th October 2008, five hijras were caught by the police and taken to the Girinagar police station. In the station, they were beaten up by the police present and this included the Assistant Commissioner of Police (ACP). False charges under section 341 (wrongful restraint) and 384 (extortion) of

In Paragraph 11 of the case, Justice Radhakrishnan defines “transgender” as an “umbrella term for persons whose gender identity, gender expression or behavior does not conform to their biological sex.”

National Legal Services Authority v. Union of India, Writ Petitions (Civil) No. 400 of 2012

the IPC (Indian Penal Code) were brought upon the Hijras; they were produced before the magistrate at 7:30 pm and were sent into judicial custody. All through the process, the hijras were handled by male police and no medical treatment was offered to the hijras who had been injured in police custody. They were released on bail two days later.

The other part of this case is that a call for help went out to a NGO Sangama, that works on rights and health issues for the SOGI communities in the state. When the crisis team members reached the police station where the five hijras had been illegally detained, they were verbally and physically assaulted by the officers at the station, and charges were framed against the team who had come to help the hijras being detained. The NGO members were charged and arrested by the police and accused of offences punishable under unlawful assembly, joining unlawful assembly ordered to be dispersed), rioting and obstructing government officials in performing their duty. The NGO crisis team members were produced before the magistrate that night and were sent into judicial custody where they remained for two days until they were released on bail. Around 150 human rights activists and lawyers from various organizations gathered outside the police station on the first day and attempted to negotiate the release of the NGO members. All negotiations and dialogues with

the senior officers of the law enforcement involved in this case did not succeed. The hijras and the crisis intervention team were eventually released two days later. A complaint was made to the Karnataka State Human Rights Commission who ordered a detailed report from the Commissioner of the Police within 6 weeks.

**Decision on police harassment: Jayalakshmi vs The State Of Tamil Nadu, 10 July, 2007, Madras High Court**

The petitioner was the sister of a young transgender named Pandian, in Tamil Nadu, who was being interrogated by the Police regarding a theft case. The Police officials took him to the Police station for interrogation and he was then released on bail on condition that Pandian would report to the Police station regularly. Pandian was sexually harassed and abused by the Police personnel inside the police station every day. They even threatened Pandian against disclosure of the sexual harassment. Pandian later set himself on fire and after a few days succumbed to the injuries. In his dying declaration, he stated that he was unable to bear the torture and pain so he had wanted to end his life. The Court ordered that the State Government shall pay compensation of a sum of Rs.5 lakhs to the petitioner for the harassment meted out to her brother Pandian.

The State Government was asked to initiate disciplinary action against respondents for the treatment meted out to Pandian.

**The Supreme Court Judgment – NALSA v Union of India** On the 15th of April 2014, in a historic decision, a two-judge bench of the Supreme Court of India, ruling on a petition brought by the National Legal Services Authority and by groups and individuals on behalf of members of the transgender community, has declared that among the human rights protected by the Indian Constitution are the rights of individuals to State recognition of their gender identity and sexual orientation, and to be free of official discrimination on these grounds - National Legal Services Authority v. Union of India, Writ Petitions (Civil) No. 400 of 2012 and No. 604 of 2013. In the judgement, the Supreme Court issued a landmark ruling recognising transsexuals as a third gender, and upholding their rights to equality (Article 14), non-discrimination (Article 15), expression (Article 19(1)(a) and autonomy (Article 21). It also involves an extensive examination of international law and domestic legislation in other countries, engages in large quantities of evidence of actual discrimination against transsexuals in Indian society, and discusses the idea and theory of human rights.

The Indian Supreme Court's decision, which relied on the Constitutional guarantees of

non-discrimination, equality and freedom of expression to protect transgender rights, was groundbreaking. If implemented correctly, it will mean that some of the barriers that transgender persons face in exercising their human rights will be dismantled; this is a step towards enabling them to live their lives out of the shadows, have their identities respected and be treated no differently from anyone else.

The Court recognized that the failure ".....lies in the society's unwillingness to contain or embrace different gender identities and expressions, a mindset which we have to change<sup>103</sup>," and that constitutional protections cannot be restricted to binary genders of male or female. The Court became part of the change when it issued this judgment, not only because it recognized this failure, but also in the tools it used to do so. In grounding its judgment in international human rights law, the Court used the human rights principles that are enshrined in international legally binding agreements and the Constitution of India and breathed life into them. It also speaks extensively on the Yogyakarta Principles<sup>104</sup>, a set of international principles relating to sexual orientation and gender identity drawn up in 2006 by a distinguished group of international human rights experts in response to well-documented patterns of abuse. The Indian judgment marks one of the first comprehensive applications of the

---

103. National Legal Services Authority v. Union of India, Writ Petitions (Civil) No. 400 of 2012

104. <http://www.yogyakartaprinciples.org/>

Yogyakarta Principles by any national-level court in the world. The court noted that constitutional protections must be read in harmony with these international human rights protections. In doing so, it found that, "Each person's self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom<sup>105</sup>". A brief history of the traditions and histories of the transgender communities was also discussed and it remarked on uncovering traditions that were more open and tolerant before they were attacked by colonial laws.

#### Key highlights of the judgment

- Recognition of people who identify in the opposite sex is based on self-identification.
- This includes female identifying as male and male identifying as female.
- Discrimination on the ground of sexual orientation and gender identity amounts to discrimination on the ground of sex under Article 15.
- No sex reassignment surgery is required for recognition of gender identity.
- The right of individuals to choose their gender identity is protected under the Constitution.

The Judgment also directs State governments to ensure livelihoods, expand social security, provide health care, and to make civil amenities like public toilets and

restrooms accessible and available for them.

Shortly after, the Union of India filed a brief seeking clarification on various aspects of the judgment, such as the definition, reservation etc. This was seen by many as a stalling tactic as no implementation of the orders happened in the time after, and the stand of the Government was that it had asked for some clarity on the orders passed and the work would only begin there after.

The Supreme Court on 29 June 2016, refused to modify its order from 2014, in which it granted transgender people the status of a third gender.<sup>106</sup> The top court clarified that only transgender persons made up the third gender, not gays, lesbians or bisexuals, PTI reported.

The apex court was hearing a petition filed by the Centre, challenging the definition of 'transgender'.

The Rights of Transgender Persons bill, 2014 is a proposed Act of the Parliament of India which seeks to end the discrimination faced by transgender people in India.

The bill was passed by the upper house Rajya Sabha on 24 April 2015; it was subsequently introduced in the lower house Lok Sabha on 26 February 2016.

The Bill was introduced in the Rajya Sabha by Mr. Tiruchi Siva as

105. <http://livewire.amnesty.org/2014/05/02/embracing-difference-indias-ground-breaking-judgment-on-transgender-rights/>

106. <http://scroll.in/latest/810903/only-transgender-people-not-gays-lesbians-or-bisexuals-are-the-third-gender-supreme-court>

a private member's bill. The Minister of Social Justice and Empowerment Thawar Chand Gehlot said that some clauses of the bill were impractical and too complicated. He promised future policies to benefit transgender people, while requesting the Bill to be withdrawn.

The bill was unanimously passed on 24 April 2015 in the Rajya Sabha and is considered historic for being the first private member's bill to be passed by any house in 36 years and by the Rajya Sabha in 45 years.

On 26 February 2016, the bill was introduced in the Lok Sabha for debate by Biju Janata Dal (BJD) leader Mr. Baijayant Panda. Mr. Panda argued that the bill would help extend constitutional rights and end the discrimination against transgender people, allowing them to live a life of dignity. The bill provides for formulation of a comprehensive national policy for ensuring overall development of the transgender persons and for their welfare.

Describing the bill as historical, Mr Panda insisted it had the support of all sections of House and even the judiciary and should be passed as a private member's legislation. The bill, he added, would help in extending constitutional rights relating to equality, right to life of dignity and freedom of speech to transgenders who are discriminated in all spheres of life. Even the High

Courts and Supreme Court were for ending discrimination to transgenders, he said, stressing that under the Constitution all citizens must have equal rights. Mr Panda said that a law was needed to ensure that they get equal treatment in educational institutions and jobs and lead the life of a dignity. The debate remained inconclusive and will be taken up later.

#### Rights of transgender persons bill 2016

The Ministry of Social Justice and Empowerment in consultation with experts and based on the private members' Bill passed earlier in the Rajya Sabha, had drafted a Rights of Transgender Persons Bill 2016, and the ministry, headed by the Hon'ble Minister Thawar Chand Gehlot, circulated a draft Cabinet note on the 'Rights of Transgender Persons Bill, 2016' to all ministries for their comments on March 2016. The Bill was introduced in the Parliament on the 3rd of August and is pending for approval.

A transgender person, as per Bill, will be recognised as one once he/she gets a certificate issued by the District Magistrate of the district where the applicant is residing on the recommendation of a district-level screening committee comprising a chief medical officer, district social welfare officer, psychologist/psychiatrist, social worker and two representatives of the transgender community.

The draft law also proposes to create a National Council of Transgender Persons and start schemes to provide scholarships, textbooks and hostel accommodation to them. It further calls for necessary amendments in the IPC to cover cases of sexual offence against transgender persons.

#### Some important features of the Bill are<sup>110</sup>:

The Bill defines a transgender person as one who is partly female or male; or a combination of female and male; or neither female nor male. In addition, the person's gender must not match the gender assigned at birth, and includes trans-men, trans-women, persons with intersex variations and gender-queer.

#### Transgender Certificate:

The bill also states that a certificate that a person is a transgender person should be issued by a state level authority duly designated or constituted by respective the State/UT on the lines of Tamil Nadu Aravanis Welfare Board, on the recommendation of a District level Screening Committee headed by the Collector/District Magistrate and comprising District Social Welfare Officer, psychologist, psychiatrist, a social worker and two representatives of transgender community and such other person or official as the State Govt/UT Administration deems appropriate.

#### Transgender's right to home:

Section 13(1) of the Draft states that No child who is a transgender shall be separated from his or her parents on grounds of being a transgender except on an order of competent Court, if required in the best interest of the child. The Bill also has provisions regarding Health, Education and Employment of Transgenders. The bill also states that Government is duty bound to take appropriate steps in protecting rights of Transgenders and to ensure that they are not being discriminated against.

#### MOSJE expert committee

While the NALSA v Union of India matter was listed for hearing in the Hon'ble Supreme Court of India, an Expert Committee was established by the MOSJE and has recommended that 'transgender' be declared the third gender, with the individual having the right to choose gender, and has asked the government to prepare a law to prevent discrimination and atrocities against these people. Importantly, it has asked the National Crime Records Bureau to collect and compile statistics of crimes against transgender persons and cases registered against them.

The committee, set up by the Ministry of Social Justice and Empowerment in 2013 and chaired by the Additional Secretary of the Ministry, has said action must be taken against parents who neglect or abuse their gender

---

110. <http://www.livelaw.in/the-rights-of-transgender-persons-bill-draft-released-by-ministry-of-social-justice-read-the-bill/>



non-conforming children and doctors who practise electro-shock or other kinds of unethical “conversion” therapy. Criminal and disciplinary action must be taken against delinquent police officers for violation of human rights of transgender persons.

Its report<sup>111</sup>, titled “Report of the Expert Committee on the Issues Relating to Transgender Persons”, submitted a few weeks after the Supreme Court criminalised same gender consensual sex, wanted laws against sexual assault and harassment and domestic violence made transgender-inclusive. “Where transgender individuals need to be incarcerated, care must be taken to ensure that they are not in circumstances where they are vulnerable to sexual assault.” The Ministry has asked the States to implement the recommendations of the committee, which has also said slurs based on perceived gender identity may be included in Section 153A of the IPC. The committee has called for an intensive publicity media campaign and has said the Bureau of Police Research and Training should do a study on crimes against transgender persons, including alleged police excesses, to find out their causes and suggest preventive measures.

Recommending that ‘transgender’ be used as an inclusive term to cover all gender identities and expressions, the report has called for a compilation of all known transgender socio-cultural groups

to be prepared and circulated among all for guidance. The terms ‘sex’ and ‘gender’ should not be used interchangeably, and only the term ‘gender’ should be used in official documents, such as identity documents, application forms, returns and reports.

Pointing out that the Constitution is ‘sex blind’ — equality before the law irrespective of sex — the report says a harmonious reading of the constitutional provisions as well as provisions of the Citizenship Act, 1955, and the General Clauses Act, 1897, will show that in fact any of these laws are not in conflict with the concept of ‘person,’ and a transgender person will undoubtedly fall within the definition of ‘person.’

The Medical Council of India, along with leading mental health institutions and organisations working on transgender issues, should develop practice protocols for the care of transgender adolescents. The Ministry of Health and Family Welfare will prepare a policy statement on providing essential gender-transition services in public hospitals, and a national clinical guidance document in keeping with international guidelines.

**The University Grants Commission has notified India’s first gender-neutral Regulations relating to Sexual harassment**<sup>112</sup>

New UGC regulations on Sexual harassment prevention and prohibition which was notified last month, has made sexual harassment a gender neutral

111. <http://socialjustice.nic.in/writereaddata/UploadFile/Binder2.pdf>

112. <http://www.livelaw.in/ugc-notifies-indias-first-gender-neutral-regulations-sexual-harassment/>

Defending India's decision, External Affairs Ministry Spokesperson Vikas Swarup in New Delhi said India took the decision considering the "legal" reality in the country. "The issue of LGBT rights in India is a matter being considered by the Supreme Court (SC) under a batch of curative petitions filed by various institutions and organisations. The SC is yet to pronounce on this issue," said Swarup. "As such we had to take this into account in terms of our vote on the the UN resolution to institutionalise the office of an independent expert to prevent discrimination against the LGBT persons," he told reporters.

[http://www.huffingtonpost.in/2016/07/01/lgbt-un-expert\\_n\\_10772378.html](http://www.huffingtonpost.in/2016/07/01/lgbt-un-expert_n_10772378.html)

affair and now male students and students of the third gender in universities can also lodge complaints against sexual harassment faced by them. The UGC (Prevention, prohibition and redressal of sexual harassment of women employees and students in higher educational institutions) notified recently says that it is the responsibility of higher educational Institutions to 'act decisively against all gender based violence perpetrated against employees and students of all sexes recognising that primarily women employees and students and some male students and students of the third gender are vulnerable to many forms of sexual harassment and humiliation and exploitation' Earlier in a report published by University viz.

SAKSHAM Report (Measures for Ensuring the Safety of Women and Programmes for Gender Sensitization on Campuses) it was said "The Sexual Harassment Act only addresses the issue of protection of women employees and is not gender neutral. Male employees, if subjected to sexual harassment, cannot claim protection or relief under the law. However, many guidelines against sexual harassment in universities have taken the next step to becoming gender plural. They recognise that men can be subjected to sexual harassment beyond ragging incidents, especially if they are identified as belonging to a sexual minority. Such cases also require all the efforts of educational, corrective and if necessary punitive responses through proper procedures."

Regulations also describe the procedure to file complaints. An aggrieved person is required to submit a written complaint to the Internal Complaints Committee within three months from the date of the incident and in case of a series of incidents within a period of three months from the date of the last incident. Friends, relatives, colleagues, co-students, psychologist, or any other associate of the victim may file the complaint in situations where the aggrieved person is unable to make a complaint on account of physical or mental incapacity or death.

[UN creates post to look into violence against LGBT people](#) <sup>113</sup>

On 01 July 2016, the United Nations top human rights body has decided to appoint an expert to monitor violence and discrimination based on sexual orientation and gender identity. The UN's top human rights body has decided to appoint an expert to monitor violence and discrimination based on sexual orientation and gender identity. In a narrow 23-18 vote with six abstentions, the Human Rights Council yesterday called for the creation of a three-year position for an independent expert to look into wrongdoing against gays, lesbians and transgender people. The expert is expected to be appointed at the next meeting of the 47-member, Geneva-based body in September. "This is truly momentous," said Micah Grzywnowicz of the Swedish Federation for LGBTQ Rights in a statement. "This is our opportunity to bring international attention to specific violations and

113. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20220&LangID=E>; <http://www.financialexpress.com/world-news/un-body-creates-post-on-sexual-orientation-gender-identity/302899/>

challenges faced by transgender and gender non-conforming persons in all regions.”

The resolution benefited from strong support from Latin America and the West, while many African and Middle Eastern countries joined China voting against it. India has abstained at the UN Human Rights Council voting in Geneva to appoint an independent expert to look into cases of violence and discrimination based on sexual orientation and gender identity, a resolution which was passed by a narrow margin<sup>114</sup>.

The expert’s duties will include assessing international human rights laws, raising awareness of violence based on sexual orientation, and engaging in dialogue with member states and other stakeholders.

### Employment

For PLHIV, both getting jobs and retaining them have proven to be highly problematic, in environments fraught with discriminatory attitudes about everything from their capacity to perform to them being a danger to other employees. In India private companies run mandatory health checks, which include HIV testing, and this results in PLHIV being denied jobs at the time of recruitment. Discrimination within the work place against employees found to be HIV-positive ranges from subtle actions such as non-promotion and being ostracised by other employees to outright termination of employment. Considering that a large proportion of the HIV-positive

population in India is either employed or of employable age<sup>115</sup>, it is imperative that workplace policies on HIV and AIDS be created and enforced within the public and private sectors. Further complicating this situation is the fact that approximately 92 % of the workforce is in the informal sector, which is characterised by low productivity, income levels and poor social protection.

As mentioned above, India has ratified the ILO Convention No. 111 on Discrimination (Employment and Occupation). In keeping with this the Government has also created a policy on HIV and AIDS and the workplace, which specifically prohibits “discrimination or stigmatization of workers on the basis of real or perceived HIV status.”<sup>116</sup> The policy also states that HIV/AIDS screening should not be carried out for the purposes of determining employment and that confidentiality of workers must be protected<sup>117</sup>. The courts in India have affirmed this stance on non-discrimination within the workplace.

One landmark anti-discrimination case in the Bombay High Court, *MX vs. ZY*, which affirmed the rights of PLHAs in the workplace, concerned a casual labourer who was tested for HIV by his employer, a public sector corporation, prior to being regularised into a permanent position<sup>118</sup>. In this case the labourer’s contract was terminated on the basis of a positive HIV test despite the fact that he was otherwise perfectly fit. He subsequently filed a writ

114. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20220&LangID=E>

115. According to the National Policy on HIV and the Workplace, “90% of the reported HIV infections are from the most productive age group of 15–49 years.”

116. Government of India, Ministry of Labour and Employment, National Policy on HIV/AIDS and the World of Work, Section 3.4 (ii).

117. *Ibid.*, Section 3.4 (vi, vii).

118. *MX v. ZY* [AIR 1997 Bom 406], available at <http://www.hivaidsonline.in/index.php/Debates/do-we-need-a-separate-law-on-hiv-aids.html>

petition in the Bombay High Court, on the basis that mandatory HIV testing and denial of employment to positive people violated Articles 14 (equality before the law), 16 (equality of opportunity) and 21 (right to life and personal liberty) of the Indian Constitution.

The ruling was significant in that it stipulated that "a government/public sector employer cannot deny employment or terminate the service of an HIV-positive employee solely because of their HIV-positive status, and any act of discrimination towards an employee on the basis of their HIV-positive status is a violation of Fundamental Rights."<sup>119</sup> This judgement set a precedent in India and has been called upon in several other cases over the last decade to protect the rights of PLHIV in the workplace<sup>120</sup>.

Other notable cases are *Mr. Badan Singh v. Union of India & Anr.* (2002), Delhi High Court; *X v. State Bank of India* (2002), Bombay High Court; *G v. New India Assurance Co. Ltd.* (2004), Bombay High Court; *X v The Chairman, State Level Police Recruitment Board & Ors* [2006 ALT 82]; *RR v. Superintendent of Police & others* [Unreported (2005) Karnataka Administrative Tribunal]; *S. Indian Inhabitant of Mumbai v. Director General of Police, CISF and others* [Unreported (2004)], High Court at Bombay in WP No. 202 of 1999; *Av Union of India* [Unreported (28 November 2000), High Court at Bombay, WP No. 1623 of 2000 and Review Petition No. 3 of 2000.

Whilst public sector companies come under the purview of these constitutional guarantees,

discrimination issues within the private sector are harder to address. The absence of a legislative framework means that it is largely up to a company's discretion as to whether it implements government recommendations on workplace policy. Most private companies still subject prospective as well as existing employees to HIV/AIDS screening as part of the assessment of fitness to work and refuse employment if they test positive. If someone refuses either to take the test or to disclose its results to the company, they are not offered the job and no legal redress is available in this situation. Those already employed in the private sector are also in a tenuous situation since they can be dismissed on the grounds of ill health or lack of "fitness" to carry out work. This issue of "fitness" is particularly resonant for people working in areas where high levels of physical performance are required<sup>121</sup>.

The transmission or spread of sexually transmissible diseases, including HIV has been within the purview of not just the public health laws, but also of criminal laws. The criminal law is used as a deterrent and as a tool to prosecute sexual conduct that may endanger the lives of others or spread disease to others. Unfortunately, criminal laws penalize not only the coercive, malignant, intentional conduct to spread disease, but also consensual sexual conduct between adults, even where there is little or no danger of spreading disease.

119. Ibid.

120. See: *MX v. ZY* [AIR 1997 Bom 406];

121. See: *Lawyers Collective*, 2003, p. 7.



# LAWS THAT PENALISE AND OR ILLEGALISE VULNERABLE GROUPS

Indian criminal law penalizes the malignant or negligent transmission of a disease dangerous to life, like HIV, to another. Even placing a person in the fear of transmission, without actual transmission is enough to make it an offence. There is no clarity as to whether using a condom and/or informed consent from the other person can be used as grounds to prevent conviction.

The Indian Penal Code penalizes the unlawful, negligent or malignant spread of disease dangerous to life under Sections 269 and 270. There have been few judgements applying these provisions to the case of HIV and even those do not interpret these provisions to determine whether informed consent along with the knowledge of the methods by which HIV is transmitted would absolve a person living with HIV from criminal liability for exposing another person to the risk of transmission. It is also unclear whether taking precautionary measures, such as using condoms in the case of safer sex practices in the context of HIV, would be considered to be mitigating factors.

Estimates suggest that India is home to approximately 868,000 female sex workers (FSWs). HIV prevalence among FSWs has declined from 5.06 per cent in 2007 to 2.67 per cent in 2011. Though sex workers comprise about 0.5 percent of India's adult female population, they account for 7 per cent of HIV infected females.

Source: NACO, Department of AIDS Control, Ministry of Health & Family Welfare, Annual Report 2012–13

## Criminalisation of marginalized populations

Criminal laws also penalize marginalized populations, such as sex workers, drug users, prisoners and men who have sex with men. The combination of criminal laws, that penalize multiple activities of these populations, and harassment by law enforcement mean that sex workers often report being harassed for carrying condoms while drug users are prevented from accessing clean needles. Criminalisation also pushes marginalized populations underground and away from health services.

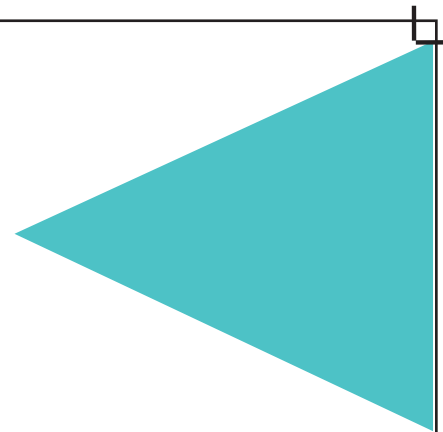
Health issues and high prevalence of STIs and HIV amongst vulnerable and marginalized populations of sex workers, drug users, men who have sex with men, and prisoners have highlighted the fact that the laws that criminalize their activities have actually impeded their access to health care and protection from disease and have pushed them in a further state of vulnerability by violating their human rights including their sexual and reproductive rights.

## Sex work

According to the National AIDS Control Organisation, "clients of sex workers are the single most powerful driving force in India's HIV epidemic and constitute the largest infected population group in the country."<sup>122</sup>

---

122. Ibid, p. 5.



" Sex work is considered to be a primary driver of the epidemic, along with unprotected sex between men and injecting drug use. It is important to acknowledge that there are considerable numbers of male and transgender persons engaging in sex work in India but ironically, whilst MSM are specifically targeted in government interventions, those who do so for a living are not. For a majority of sex workers in India, taking control of their health and safety is deeply problematic in a context where their work is criminalised and where they face high levels of stigma, discrimination and moral censure from society. As one activist puts it, this stigma is "rooted in a series of interlocking gazes: a societal gaze that perceives prostitutes as debauched, deviant, wanton and weak; a religious gaze that considers prostitution a sin; a legal gaze that sees it as a crime; and an umbrella gaze that characterizes a sex worker as 'throwaway' or 'disposable' women<sup>123</sup>."

Sex workers are discriminated against within public services and subjected to violence from clients, brokers, brothel owners, family members and police. The situation is exacerbated by laws that criminalise sex work and push sex workers on to the streets (and into unsafe and violent situations), negatively affecting their access to health services as well as their ability to demand condom use

from clients. In addition, sex workers are unable to get help from the police in situations where they are the victims of violence<sup>124</sup>. Laws that allow the police to abuse, harass and extort money and sex from sex workers create a considerable barrier to accessing health services and HIV prevention, testing and treatment services. The UN special rapporteur on violence against women has recommended that the government review the Immoral Traffic (Prevention) Act, 1956 that de facto criminalises sex work, and ensure effective measures to protect the human rights of sex workers<sup>125</sup>.

In India, despite the fact that sex work per se is not illegal, various other provisions exist within the relevant legislation which inadvertently support prohibition and which have been used to sanction sex workers. Globally, this is most seen in legal frameworks that conflate sex work with human trafficking. This conflation results in laws and strategies that are meant to combat trafficking being at odds with programmatic interventions and policy required to ensure rights for sex workers.

The Immoral Trafficking Prevention Act, 1986 (ITPA) is the primary piece of legislation dealing with sex work in India and a good example of the problems associated with the conflation of trafficking and sex work. Whilst ITPA does not criminalise the

---

123. Datta, Bishakha, "Steel Knife in My Windpipe: What violence against sex workers looks like from the inside", Count Me In, Conference Papers, 2011, available at [http://www.countmeinconference.org/downloads/background\\_papers.pdf](http://www.countmeinconference.org/downloads/background_papers.pdf)  
124. Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, Issues Brief: Laws and Practices Relating To Criminalization Of People Living With HIV and Populations Vulnerable To HIV, 2011.

125. UN Human Rights Council, Report of the Special Rapporteur on violence against women, its causes and consequences, Addendum: Mission to India, 1 April 2014. A/HRC/26/38/Add.1, available at <http://www.refworld.org/docid/53982c3e4.html> [accessed 4 July 2014]

commercial exchange of sex, it does penalise Acts like keeping a brothel<sup>126</sup> soliciting in a public place<sup>127</sup>, living off the earnings of prostitution and living with or habitually being in the company of a prostitute.<sup>128</sup>

There are specific problems with the Immoral Trafficking Prevention Act, 1986 (ITPA), some of these issues are"

#### Consent:

All the provisions in ITPA exist "with or without consent" of the women involved, thus infantilising adult women. The assumption that adult women could not possibly have given their consent to be sex workers is inconsistent with laws on other issues, such as abduction or illegal confinement, where consent or the lack thereof is considered critical to determining whether a crime has taken place.

#### Penalties for soliciting:

While the purpose of ITPA is ostensibly to protect people from being trafficked, data has shown that over 90 per cent of those arrested under ITPA are female sex workers.<sup>129</sup> Section 8 criminalises "solicitation" which refers to the "drawing attention of potential customers from a visible, conspicuous site, whether in a street or private dwelling."<sup>130</sup> This directly targets sex workers, who usually confess rather than facing detention and trial, which would lead to loss of earnings.

#### Prohibition of brothels:

Section 2 defines a brothel as "any house, room, conveyance or place or any portion of any house, room, conveyance or place which is used for purposes of sexual exploitation or abuse for the gain of another person or for the mutual gain of two or more prostitutes."<sup>131</sup> Section 3 provides punishment for keeping, running and managing a brothel. The phrase "two or more prostitutes" has been used to target residences, if shared by two or more sex workers. This results in the closure of various relatively safe spaces where sex workers live and work, under the aegis of closing down brothels.

#### Statutory powers:

The implementation of ITPA commonly results in operations involving raid, rescue and forcible rehabilitation. In these the sex worker is seen either as criminal or hapless victim whilst the traffickers are seldom caught. Again, powers given to the police for rescuing people from brothels make no distinction between minor or adult and voluntary vs coerced sex workers, which means that anyone found in the brothel at the time of a raid can be forcibly removed<sup>(132)</sup>. In addition, the law provides for mandatory medical examination of rescued persons to determine the "presence of any sexually transmitted diseases,"<sup>133</sup> implying that mandatory testing for HIV can be carried out on rescued sex workers. Rules enacted by state governments under ITPA have

126. See: Section 3, ITPA.

127. See: Section 8, ITPA.

128. See: Section 4, ITPA.

129. Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, "Issues Brief: Laws and Practices Relating To Criminalization Of People Living With HIV and Populations Vulnerable To HIV", 2011, p. 12.

130. National Network of Sex Workers and Lawyers Collective, "Sex Workers meet Law Makers", Report of meeting, March 2011.

131. Section 2 (a), ITPA.

132. Section 14, 15, 16, ITPA.

133. See: Section 15, 5 (A), ITPA.

Estimates suggest that India is home to approximately 177,000 injecting drug users (IDUs). HIV prevalence among IDUs has remained relatively unchanged, from 7.23 per cent in 2007 to 7.14 per cent in 2011.

Source: NACO, Department of AIDS Control, Ministry of Health & Family Welfare, Annual Report 2012–13

decreed that people found with any STI should be kept segregated from other inmates to the degree possible. Mandatory testing, followed by isolating people found to be HIV-positive, is a serious human rights violation and provides yet another deterrent for women to approach the state even if they do so voluntarily.

**Vagrancy, Public Nuisance and Beggary Laws are also used on Sex workers** who are frequently detained and harassed under provisions of the Indian Penal Code (IPC), 1860 and various state level acts on police, beggary, public nuisance and vagrancy. The Bombay Police Act, which penalises indecent behaviour in public, is often used against street based sex workers<sup>134</sup>. Police in Gujarat have used their powers under ITPA and under the Gujarat Prevention of Anti Social Activities Act, 1985 to raid brothels, destroy property and arrest sex workers who have been brutally assaulted during these operations and in custody.<sup>135</sup>

The current legal framework, which allows or leads to forced removal from their places of work, violence, harassment, extortion and confinement in shelters as well as mandatory testing for HIV and isolation are not only barriers to effective HIV responses, fuelling further vulnerability to HIV, but also serious violations of the human rights of this section of society. There is a growing body of evidence that shows that "criminal

sanctions attached to sex work push sex workers underground into hidden and dangerous settings where they have minimal control over working conditions including health, safety and earnings.<sup>136</sup>"

Reports from sex worker organisations show that sex workers are less likely to use condoms in areas where they are negotiating their livelihoods in a constant atmosphere of fear and insecurity. The fear of being apprehended by police and losing a client deters sex workers from spending time trying to negotiate condom use. Organisations also report that sex workers are deterred from carrying condoms because police assume possession of condoms to be evidence of solicitation and therefore grounds for arrest<sup>137</sup>. Due to the stigma and moral censure associated with sex work in India, sex workers are very unlikely to access mainstream health services or get themselves tested for HIV. In addition, they are perceived as "carriers" of HIV and have been refused entry into hospitals on this basis. Fear of harassment and prosecution and violence from the police pushes sex workers into ghettoised locations where they cannot be reached, therefore increasing their vulnerability to abuse by clients and pimps and correspondingly to HIV and AIDS.

134. See: Section 101 (A), Bombay Police Act, 1951.

135. Lawyers Collective, 2003, p. 125.

136. Ibid., p. 126.

137. Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, 2011.



### People who use drugs

PWUD in India face tremendous prejudice and stigma from legal and health institutions as well as from society at large. They are disproportionately affected by HIV and AIDS, living, as they often do, in conditions of poverty and squalor within which their health, social and legal needs are completely neglected. Frequently reported health issues for PWUD include fever, diarrhoea, tuberculosis, STIs, abscesses, impairment and deaths related to drug overdose.

In addition, unsafe drug injecting practices put them at risk of blood borne infections such as Hepatitis C and HIV and AIDS. Global estimates suggest that one in 10 new HIV infections is related to injecting drug use<sup>138</sup>. Reports have documented practices such as sharing of injection equipment including needles, syringes, water, cotton, use of contaminated needles and incorrect cleaning practices at sites across the country.

These risks are exacerbated by unsafe sexual activity and an apparent lack of perceived risk amongst PWUD on the chances of contracting HIV<sup>139</sup>. Studies have shown that once HIV enters a population of IDUs, it spreads quickly. For example, between 1993 and 1998, the prevalence of HIV among IDUs in Manipur went up from one to 60 per cent. Low condom use amongst PWUD with sexual partners allows HIV to quickly spread outside of this

community through sexual transmission<sup>140</sup>.

In this context reaching affected populations with harm reduction programmes is critical. Harm reduction policies are widely acknowledged to “mitigate problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs.” WHO guidelines confirm that substitution therapy, such as methadone and/or buprenorphine maintenance, is still the most promising method of reducing drug dependence<sup>(141)</sup>. Indeed, the UNAIDS Practical Guidelines for Intensifying HIV Prevention recommend the provision of a comprehensive package of harm reduction interventions for PWUD, “including substitution treatment (eg. methadone maintenance), needle and syringe programmes, peer education and outreach, voluntary HIV testing and counseling, prevention of sexually transmitted infections, primary health care and anti retroviral therapy.”<sup>(142)</sup> Multiple studies have shown that the risk and incidence of HIV infection amongst PWUD can be significantly lowered by the delivery of comprehensive harm reduction services<sup>143</sup>.

Experience and research over the last few decades has also shown that punitive laws and policies “do not achieve their purported goals, whether fighting crime or reducing drug use or drug-related harm...and decidedly do not stem HIV infection”<sup>144</sup>

138. Global Commission Report, 2012.

139. UNODC-commissioned review by Lawyers Collective, “Legal and Policy Concerns Related to IDU Harm Reduction in SAARC Countries”, 2007.

140. The World Bank, Legal Aspects of HIV and AIDS: A Guide to Policy and Law Reform, 2007.

141. World Health Organisation, “The Methadone Fix”, Bull World Health Organ, March 2008, 86 (3): 164–5.

142. UNAIDS, Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access”, 2007.

143. See footnote 91 in Global Commission Report, 2012, for a list of these studies.

144. Global Commission Report, 2012, p. 30.

Court admits plea for scientific and human rights standards for drug dependence treatment  
22nd April 2009, Chandigarh: SHARAN, an NGO working with people who use drugs, approached the Punjab and Haryana High Court for protection of rights of persons dependent on drugs. Intervening in *Talwinder Pal Singh v. State of Punjab*, Crl. Misc. No. M- 26374 of 2008, SHARAN, sought the observance of clinical and human rights standards in the delivery of drug dependence treatment. Admitting SHARAN as a party to the proceedings, a single bench of Justice Rajiv Bhalla issued notices to the Ministries of Health and Family Welfare and Social Justice and Empowerment – the two agencies in charge of drug related treatment. Facts leading up to the case date back to August 2008, when the District Magistrate, Mohali, Chandigarh directed centres providing treatment for drug dependence to ensure adequate accommodation, food, sanitation and medical care, documentation and record keeping and allow family visits. The said order was passed in response to a report of a death of a drug user due to alleged beating at a “de-addiction centre” near Mohali.

<http://www.lawyerscollective.org/vulnerable-communities/drug-use/treatment.html>

Buprenorphine is legally available in India. However, harm reduction efforts are often hindered by the existing legal framework, which heavily criminalises drug use. Laws related to drug use provide disproportionately harsh punishment even for small-quantity consumption and possession, thus unnecessarily criminalising the user. In light of the fact that approaches to drug use in India have included disruption of HIV prevention programmes, prevention of the delivery of clean needles, syringes or substitute drugs, and pushing more people through prisons and the criminal justice system (thus further increasing their vulnerability to HIV and AIDS), India’s legal framework concerning drug use needs detailed re-examination.

The *Narcotic Drugs and Psychotropic Substances Act, 1985*, is the primary law concerned with and affecting PWUD in India. Ironically, this Act (which introduced a draconian penal regime for trafficking, usage, possession and consumption of drugs, and banned the consumption of opium and its derivatives) appears to have had the unintended effect of shifting drug usage habits in India with disastrous public health consequences. It has been suggested that drug users, now facing criminal penalties for possession of very minimal quantities of drugs, needed to resort to alternative methods of drug intake-injecting themselves

—in order to attain a “high”. In addition, the ban on the production and consumption of opium and its derivatives may have encouraged the shift to heroin, brown sugar and certain pharmaceutical drugs<sup>145</sup>. PWUD in India are criminalised under the NDPS Act as a result of a range of offences, including possession of drugs, self-offences, including possession of drugs, self-administration of drugs and possession of equipment for drug use, such as syringes.

#### Consumption and usage:

Section 21 states that anyone who “manufactures, possesses, sells, purchases, transports, imports inter-State, exports inter-State or uses any manufactured drug or any preparation containing any manufactured drug shall be punishable.... where the contravention involves small quantity, with rigorous imprisonment for a term which may extend to six months, or with fine which may extend to ten thousand rupees, or with both”<sup>146</sup> and Section 27 of the Act states, “Whoever, consumes any narcotic drug or psychotropic substance shall be punishable... with rigorous imprisonment for a term which may extend to one year, or with fine which may extend to twenty thousand rupees; or with both.”<sup>(147)</sup> The critical point is that the law criminalises all those who possess or consume drugs, however small the quantity.

146. See: The Narcotic Drugs And Psychotropic Substances Act, 1985, Sections 21 and 21 (a).

147. Ibid., Section 27 (a).

### Possession of paraphernalia:

Section 54 criminalises the possession of drug “paraphernalia” as well as creating an ambiguous category of offenders who will be prosecuted unless they are able to provide a satisfactory explanation for why they possess certain materials.

### Bail and warrants:

All offences under the Act are recognizable and non-bailable. This means that police are empowered to act without a warrant and that those arrested do not have the right to be released upon posting bail<sup>148</sup>.

### De-addiction and referral provisions:

These are superficially addressed by the Act, but without adequate infrastructural machinery that can deal with PWUD in a humane way, those that do exist are of little use. These provisions are also subject to the court’s discretion in examining and deciding on various grounds such as age, character and physical and mental condition of the offender, on whether these alternatives should be offered or not<sup>149</sup>.

The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988, further supports the stringent approach towards drug related offences in India. This Act allows the government wide-ranging powers to detain those suspected to be involved in “illicit trafficking”, which is deemed to include

“possession” and “use and consumption”<sup>150</sup>.

### Miscellaneous laws:

As in the case of sex workers, the criminalised nature of the activities of PWUD means that police are able to use vagrancy, nuisance and public order laws against them in an arbitrary way.

### Penal Code provisions dealing with obscenity

are also relevant in this context. Public education campaigns dealing with HIV and AIDS in the context of drug use can, under Section 292 of the IPC, be prosecuted for obscenity. Provisions include the prohibition on the sale and distribution of “obscene” material, printing of grossly indecent material, sale of obscene objects to young persons, and obscene acts and songs<sup>151</sup>. Penal Code provisions on abetment are also relevant, especially for those working towards harm reduction. Section 109 of IPC states “Whoever abets any offence shall, if the act abetted is committed in consequence of the abetment... be punished with the punishment provided for the offence<sup>152</sup>”. The NDPS Act also contains provisions related to abetment, which can be called upon specifically in drug related offences<sup>153</sup>.

**State laws:** Sikkim Anti Drugs Act (SADA), 2006: SADA contains strict penalties for the use and consumption of drugs, including six months’ imprisonment and a fine.

148. See: NDPS Act, Section 37: “(a) every offence punishable under this Act shall be cognizable and (b) no person accused of an offence punishable for 2 offences under section 19 or section 24 or section 27 A and also for offences involving commercial quantity] shall be released on bail....”

149. See, for instance, Section 39, which does give power to the court to release certain offenders on probation. If they deem it necessary the court may, “instead of sentencing him at once to any imprisonment, with his consent, direct that he be released for undergoing medical treatment for de-toxification or de-addiction from a hospital or an institution maintained or recognised by Government.” Section 64 (a) also provides for “voluntary” de-addiction treatment.

150. See: Section 2 (e) of the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988.

151. See: Sections 292, 292 (a), 293 (higher penalty if distributed to young people) and 294, Indian Penal Code, 1860.

152. See: Section 109 of the Indian Penal Code.

153. See: Section 29 of the NDPS Act: “Abetment and Criminal Conspiracy”.

### National Policy on Narcotic Drugs and Psychotropic Substances, 2012

This policy was passed by the government in January 2012 to further elucidate upon provisions in the NDPS Act. Certain points are particularly relevant in the context of this report such as the approach towards harm reduction and those conducting these programmes. The policy also acknowledges that in certain areas there is a lack of uniformity in approach between different arms of the government. For instance, with regard to harm reduction, the Ministry of Social Justice & Empowerment promotes an abstinence only policy while the Ministry of Health and Family Welfare and NACO have been promoting harm reduction. Therefore the policy lays down certain rules with the aim of addressing “this kind of divergence in approach on related issues.”<sup>154</sup>

Criminal sanctions, such as those imposed by the NDPS Act, are a serious hindrance to HIV prevention, treatment and care programmes. These laws leave “drug users widely exposed to exploitation, harassment, abuse and arrest by the law enforcement machinery” and prevent them “from accessing prevention, harm reduction and treatment information and services.”<sup>155</sup>

As noted above, the current legal framework allows prosecution of personnel of organisations providing shelter or services or disseminating information on safe

sex or overdose management under various provisions in the penal code. In addition, police are reported to have harassed outreach workers involved with needle/syringe exchange programmes (NSEPs), including verbally abusing them, threatening them with arrest under abetment clauses and arresting drug users who access their services. Under the NDPS, the legality of NSEPs remains an open question, as the provision of drug paraphernalia can be seen as facilitating the offence of drug consumption<sup>156</sup>. This results in a situation where outreach workers operate in a grey area, often sanctioned by one arm of the government, but needing to get permission from local law enforcement to ensure that their work is not disrupted, existing “despite the law and in constant fear of it.”<sup>157</sup>

#### Harm reduction:

The National AIDS Prevention and Control Policy (NAPCP) recognises the importance of harm reduction methods such as health education, provision of sterile needles and bleach in containing HIV/AIDS and encourages NGOs working in the field of drug demand reduction to initiate harm minimisation, including drug substitution therapies.

However, despite this apparent conviction, these programmes have been seriously impacted by criminalisation of drug users. As we have noted above, the NAPCP approach is not in line with the government’s recently approved

154. National Policy on Narcotic Drugs and Psychotropic Substances, p. 6, available at [india.gov.in/allimpfirms/alldocs/16470.pdf](http://india.gov.in/allimpfirms/alldocs/16470.pdf)

155. Lawyers Collective, 2003, p. 75.

156. Ibid.; UNODC, 2007, p. 72.

157. Lawyers Collective, 2003, p., 76.

policy on drugs. If NACO was to of all in line with this policy, it would seem that an increasingly stringent approach to harm reduction and outreach workers involved in related programmes would become the norm. For instance, the National Policy specifically refers to the fact that any organisation utilising harm reduction techniques must be supported by or recognised by the central government or risk being prosecuted under abetment provisions.

#### Death Penalty made discretionary instead of mandatory under the NDPS Act

Section 31A of the NDPS Act prescribes the death penalty for certain offences under the Act. The provision is a mandatory provision. However, the Bombay High Court in a case involving second conviction of an accused with commercial quantity, read the 'shall be' provision of section 31A as 'may be' and left the discretion to the court to decide whether death sentence should be given or not.

#### Indian Harm Reduction Network v. The Union of India, in Criminal Writ Petition No. 1784 of 2010 at the High Court at Mumbai, judgment dated 16.6.2011

This constitutional challenge to Section 31-A of the Narcotic Drugs and Psychotropic substances Act 1985 (NDPS) was brought by the Indian Harm Reduction Network (IHRN) – a consortium of NGOs

working for humane drug policies in India. IHRN's challenge was heard and decided together with petition no. 1790 of 2010, which was filed by Gulam Mohammed Malik, a repeat offender, who had been sentenced to death for possession of hashish. The petitioners argued that the mandatory death penalty for drugs violates the right to life – protected under Article 21 of the Constitution – due to its failure to consider the individual circumstances of a case. The petitioners also argued that drug offences do not qualify as a 'most serious crime' under international legal norms. In India, capital punishment is attracted for a subsequent offence involving a fairly large quantity of drugs. The threshold for imposing a death sentence under Indian law is higher than in most other countries.

The petition states, 'Article 21 of the Constitution forbids the State from interfering with a person's life and liberty, except in accordance with procedure established by law. It is a settled position that "procedure established by law" does not simply refer to a validly enacted legislation, but it requires that legislation be fair, just and reasonable, substantively as well as procedurally.'

Mandatory capital sanctions, it was argued, are also excessive, disproportionate and arbitrary, and thus in violation of Article 14, which ensures equal protection under the law. The petitioners

further argued that making 'death the norm' for a particular category of offenders is arbitrary and unjust<sup>158</sup>. Like the Indonesian courts, the judges referred to the obligations of the UN drug control treaties. They noted that one of the reasons for the NDPS was 'to implement the provisions of Unfortunately, any in-depth discussion of balancing international obligations imposed by drug control treaties and human rights law was mostly cast aside. The court wrote<sup>159</sup> :

Reliance was placed on Article 7 of the ICCPR, which provides that no one shall be subjected to cruel, inhuman or degrading punishment. That argument need not detain us, in view of the well-established position expounded by the Supreme Court that, as per the municipal law and the constitutional scheme as applicable in India, providing for death penalty is within the domain of the Legislature. Further, the International Covenants and judicial decisions cannot be the basis to overlook the express provision in the municipal law.

With regard to the 'most serious crime' question, the court argued<sup>160</sup>: Reliance was placed on Article 6, paragraph 2, of the ICCPR, which stipulates that the State-Parties may retain the death penalty to the most serious crime. As per the International Human Rights' norms, the phrase 'most serious crime' refers to crime involving intentional taking of life. For that, reliance was placed on materials,

including pertaining to the International Conventions. However, it is well-established position that the International Conventions cannot be the governing law. It is the Municipal Law which ought to prevail. The justices added that they were comfortable allowing the legislature to determine the proportionality of sanctions with respect to crimes, including the application of the death penalty. However, the court was less at ease with being stripped of its ability to consider mitigating circumstances. Fearing that mandatory sanctions would 'sacrifice justice at the altar of blind uniformity', the court wrote<sup>161</sup> :

The use of wise and beneficent discretion by the Court in a matter of life and death after reckoning the circumstances in which the offence was committed and that of the offender is in dispensable; and divesting the Court of the use of such discretion and scrutiny before pronouncing the preordained death sentence cannot but be regarded as harsh, unjust and unfair, thereby violative of the tenets of Article 21 of the Constitution. The provisions relating to the death penalty were thus not struck down as unconstitutional, but were 'read down' so as to allow for judicial discretion.

On 8th September, 2011, the Government introduced the NDPS (Amendment) Bill, 2011 in the Lok Sabha. The Bill was referred to the Parliamentary Standing Committee

158. [https://www.hri.global/files/2014/08/06/HRI\\_-\\_2012\\_Death\\_Penalty\\_Report\\_-\\_FINAL.pdf](https://www.hri.global/files/2014/08/06/HRI_-_2012_Death_Penalty_Report_-_FINAL.pdf)

159. Indian Harm Reduction Network v. Union of India, High Court of the Judicature at Bombay, criminal writ petition no. 1784 of 2010, June 2010

160. [https://www.hri.global/files/2014/08/06/HRI\\_-\\_2012\\_Death\\_Penalty\\_Report\\_-\\_FINAL.pdf](https://www.hri.global/files/2014/08/06/HRI_-_2012_Death_Penalty_Report_-_FINAL.pdf)

161. Indian Harm Reduction Network v. Union of India, High Court of the Judicature at Bombay, criminal writ petition no. 1784 of 2010, June 2010

on finance on 13th September, 2011 for further consideration<sup>162</sup>. The bill seeks to amend a number of provisions of the NDPS Act including<sup>163</sup>:

- Modification of the definitions of small and commercial quantity to include the entire amount of drugs involved and not only the pure drug content [Section 2(xxiii) and Section 2(via)]
- Standardisation of punishment for consumption of drugs to a maximum of 6 months or fine [Section 27]
- Transfer of power to regulate “poppy straw concentrate” from the State to the Central Government [Sections 9 and 10]
- Widening provisions for forfeiture of illegally acquired property, wherein any property of a person who is alleged to be involved in illicit traffic whose source cannot be proved is termed as ‘illegally acquired property’ and liable to be seized [Sections 68-B, 68-H and 68-O]
- Addition of the term ‘management’ to provisions on treatment for drug dependence [Section 71]

Concerns<sup>164</sup> over the bill: The proposed quantity definitions would have far reaching implications on sentencing for NDPS offences and may expose low-level drug offenders, including people who use drugs to stringent punishment. Despite standardisation of punishment for consumption of drugs, the policy of criminalisation of drug use remains unchanged. The over-broad scope of the forfeiture

provision makes it susceptible to misuse and subject to constitutional challenges. Further still, the bill fails to address key issues and contradictions that have arisen such as, death penalty for repeat offenders, immunity for treatment seeking, regulation of treatment centres, support for harm reduction measures and access to opioid medicines. The passage of the Narcotic Drugs and Psychotropic Substances (Amendment) Bill, 2014 showed some important amendments, path breaking changes for medical access to narcotic drugs by removing barriers that date back to 1985, when the Act was first introduced. The amendments also include provisions to improve treatment and care for people dependent on drugs, moving away from abstinence oriented services to treating drug dependence as a chronic, yet manageable condition<sup>165</sup>.

India is one of the leading producers of morphine, yet patients in the country could not access it owing to the stringent licensing requirements under the NDPS Act and Rules framed by State Governments. Statistics reveal that the medical use of morphine declined by 97% after the NDPS Act came into force. This will now change as Parliament has adopted a new category of “essential narcotic drugs” in section 2(viia) of the Act – a list, which the Central Government can notify on the basis of expediency in medical practice. Drugs identified as essential will be subject to Central Rules under section 9(1)(a), which

162. <http://www.lawyerscollective.org/vulnerable-communities/drug-use/ndps-amendment-bill-2011.html>

163. <http://www.lawyerscollective.org/vulnerable-communities/drug-use/ndps-amendment-bill-2011.html>

164. <http://www.lawyerscollective.org/vulnerable-communities/drug-use/ndps-amendment-bill-2011.html>

165. <http://www.lawyerscollective.org/updates/parliament-passes-ndps-amendment-bill-2014-gains-losses.html>

will apply uniformly throughout the country, bringing to an end the unwieldy and inept practice of obtaining multiple State licenses for possession, transport, purchase, sale, distribution, use and consumption. The amendments broaden the object of the NDPS Act from containing illicit use to also promoting the medical and scientific use of narcotic drugs and psychotropic substances. The language incorporated in section 4, which is an overarching provision, reflects the principle of 'balance' between control and availability of narcotic drugs, which is at the heart of international drug control but has eluded the NDPS Act so far. This widening of scope, it is hoped, will pave the way for more research on the beneficial use of narcotics, which up till now, remained out of bounds for the medical and scientific community due to the overtly prohibitive nature of the law. Importantly, medical use has not been specified and could include a variety of medical conditions, besides drug dependence and pain relief<sup>166</sup>.

Other salutary changes have been introduced in section 71, which significantly impact the health and rights of people who use drugs. The NDPS Act now allows for "management" of drug dependence, there by legitimizing opioid substitution, maintenance and other harm reduction services. Secondly, it authorizes the Government to "recognize and approve" treatment centres, which currently operate without license

or accreditation, and inflict violence and torture on drug users. The amendments will allow for instituting evidence based and human rights compliant standards for drug treatment facilities, whether public or private<sup>167</sup>.

### Prisoners

HIV is a major health challenge for prison authorities and HIV in prisons has implications for HIV in the general community. Prisoners face specific vulnerabilities to HIV infection due to practices such as unsafe sex—often coerced<sup>168</sup>—and sharing of syringes and needles. A large proportion of convictions in India are drug related so it is safe to assume that drug users form a substantial number of detainees in any given prison. Prisoners are also exposed to risk due to large populations of pretrial detainees, implying a very large inmate turnover. It is also important to remember that prisons do not exist independent of society, and that "the majority of prisoners return to the cities and towns they came from and resumption of risk behaviours such as unprotected sex and drug abuse shortly after release from prison is common<sup>169</sup>" Thus, in addition to the issue of the rights, health and safety of prisoners is the very real public health concern of the spread of HIV from prisons into communities of origin.

Prisoners in India usually co-exist in overcrowded, unsanitary and unsafe conditions. Moreover,

166. <http://www.lawyerscollective.org/updates/parliament-passes-ndps-amendment-bill-2014-gains-losses.html>

167. <http://www.lawyerscollective.org/updates/parliament-passes-ndps-amendment-bill-2014-gains-losses.html>

168. Violent sexual relations in prison can cause injuries and bleeding, thereby further heightening vulnerability to HIV infection.

169. Dolan, Kate and Larney, Sarah, "HIV in Indian prisons: Risk Behaviour, Prevalence, Prevention & Treatment", *Indian Journal of Medical Research*, 132, December 2010, pp. 696–700.



traditionally, the care of prisoners has been left to the discretion of super intendants and prison officials and this has not been conducive to guaranteeing prisoners' rights. As human rights activists have pointed out, "The UN Human Rights Committee has found that various acts of corporal punishment.....are still routinely practiced in India. These include the whipping or flogging of prisoners; use of solitary confinement for lengthy periods as a disciplinary measure; using methods of restraint such as shackles; and holding prisoners on 'death row' for extended periods, inducing mental anguish."<sup>170</sup> In addition, prisoners with HIV have been "subject to coercive measures that are not used in the general community such as segregation, isolation and mandatory HIV testing."<sup>171</sup> Such treatment violates Indian law as well as international conventions to which India is party.

#### The Prisons Act, 1894:

This is a fairly archaic act and although it is the primary relevant law dealing with prisoners, it has remained unchanged in more than 100 years. Moreover, State Prison manuals still contain penalties such as whipping or withholding food to punish prisoners<sup>172</sup>. This notwithstanding, the Supreme Court has stepped in to provide guidance and reform in terms of prisoners' rights in India. The Supreme Court has stated, "Convicts are not by mere reason of the conviction denied

of all the fundamental rights which they otherwise possess."<sup>173</sup>

Therefore, logically, they are entitled to various rights derived from Articles 14, 21 and 22 of the Constitution, which have been interpreted broadly to confer rights including the right to freedom from torture and maltreatment as well as the rights to access treatment, prison facilities, etc<sup>174</sup>.

Internationally, the most significant treaty dealing with prisoner's rights remains the International Covenant on Civil and Political Rights (ICCPR). As mentioned previously, India ratified the Covenant in 1979 and is bound to incorporate its provisions into domestic law and state practice. The central provisions relating to corporal punishment and the rights of prisoners are found in Articles 7 and 10(2). Article 7 provides that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." Concurrently, Article 10(2) of ICCPR provides that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." Practices in Indian prisons are in clear contravention of these provisions. There are various other relevant international instruments and guidelines which should inform the treatment of prisoners in India's jails<sup>175</sup>. Each of these instruments, and therefore the standards they define, has been adopted by the UN General

170. SAHRDC, Human Rights Features, "Corporal Punishment in India's Jails", HRF/142/06, May 2006.

171. Lawyers Collective, 2003, p. 97.

172. Ibid.

173. D.B.M. Patnaik v. State of A.P. [AIR 1974 SC 2092]; Sunil Batra v. Delhi Administration (Justice V.R. Krishna Iyer) (1978) 4 SCC 409.

174. See: Lawyers Collective, 2003, p. 98; and Charles Sobraj v. Supdt. Central Jail, Tihar, New Delhi [AIR 1978 SC 1514, (1978) 4 SCC 104]: "Like you and me, prisoners are also human beings. Hence, all such rights except those that are taken away in the legitimate process of incarceration still remain with the prisoner. These include rights that are related to the protection of basic human dignity as well as those for the development of the prisoner into a better human being."

175. See: GA Resolutions, Standard Minimum Rules for the Treatment of Prisoners (1955), Code of Conduct for Law Enforcement Officials (1979), Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988), and Basic Principles for the Treatment of Prisoners (1990).

Assembly and obligates the State to take action accordingly. Thus, in addition to fundamental rights guaranteed by the Constitution and expanded on and upheld in case law, India is also under an international obligation to treat prisoners according to certain standards of care. There are several key issues involved in protecting prisoner's rights with regards to HIV and AIDS.

- HIV efforts are hindered by prison policies that condone mandatory testing and segregation and do not ensure consent.
- Endemic to the prison environment is violence, poor nutrition, lack of medical facilities, overcrowding and lack of hygiene. This is not conducive to the good health of inmates.
- Harm reduction measures in prisons are hindered by legal provisions criminalising specific behaviour.

As noted above, prisoners regularly find their basic rights violated in Indian prisons. Mass screening programmes, without informed consent, have been followed by segregating HIV-positive prisoners and denying them participation in prison programmes. Researchers have pointed out that segregation undermines prevention messages by giving the false impression that other prisoners do not need to change their behaviour and by reinforcing stigmatising beliefs such as that HIV can be transmitted through casual contact and living together<sup>176</sup>. In

addition, confidentiality is almost impossible to maintain in a prison scenario, making voluntary testing unlikely due to fear of disclosure leading to isolation, potential segregation and violence. Prison authorities have refused to acknowledge the existence of drug use and unprotected sexual activity in prisons. The laws criminalising these behaviours<sup>177</sup> have meant that prison authorities can deny their prevalence among inmates and refuse to initiate harm reduction programmes<sup>178</sup>. As noted earlier, the national policy on drugs, in fact, explicitly states that harm reduction should not be carried out in prisons. This despite the fact that it has been globally acknowledged that these measures, which include provision of condoms, needles, clean syringes, bleach, counselling and drug substitution therapies, would significantly reduce the vulnerability of prisoners to HIV transmission.

#### HIV-positive prisoners:

There is also the question of medical facilities for the treatment of prisoners once they are found to be HIV-positive. Health systems within prisons are poorly prepared for the exigencies of HIV, constrained as they are by lack of space, very little acute or emergency care, no special diets and poor record keeping as well as limited budgets.

#### Case law:

Medical facilities for HIV-positive prisoners. The issue of medical

176. Lawyers Collective, 2003, p. 100.

177. The NDPS Act and Section 377 of the Indian Penal Code.

178. In 1994, Kiran Bedi, the then Director General of Prisons in India refused to let a medical team distribute condoms, saying it would encourage "gay behaviour".

facilities for HIV-positive prisoners has been addressed by a division bench of the Bombay High Court who took serious note of the neglect in this regard in a recent case. The case began in September 2008 when the Bombay High Court heard a petition filled by a prisoner with HIV seeking bail in order to obtain treatment. The petition stated that 32 HIV-positive prisoners had died in a single jail in Maharashtra between 2001 and 2006 because they weren't getting healthcare, and they were not taken to ART centres regularly to collect their medication. In response, the court appointed a committee to conduct a survey of HIV prevalence among inmates of the state's prisons. Between October 2008 and February 2009, 2,787 inmates (out of 9,830) in jails across the state voluntarily tested for HIV and 77 tested positive. The court also ordered the Maharashtra State Government to provide voluntary HIV counselling and testing to 7,000 inmates in the state's four central prisons as part of a campaign to assess HIV prevalence among inmates. On 9 July 2009, it fined three officers of the Maharashtra government for not reporting the government's plans to provide care to HIV-positive prisoners in the state.

**LX V. union of india & ORS:** Another issue in this context is the question of whether the state is responsible for continued treatment after a prisoner is released, especially if he or she contracted HIV within the prison.

With regard to this, the High Court of Delhi upheld an HIV-positive ex-prisoner's fundamental right to access treatment and medicines. The case involves LX, a man who was diagnosed as HIV-positive while incarcerated at Tihar Jail in Delhi. Upon diagnosis, the hospital prescribed a combination of ARVs. When LX was granted bail in May 2000, the jail authorities informed him that they would discontinue his ARV medicines upon his release. In December 2000 the ex-prisoner filed a writ before the High Court of Delhi. He argued that there is a positive obligation on the state to ensure the continuation of the ARVs even after bail, and that a failure to fulfil this obligation would constitute an infringement of the constitutional right to life and health. In January 2001 the court issued an interim order directing the jail hospital to supply the ARVs. This order was later modified so that the All India Institute of Medical Sciences (AIIMS) was directed to provide the ARVs instead.

#### **WOMEN living with and affected by HIV and AIDS**

In India women face discrimination throughout their lives. This discrimination is manifested in son preference at birth, unequal access to education and nutrition for the girl child, lack of control over household income, lack of access to information and resources, high levels of violence within the home and lack of control over sexual and reproductive choices. Young women are particularly vulnerable

**"This epidemic unfortunately remains an epidemic of women."**

Michel Sidibé, Executive Director of UNAIDS, 9 June 2010

“Violence against women cannot be tolerated, in any form, in any context, in any circumstance, by any political leader or by any government. The time to change is now.”

UN Secretary-General Ban Ki-moon

since they are usually disempowered within the household and have little access to information and opportunities that would allow them to make informed choices about their sexual and reproductive health. Early marriage to men that young girls have no influence in choosing and early childbirth are common in India, and husbands and their parents generally wield the control over choices relating to contraception.

It is widely acknowledged that all women face differential HIV risks as well as disproportionate impacts of the HIV epidemic. Indeed, “gender inequality, manifested in women and girls’ restricted access to education; health; assets, resources, and economic opportunities; their diminished participation in decision making processes; their lack of control over their own sexual and reproductive choices; their disproportionate care responsibilities; influence women’s and girls’ experience of the HIV epidemic, and its response.”<sup>179</sup> However, it should be noted that women come from diverse backgrounds and face “multiple and intersecting discriminations on the basis of their class, caste, race, ethnicity, age, sexual orientation, gender identity, and other factors.”<sup>180</sup> To put it simply, some women are more vulnerable, marginalised and discriminated against than others. In the context of HIV, this includes women who face multiple discriminations, often sanctioned by the state, on the

basis of their work (sex workers), drug use, gender identity (transgender women) and HIV status (women living with HIV). Other vulnerable groups of women, or key affected women and girls (KAWG) include female spouses of men who engage in high-risk behaviour<sup>181</sup>. Research from Asia shows that women living with or affected by HIV face significant burdens including:

- Differences in asset accumulation, with women being denied a share in property or assets after the death of her husband.
- Across the region, girls in HIV affected households were the least likely to be attending school, and the most likely to have dropped out and/or be employed.
- Greater levels of discrimination within the family and within the healthcare system.
- Less likelihood of them seeking care, with financial reasons being the most commonly cited.
- Female-headed households are more likely to have had to migrate. Several Indian studies have found that where both husband and wife are diagnosed with HIV, it is invariably the woman who is denied shelter, access to household property, and access to the children. She is usually blamed for the husband’s HIV status, the rationale being that even if he did visit sex workers it was because she could not keep him “under control”<sup>182</sup>.

The prevalence of stigma and discrimination and the very tangible

179. Mukherjee, N., “Linkages Between Violence against Women and HIV in Asia and the Pacific Region”, Discussion paper, UNDP Asia-Pacific Regional Centre, 2013, p. 16. For more information, see: UNAIDS Agenda for Accelerated Country Action; UNAIDS and UNDP, Essential Actions on Gender and AIDS, 2009; UNIFEM, Transforming the National AIDS Response: Mainstreaming Gender and Women’s Human Rights into the “Three Ones”, 2009.

180. Mukherjee, 2013.

181. According to UNAIDS terminology, key HIV-affected women and girls include: i) women and girls living with HIV; ii) female sex workers iii) female spouses of male clients of sex workers iv) women who use drugs v) female spouses of men who inject drugs; vi) female spouses of men who have sex with men; and vii) women and girls from households impacted by HIV/AIDS.

182. Nyamathi, A., Thomas, B., Greengold, B., Swaminathan, S., “Perceptions and health care needs of HIV-Positive mothers in India”, Progress in Community Health Partnerships: Research, Education and Action, 3(2), Summer 2009.

ways in which women are treated differently upon disclosure of being HIV-positive results in them developing very negative perceptions about themselves. Internalised stigma or self-stigma plays an important part in determining how women deal with their illness and move forward in their lives. The above-mentioned study found that more than two-thirds of the women surveyed felt disgusted with their HIV status and believed they were paying for sins committed in a previous life. In addition, "slightly less than two-thirds thought they should avoid feeding children (62%) or holding a new infant (60%). Over half thought they had brought shame to their families and that they should avoid cooking for others. Slightly less than half (49%) avoided visiting people...."<sup>183</sup> This self-stigma has been shown to be correlated with inadequate social support, knowledge and understanding of AIDS, and lower ART adherence.

Researchers note that a recurrent theme in the discrimination against HIV-positive women in the household is the unwillingness of the family to expend money towards the daughter-in-law's treatment. Discrimination towards women living with HIV, within the household and family and society at large, is mirrored in healthcare settings.<sup>184</sup> Mothers with HIV face additional challenges related to inheritance, access to education for their children and custody issues<sup>185</sup>.

One factor recognised to increase women's vulnerability to HIV is high levels of violence against women within the family. Violence has been observed to be "both a contributing cause and consequence of women's HIV diagnosis."<sup>186</sup> Women who are victims of sexual violence are at a higher risk of being exposed to HIV, and the lack of condom use and the forced nature of rape immediately render women more vulnerable to HIV infection. In addition, an HIV diagnosis may also be associated with escalation of violence against women, especially by family members of the husband. This is especially so after the death of the spouse/partner. The links between violence and HIV are widely acknowledged, with research showing that "violence or the fear of violence can restrict the ability of women and girls to seek HIV prevention services and their ability to refuse sex or negotiate safe sex. It can also inhibit the ability of women and girls to disclose their status and to access voluntary, counseling and treatment (VCT) services as well as care and support services."<sup>187</sup>

The lack of property rights of women is another contributory factor that increases their vulnerability to HIV. Not being able to own property means that women have limited economic stability. This can lead to increased risk of sexual exploitation and violence, as women may have to endure abusive relationships or resort to informal sex work for

183. Nyamathi, A., Thomas, B., Greengold, B., Swaminathan, S., "Perceptions and health care needs of HIV-Positive mothers in India", *Progress in Community Health Partnerships: Research, Education and Action*, 3(2), Summer 2009.

184. Some of the data in this section is a reflection of data used in a recent report by the same author, UNDP, SAARCLAW and WAP+, "Protecting the rights of key HIV-affected women and girls in health care settings: A legal scan: Regional Report, Bangladesh, Indian, Nepal and Pakistan", 2013.

185. Nyamathi, A., Thomas, B., Greengold, B., Swaminathan, S., "Perceptions and health care needs of HIV-Positive mothers in India", *Progress in Community Health Partnerships: Research, Education and Action*, 3(2), Summer 2009: 99–108.

186. Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, "Regional Issues Brief : Rights of Women And Girls", 2011

187. Program on International Health and Human Rights, Harvard School of Public Health, Gender Based Violence and HIV, 2011, cited in Mukherjee, Neelanjana, Linkages between violence against women and HIV in Asia and the Pacific Region, UNDP Asia-Pacific Regional Centre, 2013, p. 16.

The epidemic continues to be attended by human rights violations fuelled by discrimination, violence, punitive laws, policies and practices. HIV-related discrimination is often deeply interwoven with other forms of discrimination based on gender, race, disability, drug use, sexual orientation and gender identity, immigration status, being a sex worker, prisoner or former prisoner.

Joint Statement by UN human rights experts on the occasion of the High-Level Meeting on ending AIDS by 2030

economic survival, thereby increasing their vulnerability to HIV and AIDS.

The issue of which legislation affects women in India, with regard to increasing their vulnerability to HIV and AIDS, is a complex one since, unlike with other key communities, all laws that do not empower women socially, economically or within the family technically work to increase women's vulnerability. Moreover, even where laws exist, structural weaknesses such as illiteracy, lack of economic power and gender bias within the system obstruct women's access to justice. Therefore, this section attempts to look at a wide gamut of laws that confer rights to women and examines what is problematic or missing within the existing legislation.

#### Equality and non-discrimination

The Indian Constitution specifically prohibits inequality on the basis of sex in Article 15. In addition, the Directive Principles of state Policy mandate equality and declare that state policy must strive to minimise income inequalities and ensure that men and women have equal rights to an adequate means of livelihood. The Supreme Court has used these provisions to direct the state to enforce the right of equality and has recognised the rights of women as human rights as well as recognising the importance of international covenants in

interpreting law relating to gender inequality in India<sup>188</sup>.

India has ratified the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), which prohibits all forms of discrimination and calls on states parties to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."<sup>189</sup> Unfortunately, India made a reservation under CEDAW on those articles that would require reform of personal laws. This means that action need not be taken under Articles which specifically provide for modification of "the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women"<sup>190</sup>. This also acts as a refusal to modify laws that deal with "appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations."<sup>(191)</sup>

Indeed, in the context of HIV and AIDS, they also represent a lost opportunity given that Article 16 deals with fairly critical issues such as equal rights to property, decision making and custody of

188. Lawyers Collective, 2003, p. 136.

189. See: CEDAW (1981), Article 3.

190. Ibid., Article 5 (a).

children. In addition, social and cultural patterns of conduct are very relevant in terms of women having decision making power in a household, including over her own sexual and reproductive health. The special rapporteur on violence against women has, in her most recent report, recommended that the government withdraw these reservations<sup>192</sup>.

As noted above, violence against women contributes to women's HIV risk for various reasons. HIV-transmission risk increases during violent or forced-sex situations, because abrasions caused by forced penetration facilitate entry of the virus. Moreover, women who are beaten by their partners tend to suffer from lack self-esteem and feel a sense of powerlessness and fear with regard to their lives, which undermines their ability to protect their health or seek treatment<sup>193</sup>.

#### The protection of women from domestic violence act (pwdva), 2005:

This Act includes measures to protect women from physical, psychological and economic threats (such as dowry harassment) and directs the Central Government and every state government to take measures to ensure that the provisions of the act are given wide publicity through public media, including television, radio and print media, at regular intervals. Section 3 of the act defines

violence as any act that "harms or injures or endangers the health, safety, life, limb or well being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse."<sup>194</sup> The Act is highly relevant with regard to women living with or affected by HIV. Under this Act a woman can request a "residence order", which ensures her right to live in the shared household, so that she cannot be thrown out. She may also get a temporary order for custody of the children if she wishes it. Importantly, the Act also grants the right to monetary relief to provide for maintenance for women and children, medical expenses, etc.

#### The criminal law (Amendment) ordinance, 2013:

This law provides for an amendment of the Indian Penal Code, Indian Evidence Act and the Code of Criminal Procedure on laws related to sexual offences. Passed in the wake of the brutal gang rape and subsequent death of a student in Delhi in December 2012, the law seeks to be a more rigorous mechanism for cases of sexual violence.

The most critical change in the law has been an expanded definition of rape, which has been replaced in Section 375 by "sexual assault", which implies penetration by penis or any object or any part of the body to any extent into the vagina,

---

192. UN Human Rights Council, Report of the Special Rapporteur on violence against women, its causes and consequences, Addendum: Mission to India, 1 April 2014, Para 78 (b). A/HRC/26/38/Add.1, available at: <http://www.refworld.org/docid/53982c3e4.html> (accessed 4 July 2014).

193. The World Bank, Legal Aspects of HIV and AIDS: A Guide to Policy and Law Reform, 2007.

194. Protection of Women from Domestic Violence Act, (PWDVA) 2005.

mouth, urethra or anus. The new law also lists offences such as acid attacks, stalking, sexual harassment and voyeurism. The law is significant in the context of empowering women and specifically KAWG in as much as it now includes a recognition of graded sexual assault, making offences such as "making of sexually coloured remarks by a man" punishable by one year in prison and "Physical contact involving unwelcome and explicit sexual overtures" punishable by three years<sup>195</sup>. The inclusion of these offences has widened the scope of the law and affords protection for certain types of violations, such as those faced by KAWG in healthcare settings. For instance, verbally humiliating treatment, such as inappropriate and degrading questions asked or remarks passed towards sex workers or transgender women, would presumably be covered by this provision. Sexual harassment by physicians, which has also been reported by sex workers, whether verbal or non-verbal, would also be covered.

While the Act is definitely progressive in terms of clarifying the parameters of sexual assault and laying down harsher penalties according to the severity of the crime, there has been an outcry from women's rights groups, disappointed with the fact that critical recommendations from the Verma Committee Report<sup>196</sup> were not incorporated into the changes. One of these relates to

the stipulation of marital rape as an offence. There is currently no law that prohibits marital rape in India. A husband who engages in non-consensual sex with his wife is not guilty of rape if his wife is over the age of 15<sup>197</sup>.

Provisions relating to family, such as marriage, divorce, custody of children, maintenance and succession, differ under personal laws based on religion. And specific provisions and amendments in the law are not applicable to all women. Under the realm of family law, the main issues for women in the context of HIV and AIDS are inheritance, property and maintenance, and the right to reside in the marital home and retain custody of her children. Various diverse statutes govern divorce in India. Divorce on the grounds of cruelty or desertion is allowed to both men and women along with one other ground. According to an amendment in the law, cruelty is now recognised as an exclusive ground for divorce for Indian Christian women<sup>198</sup>. Under Muslim personal law, a man may unilaterally divorce his wife by uttering "Talaq" thrice. Personal laws also provide for divorce in the case of one partner having a venereal disease including HIV and AIDS<sup>199</sup>. Although these provisions are equally applicable to women the reality is that most women are not socially or economically empowered enough to be able to exercise this option.

---

195. See: The Criminal Law (AMENDMENT) Ordinance, 2013, Section 354 (a), available at <http://mha.nic.in/pdfs/criminalLawAmndmt-040213.pdf>

196. On 23 December 2012 a three-member Committee headed by Justice J.S. Verma, former Chief Justice of the Supreme Court, was constituted to recommend amendments to Criminal Law so as to provide for quicker trial and enhanced punishment for criminals accused of committing sexual assault against women. The Committee submitted its report on 23 January 2013.

197. Section 375, Indian Penal Code, 1860.

198. Indian Divorce (Amendment) Act, 2001

199. See Special Marriage Act, section 27 (f) and Hindu Marriage Act, section 13 (iv), The Dissolution of Muslim Marriages Act, Section 2 (VI) and Parsi Marriage and Divorce Act, Section 32 (e).



### Inheritance and property

Unmarried women have certain rights relating to maintenance and inheritance in their capacity as daughters. For instance, Parsi inheritance law is gender neutral, proscribing an equal share of property to sons and daughters. This is also true of Christian law and Hindu law under amendments that were introduced in 2005. Under Islamic law both men and women have the right to inherit but the female generally gets half the share of the male. However, findings from a recent survey show that inheritance of property among all women in India is deeply inequitable. The study showed that despite the passage of the 2005 Hindu Succession Act (Amendment), which gave Hindu women the right to inherit land from their parents, "women across three Indian states (Andhra Pradesh, Bihar, and Madhya Pradesh) report that they are unaware of their right to inherit land and sometimes barred from exercising that right.<sup>200</sup>" Indeed, only 13% of the women surveyed, whose parents own land, said they have inherited land or expect to inherit land from their parents, and 69% of the women interviewed stated that they had not heard of even one case wherein women had inherited land from their parents<sup>201</sup>.

A Hindu widow is supposed to have the same interest in marital property as her husband under the provision on the Hindu Undivided Family (or HUF). Case law has also upheld the right of a widow to

continue residing in her marital home<sup>202</sup>. However, evidence shows that HIV-positive women, especially in cases where the husband dies of AIDS, are invariably thrown out of the marital home. A UNDP study conducted in 2006 shows that 90 % of HIV-affected widows were no longer living in their marital homes. As researchers have pointed out, "the loss of shelter and livelihood experienced by women can push them into a vortex of destitution and marginalisation, intensified vulnerability to HIV and AIDS, while enhancing intergenerational poverty."<sup>203</sup>

Soudamini, an NGO which provides support to over 300 women who have been denied their right to property, reports that property grabbing, dispossession, or eviction of women after their husband's death or because they are HIV-positive are being reported in large numbers from various parts of Maharashtra. This is despite the fact that women have distinct rights to property after the death of a spouse. As one advocate puts it, "Property, as articulated by women, goes beyond land and housing. It is linked to one's livelihood and economic security. It includes all that she receives from her family at the time of marriage, and all that she is entitled to as a wife, including jewelry, dowry, furniture, insurance, pensions, bank accounts, fixed deposits and land/house or any other asset acquired by her husband. As per the law, a woman is entitled to all these as the wife of

"Maintenance" under S.18 of the Act includes residence and further, for the purpose of maintenance, the term "wife" includes a divorced wife. Since there were no Indian legal precedents that had addressed the issue directly, the court referred to the legal principles under English law and approvingly quoted Lord Denning: "A wife is no longer her husband's chattel. She is beginning to be regarded by the laws as a partner in all affairs which are their common concern. Thus the husband can no longer turn her out of the matrimonial home. She has as much right as he to stay there even though the house does stand in his name.... Moreover it has been held that the wife's right is effective, not only as against her husband but also as against the landlord."

B. P. Achala Anand v S. Appi Reddy, (2005) 3 SCC 313

200. Landesa and UN Women, The Formal and Informal Barriers in the Implementation of the Hindu Succession (Amendment) Act 2005, 2013.

201. Landesa and UN Women, The Formal and Informal Barriers in the Implementation of the Hindu Succession (Amendment) Act 2005, 2013.

202. See B. P. Achala Anand v S. Appi Reddy, (2005) 3 SCC 313: On 11 February 2005, a Bench comprising Chief Justice R.C. Lahoti and Justices G.P. Mathur and P.K. Balasubramanyan pronounced a landmark ruling in a case titled B.P. Achala Anand vs. S. Appi Reddy, breathing new life into the right of women to the matrimonial home. Since the parties were Hindus, the court examined the right in the context of Hindu law and held that the right to residence is a part and parcel of a wife's right to maintenance and that the right has been statutorily recognised with the enactment of the Hindu Adoption and Maintenance Act, 1956.

203. Swaminathan, Hema, Bhatla, Nandita and Chakraborty, Swati, "Women's Property Rights and HIV/AIDS: Evidence From India", available at <http://www.hivaidsonline.in/index.php/HIV-Human-Rights/>

a deceased man irrespective of her HIV positive status.<sup>204</sup> Unfortunately, as mentioned above, thanks to the stigma attached to being HIV-positive, women are reluctant to exercise these rights and go to court. A recent ruling by the Mumbai High Court has tried to address this problem by allowing pseudonyms to be used when filing cases relating to HIV, and by allowing “in camera” hearing of trials to better protect people’s privacy and confidentiality. Alternative dispute resolution mechanisms may also present a solution in terms of women being able to claim property due to them.

#### Maintenance and alimony

These provisions are contained in various personal laws as well as the Code of Criminal Procedure (CrPc), 1973. It is important to note that none of the moveable assets and property that are acquired by a couple belongs to the wife unless it has been bought in her name. Except in the state of Goa<sup>205</sup>, Indian family laws still follow what is known as the “separation of property” regime.

Currently, the law provides for a wife to be maintained by her husband during the “subsistence of marriage, on separation and to alimony and maintenance on divorce.” Maintenance has, however, proved to be a very uncertain entitlement for a variety of reasons. Firstly, most women find it difficult to access the courts and when they do it takes an inordinate length of

time to obtain an order. Secondly, despite the fact that the Supreme Court and various High Courts have laid down principles to guide the awarding of maintenance, the amount is often extremely low and akin to a token sum. Thirdly, the burden of proof to establish the husband’s income is placed on the woman and this is a problem when she does not have access to documents or papers in her husband’s custody. It is also a picture of reality that when maintenance is awarded women often do not get it regularly.

#### The marriage law (amendment) act, 2010:

This bill was passed by the upper house (Rajya Sabha) of Parliament in August 2013. However, it is still pending before the lower house (Lok Sabha). It seeks to amend the Hindu Marriage Act, 1955 and the Special Marriages Act, 1954. The bill aims to give divorced women an equal share in property acquired during marriage, including “immoveable assets” such as home and land. The husband’s ancestral property will also come into consideration when deciding on alimony. While asserting that women have a right to marital property the bill stipulates that the amount will be left to the discretion of the judges in the case. Enactment and subsequent implementation of this bill could allow women to make empowered decisions regarding separation and divorce, with the assurance that they will be able to care for themselves and

204. <http://aidssupport.aarogya.com/news-and-events/year-2010/551-hiv-widows-often-denied-right-to-property-say-experts.html>

205. Goa is governed by the old Portuguese family laws enshrined in the Civil Code of 1867.

their children and will not be left destitute. Further interpretation of this and other existing laws is needed to define the responsibilities of the husband vis-à-vis HIV-positive women who almost inevitably face abandonment by the family and destitution, and often must bear responsibility for the costs of treatment and care of their children as well.

#### Custody of children in India

Laws governing custody of children in India are predicated on the notion that the father is the natural guardian of the child<sup>206</sup>. However, the Supreme Court has held that the law cannot give preferential rights to the father over the mother who is also a natural guardian to the child<sup>207</sup>. Thus, under Hindu law mothers generally get custody of their children until they attain puberty. After this, children are allowed to decide which parent they should live with. Under Muslim law a woman generally gets custody of her sons until the age of seven, and daughters until they attain puberty. Parsi and Christian law decides each case individually according to the best interests of the child.

Custody of Children: HIV-positive status should not inform child custody decisions. However, in reality, women who are HIV-positive have been forcibly separated from their children by their in-laws. In a 2007 case, a Sessions Court stayed the order of a lower court that denied an

HIV-positive woman custody of her minor daughter. Married to a soldier in 1995 from whom she allegedly contracted the infection, the woman was thrown out of her home by her in-laws and separated from her daughter after her husband died in 2003. Widowed and ostracised by the community, the mother then approached the court for custody of her (by then) 11-year-old child. On 17 September 2007, a First Class Judicial Magistrate's Court denied her custody of the child on the grounds that she was HIV-positive, observing that it would not be appropriate and stating that "as the woman herself is HIV-positive she will not be able to look after her daughter, and it is also not in the latter's interest and welfare." Fortunately, the District Court stayed this order, which (as the woman's lawyers pointed out) was "discriminatory against an HIV-positive woman and also against the law of equality."

#### Children

NACO estimates that there are at least 145,000 children below the age of 15 living with HIV in India. Even if children are not HIV-positive, if there is AIDS in the family, children are likely to suffer adverse consequences due to loss of family income and impoverishment. Especially in countries like India where there is an absence of a social safety net for people who have medical issues, children in this situation may quickly lose one or both parents, may have to miss school in order to care for ill family

HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights – civil, political, economic, social and cultural. The rights in the general principles of the Convention... should therefore be the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support. Committee on the Rights of the Child, General Comment 3 (HIV and The Rights of The Child), 2003

206. The Guardian and Wards Act, 1890; and Hindu Minority and Guardianship Act, 1956.

207. Gita Hariharan v. RBI (1999) 2 SC 228.

members or to work to help support the family financially<sup>208</sup>. In addition to reduced parental care and supervision they face loss of access to healthcare, vagrancy, malnutrition and exposure to stigma and discrimination. Stigma and discrimination manifest themselves through children being abandoned and denied access to schooling, healthcare and medical rights.

Adolescents also face specific challenges relating to HIV and global research suggests that policies still reflect a lack of recognition of their specific needs as well as "an inadequate understanding of the developmental impact of HIV on older children<sup>209</sup>." In addition, existing laws and regulations regarding the age of consent for testing or the age at which young people can access necessary information and resources may impede their access to critical services. In India people below the age of 18 are referred to as minors. However, the age for sexual consent for women is 16 and legal employment may be undertaken at 14 years of age. The draft HIV Bill suggests that children aged 12 and above should be able to consent to HIV testing without the requirement of parental consent. NACO guide lines on HIV testing state that a minor may be tested with parental consent and do not mention the "mature minor" principle<sup>210</sup>. However, NACO's HIV training and counselling modules mention that "it is preferable that young people are allowed to

provide consent (without parental consent) for VCT [Voluntary Counseling and Testing], as parental consent is a barrier to uptake of VCT by some young people."<sup>211</sup>

Recent research within the Asia Pacific Region shows that significant numbers of adolescents continue to acquire HIV and that there are "serious health and social service gaps in meeting the needs of adolescents living with HIV."<sup>212</sup> Higher risk of acquiring HIV and poorer health outcomes are noted among adolescents from KPHR including those who sell sex, those who inject drugs, or young men having sex with men, as well as among vulnerable groups such as young girls or adolescents living and working on the street.<sup>213</sup>

#### Equality and non-discrimination

India's Constitution specifically recognises the rights of children. The State is enabled to make special provisions for children and a directive principle of state policy directs that children should be allowed to develop in a healthy manner in conditions of freedom and dignity<sup>214</sup>. This article also says that children shall be protected from exploitation and moral and material abandonment

India has also ratified the United Nations Convention on the Rights of the Child (CRC). CRC sets the upper limit of childhood at 18 years and establishes the principle that the best interests of the child shall be the primary consideration in all actions concerning children

208. UNICEF uses the terms "children affected by AIDS" and "affected children" to refer to children living with HIV, children who have lost one or both parents to AIDS, and "vulnerable children whose survival, well-being or development is threatened or impacted by HIV and AIDS.

" See: UNICEF, Child Protection and Children Affected by AIDS, 2006, available at <http://unicef.org>

209. UNICEF, UNESCO, Treat Asia and APN Plus, Lost in Transitions: Current issues faced by adolescents living with HIV in Asia Pacific, 2013, p. 10.

210. The "mature minor" principle is mentioned in both international and certain national laws, which recognise that "minors may give an effective lawful consent to medical treatment if they have sufficient maturity to understand the nature and consequences of the treatment." For a detailed discussion on these issues see: UNESCO, Young People and the Law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services, 2013, available at <http://unesdoc.unesco.org/images/0022/002247/224782E.pdf>

211. NACO, HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors, 2006, New Delhi: NACO.

212. NACO, HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors, 2006, New Delhi: NACO.

213. NACO, HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors, 2006, New Delhi: NACO.

214. See Constitution of India, Article 15 and Article 39, DPSP.

(article 3). It also guarantees the right to non-discrimination (article 2), right to life, survival and development (article 6) and the right to have views affecting the child heard and given due weight, in accordance to age and maturity of the child (article 12 and 13). In addition, it stipulates protection from exploitation, violence, maltreatment and abuse (article 19).<sup>215</sup> As mentioned above, the Committee on the Rights of the Child has deemed that these guiding principles must be considered and used to guide governments when responding to the issue of children and HIV and AIDS<sup>216</sup>.

In *Baby Manji Yamada v. Union of India*, the Apex Court highlighted the role of the existing Commission for Protection of Child Rights and said it is to examine all factors that inhibit the enjoyment of rights of children including domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution, and recommend appropriate remedial measures. According to the court the commission has a right to inquire into complaints and even to take suo motu notice of matters relating to deprivation and violation of child rights; non-implementation of laws providing for protection and development of children; and non-compliance of policy decisions, guidelines or instructions aimed at mitigating hardships to and ensuring welfare of the children (relevant in the case

of the JJ Act) and to provide relief to such children, or take up the issues arising out of such matters with appropriate authorities.

#### Guardianship and inheritance

Anecdotal evidence suggests that there are increasing numbers of child-headed households where a minor is responsible for the care of younger siblings, especially in the southern states<sup>217</sup>. Orphans who are not placed in institutions are likely to be heading households. Although the Indian extended family system is strong, there is evidence that relatives are more reluctant to look after children who are HIV-positive and that these children tend to be neglected within extended families. They also have a lack of understanding about their illness and treatment<sup>218</sup>.

The Guardian and Wards Act, 1890 does not generally recognise a minor as competent to act as guardian except in the case of male minors who are married or a managing member of the Hindu Undivided Family. It is worth noting that Muslims, Parsis and Christians cannot legally adopt as their personal laws do not sanction adoption. They can accept a child as their "ward" but are under no legal compulsions to give the child the family name and/or property. People following the Muslim, Christian or Parsi faiths are considered "guardians" of the child until the child becomes an adult.

215. See UN Convention on Rights of the Child, 1989, available at <http://www2.ohchr.org/english/law/crc.htm>

216. Committee on the Rights of the Child, General Comment 3 (HIV and The Rights of The Child), 2003.

217. <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/children-and-hiv-ii-vulnerability-and-burden.html>

218. <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/children-and-hiv-ii-vulnerability-and-burden.html>

Naz Foundation (India) Trust v. Union of India and Ors., W.P.(C), 147: March 2014.

The Supreme Court issued a notice on the above writ petition, which seeks the elimination of discrimination against children affected by HIV in schools, invoking the fundamental rights to life, education and equality guaranteed under the Indian Constitution. The Central Government, the National Commission for Protection of Child Rights and all the State Governments have been given time to respond to the directions sought by the petitioner. The petitioner has sought "a declaration from the Court that no child affected by HIV would be denied admission, suspended, segregated or expelled on the basis of their HIV status or the status of their parents or guardians; directions that the Government frame guidelines under the Right of Children to Free and Compulsory Education Act, 2009 to ensure non-discrimination in schools in this regard...children affected by HIV be notified as a 'disadvantaged' group under the Act."

In cases where both parents are HIV-positive, it is important that they account for the future care of their children and choose someone to adopt them or become their permanent guardian. Custody issues may arise in the case of death of one parent<sup>219</sup>. Guardianship rights of NGOs and orphanages looking after HIV-positive orphans should also be considered.<sup>220</sup>

Inheritance is another problematic area. In the absence of concrete legal safeguards, most HIV-affected children are left at the mercy of relatives in terms of administration of their estate. This often puts them in a situation where unethical relatives can seize their property and children are left totally unprotected.

#### Right to education

The General Comment on Children and HIV<sup>221</sup> by the Committee on the Rights of the Child has observed that, globally, discrimination against children with HIV/AIDS is seriously impacting their access to education. The Committee has noted that children from affected families face severe difficulties staying in school and reminded states of their "obligation to ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS."<sup>222</sup> In India, discrimination against HIV-affected children in educational settings continues to be a major problem with children being denied

admission, expelled or segregated from other students in schools across the country. One study conducted in 14 districts of Kerala found that denial of education is the most common problem faced by HIV-affected children<sup>223</sup>. Among the HIV-affected children in the state, 88 % have not revealed their HIV-positive status in school for fear of dismissal or discrimination<sup>224</sup>. Even children who are not HIV-positive themselves, but have an HIV-positive parent, are avoided and discriminated against, and regular HIV tests are demanded from schools.

A PIL filed by the Naz Foundation has suggested that 145,000 HIV-affected children across the country are being denied their rights as stipulated under the Right to Education (RTE) Act, 2009 and the Supreme Court has issued directives on the basis of this petition as described in the box below. Although the Indian Constitution as well as the RTE Act guarantee free and compulsory education to all children aged between six and 14, children affected by HIV and AIDS are being denied this right, and the lack of awareness amongst communities, teachers, parents and even family members exacerbates the situation<sup>225</sup>. The PIL suggested that the provision for "disadvantaged children" under the RTE Act be expanded to include HIV-positive children.<sup>226</sup> In *Payel Sarkar v. Central Board of Secondary Education* and

219. <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/children-and-hiv-ii-vulnerability-and-burden.html> 220. Lawyers Collective, 2003, p. 55.

221. Committee on the Rights of the Child, General Comment No. 3, HIV/AIDS and the right of the child, U.N. Doc. CRC/GC/2003/3 (2003).

222. Committee on the Rights of the Child, General Comment No. 3, HIV/AIDS and the right of the child, U.N. Doc. CRC/GC/2003/3 (2003).

223. UNICEF, "Situational Analysis on Children Affected by HIV and AIDS in Kerala", 2008.

224. UNICEF, "Situational Analysis on Children Affected by HIV and AIDS in Kerala", 2008.

225. Malekar, Anosh, <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/denial-of-education-most-common-problem-faced-by-hiv-affected-children.html>

226. Section 9(c) of the Act says, "Every local authority shall ensure that the child belonging to weaker sections and the child belonging to disadvantaged group are not discriminated against and prevented from pursuing and completing elementary education on any grounds."

Ors. 2010<sup>227</sup>; the Petitioner, a student, was not allowed to sit for the All India Senior School Certificate Examination because of frequent absences from school. The Court accepted that her poor attendance record was attributable to a "special learning disability." A provision in the school by-laws allowed for exemptions from school attendance policies for blind, physically handicapped and dyslexic students. The question asked was, are students suffering from serious diseases, including students living with HIV and those with special learning disabilities, exempt from the strict enforcement of school attendance policies?

The Court reviewed the school by-laws and stated that the head of the school "must make arrangements for special remedial teaching" for children "belonging to the weaker sections of the community" and those with "special learning disabilities or . . . who require specialized psycho educational counselling." The Court declared that the current grouping of students who qualified for exemption from school attendance policies was not inclusive enough. The Court held that the "rigidity of attendance should be relaxed" for students with special learning disabilities and others "in exceptional circumstances created on medical grounds, such as candidates suffering from serious diseases like cancer, AIDS, T.B. or similar serious diseases requiring long period of hospitalization."<sup>228</sup>

### The right to information

Related to the right to education is the right to access information on sexual and reproductive health. It is generally acknowledged that, "significant proportions of young people experience risky or unwanted sexual activity, do not receive prompt or appropriate care, and experience adverse reproductive health outcomes."<sup>229</sup>

Even married young people in India, who are addressed by government policies and programmes, actually have very little access to sexual and reproductive health services and very superficial information on how to protect themselves from STDs. Young people generally remain poorly informed on issues of Sexual and Reproductive Health and Rights (SRHR).<sup>230</sup>

Government-sponsored initiatives that have tried to address the issue tend to come up against serious barriers. Researchers suggest that many officials in low prevalence states did not want to encourage AIDS education and were not swayed by the argument that education is precisely what is required to ensure that prevalence stays low. In addition, many schools had decided not to implement the Adolescence Education Programme in its present form, rejecting the material that had been supplied.<sup>231</sup>

Legal activists have pointed out that denial of information that could be life-saving is a violation of the right to life. The Committee

227. AIR 2010 Calcutta 74

228. <http://www.undp.org/content/dam/undp/library/hiv/aids/English/Compendium%20of%20Judgments%20-%20Background%20Material%20BKK%20Judicial%20Dialogue%20FINA%20%20%20.pdf>

229. Jeejeboy, Shireen, and Santhya, K.G., *Young Peoples Sexual and Reproductive Health in India: Policies, Programmes and Realities*, Population Council, 2007.

230. UNDP, *Women's Empowerment, HIV and the MDGs: Hearing the Voices of HIV Positive Women-Assessment of India's Progress on MDG 3 and MDG 6*, December 2010.

231. [www.avert.org](http://www.avert.org)

on economic, social and cultural Rights has stated that government obligations regarding the right to health must be interpreted broadly to include the right to information and education regarding prevention and control of specific diseases, specifically the "establishment of prevention and education programmes for behaviourrelated health concerns such as sexually transmitted diseases, in particular HIV/AIDS."<sup>232</sup> Moreover, states must refrain from censoring or withholding information including sexual education information, and must make efforts to provide youth-friendly healthcare "which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."<sup>233</sup>

In India, in addition to the strong socio-cultural objection to sex education for young people, there are also legal obstacles to these programmes in the form of the obscenity and censorship laws of the Indian Penal Code. These, we have seen, come up repeatedly in the context of providing sexual health-related information or services to various groups as part of HIV prevention efforts. Research now suggests that young people who have access to sexual health education are able to make safer sexual choices and demonstrate reduced high-risk behaviour. These studies have also shown that information and services do not lead, as families fear, to increased sexual activity.<sup>234</sup>

### Child marriage

In a recent historic judgement on the issue of child marriage, a division bench declared that "child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy and social isolation, with little education and poor vocational training reinforcing the gendered nature of poverty."<sup>235</sup>

Child marriage has been regulated in India for many decades. The earlier law relating to it, popularly known as the Sharda Act, was amended and the minimum age of marriage was raised by three years, i.e. from 15 to 18 for girls, and from 18 to 21 for boys. The amended law came to be known as the Child Marriage Restraint Act (CMRA), 1929. The latest law in the series is the relatively recent Prohibition of Child Marriage Act, 2006 (PCMA), which came into effect in 2007 with the hope that this would be a comprehensive mechanism to effectively deal with the problem of child marriage in India. Offences under this Act are cognizable and non-bailable,<sup>236</sup> and penalties include rigorous imprisonment, which may extend to two years, or a fine of one lakh rupees or both. The penalties apply to several categories of offenders.<sup>237</sup>

However, despite legal prohibition, child marriage is still prevalent in India. One study found that almost

232. Committee on Economic Social And Cultural Rights, General Comment No. 14 (2000) on "The right to the highest attainable standard of health" (article 12 of the International Covenant on Economic, Social and Cultural Rights) Substantive Issues Arising In The Implementation Of The International Covenant On Economic, Social And Cultural Rights, Para 16.

233. Committee on Economic Social And Cultural Rights, General Comment No. 14 (2000) on "The right to the highest attainable standard of health" (article 12 of the International Covenant on Economic, Social and Cultural Rights) Substantive Issues Arising In The Implementation Of The International Covenant On Economic, Social And Cultural Rights, Paras 12 (b) and 23.

234. <http://www.avert.org/sex-education.htm>

235. Association For Social Justice & Research V. Union Of India & Others, May 2010.

236. PCMA, Section 15.

237. Sections 9, 10, 11 of the PCMA provide for punishment for: an adult male above 18 years of age marrying a child; those performing/conducting/abetting a child marriage; parents, guardians or any other person/association promoting or permitting solemnisation of child marriage.



half of all surveyed married women between the ages of 20 and 24 were married before they were 18. These marriages were found to be associated with poor fertility outcomes, such as unwanted and terminated pregnancies, repeat childbirths in less than 24 months, and increased sterilisation rates.<sup>238</sup> Research reveals that married girls are disadvantaged socially, economically and in terms of health, including being susceptible to higher rates of HIV infection than other young people even when compared to those who are sexually active.<sup>239</sup>

This vulnerability stems from specific factors:

1. Married girls have frequent, unprotected sex, often with an older partner, who is more likely to be sexually experienced and may thus have an elevated risk of being HIV-infected.
2. Girls who are forcibly initiated into sexual relations may be particularly susceptible to STIs, including HIV, both because of the physical trauma and because of the immaturity of their genital tract. Early pregnancy can also leave them with long term illness, infertility and disability.
3. Married girls will have had less schooling and less access to information than married women<sup>240</sup>. In addition, they are usually completely disempowered in the marital home and have less negotiating ability and mobility than married women. This situation is exacerbated by the fact that they

are separated from family, friends and any support structure they may have known.

### Child labour

As noted, the HIV epidemic has and will continue to raise the number of children forced into work to sustain themselves and their families. One study found that families were significantly more likely to slide into poverty if they lost a member due to HIV/AIDS than if they lost someone due to non-HIV causes<sup>241</sup>. The main reason for this is that HIV strikes an individual in his/her productive years and hence the economic impact of the loss is greater—as is the likelihood of children being pushed into the labour force. Child labour is a common phenomenon in India and children are often employed in dangerous environments despite Article 23 of the Indian Constitution, which declares that no child under 14 will work in a factory or in any field which could be considered hazardous.

Legislation protecting the rights of working children exists in the form of the Child Labour (Prohibition and Regulation Act), 1986, which prohibits employment of children in certain industries and regulates the conditions under which they are meant to work in others. The Act is deficient in several ways, being applicable only to the organised sector, having few health and safety provisions and not allowing for unions of child workers. Children at work tend to be more vulnerable to HIV for various reasons including their

238. Mishra, Vaishali, "Child Marriage and the Early Risk of HIV infection", 2003.

239. Population Council, Youth Lens (15), Early Marriage and Adolescent Girls.

240. [http://www.unicef.org/education/bege\\_70640.html](http://www.unicef.org/education/bege_70640.html)

241. USAID India, Rapid Assessment Of Children Affected and Vulnerable To HIV/AIDS In Maharashtra, March 2006.

susceptibility to sexual abuse and, sometimes, the need to engage in sex as a survival strategy. In addition, they do not have access to schools or educational materials, so available information on sexual health and HIV and AIDS will almost certainly pass them by.

#### Children living and working on the street

It is widely acknowledged that children living on the street, including runaway children, abused children, children orphaned by AIDS or children of street dwellers, are highly vulnerable to HIV transmission although they are not listed as a “most at risk” group. This vulnerability results from the lack of adult supervision, health care and nutrition, high levels of drug use and unprotected, often non-consensual sexual activity. These factors are exacerbated by lack of information or any access to primary healthcare. Street children have been observed to be “highly mobile, abused at multiple levels and totally deprived of adult affection and normal adult influence. They survive the threats of street life by joining gangs that introduce them to strategies like ‘sex for comfort, pleasure and money’ and ‘drugs for bliss and loss of pain’”<sup>242</sup>.

One strategy to assist street children to minimise the risk of HIV would be to empower them to deal with the environment within which they live. However, the Indian Government’s approach towards them is to see them as “juvenile

delinquents” and institutionalise them under the provisions of the Juvenile Justice (Care and Protection) Act, 2000 (JJ Act). This is problematic at many levels—not least because institutionalising the thousands of street children in India is totally unsustainable as a strategy. Hund-reeds of children flood into cities from rural areas every day, and the current facilities are inadequate for even the few who have been placed in institutions. Moreover, street children tend to think of government welfare institutions as places to be avoided at all costs due to their punitive and custodial nature.

#### The Juvenile Justice (Care and Protection) Act, 2000

This Act makes a distinction between children in conflict with the law and children in need of care and protection, but “effectively criminalizes both by putting them under the jurisdiction of the criminal justice system.”<sup>243</sup> Children are sent to either “observation homes” or “juvenile homes” but, in both cases, these are closed institutions where in children are completely deprived of their liberty. Often, before the children are separated they stay in the observation homes together so adolescents who may have committed serious offences are housed with much younger children who have been picked up because they have been abused or neglected. Children’s rights activists have pointed out various other problems with the Act:

242. <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/street-children-and-aids-a-hidden-time-bomb.html>

243. Ferrara, Federico, and Ferrara, Valentina, *The Children’s Prison: Street Children and India’s Juvenile Justice System*, 2005, p. 9.

- The Act allows testing of children for HIV without their consent; confidentiality is not protected and they can be isolated on the basis of their status.

- Police are empowered to come into contact with the children regularly. This is undesirable, especially for street children, whose contact with law enforcement has generally involved verbal and physical abuse, threats and extortion.

- Options for custodial care include restoration to parents, adopted parents or foster parents. This is obviously problematic in the context of children who have been abused and have run away from home, and neither does it work for abandoned children or street children.

Perhaps most critically, standards of care are generally deficient in the homes, and children perceive the option of entering these homes as a threat. Reports have documented severe neglect, overcrowding and abuse, including sexual abuse and rape of the children in these homes. As one report mentioned, "In sharp contrast with the ambitious goals outlined by the Indian government in the Juvenile Justice Act, the life of children who have the misfortune of ending up there [in the homes] is frequently more horrifying than the family environment they escaped and often more wretched than the life on the streets from which the government supposedly rescued them."<sup>244</sup>

In terms of the law and its impact on HIV and AIDS, this Act, with its focus on institutionalisation, has contributed to increasing the vulnerability of children. The fact that children's mental and physical well-being in terms of health, nutrition and care is seriously neglected in these homes is compounded by the possibility of them being sexually active without any access to HIV prevention services, and of sexual abuse.

#### Notable current interventions

It was not within the scope of this report to do a comprehensive overview of all the interventions currently taking place across the country. However, the few mentioned here were spoken about within the consultations and provide good examples of the sort of strategies and "good practices" that are working in various areas and that can be utilised as models in other parts of the country. State Government Initiatives for Transgender People. The Maharashtra State Women's Policy has for the first time acknowledged sex workers<sup>245</sup> and transgender persons as vulnerable populations whose needs must be prioritised by the state through welfare schemes and activities. Highlights of the new policy on transgender people include:

- A special literacy drive that will be undertaken for adults as well as a scholarship scheme for school education and a zero interest scheme for loans for higher education;

---

244. Ferrara, Federico, and Ferrara, Valentina, *The Children's Prison: Street Children and India's Juvenile Justice System*, 2005.

245. The policy measures for sex workers relate mainly to anti-trafficking initiatives.

According to The Hon. Michael Kirby, the AIDS paradox can be described as follows: "It is a paradox, one of the most effective laws we can offer to combat the spread of HIV is the protection of persons living with HIV, and those about them, from discrimination. This is a paradox because the community expects laws to protect the uninfected from the infected. Yet, at least at this stage of this epidemic, we must protect the infected too.

We must do so because of reasons of basic human rights. But if they do not convince, we must do so for the sake of the whole community which has a common cause in the containment of the spread of HIV."

- Additional training to be provided to doctors and hospital staff to sensitise them to issues faced by transgender people and the management of HIV;
- Occupational opportunities with financial assistance to be made available in collaboration with departments of skills development labour and industries;
- An assistance centre to be opened by the financial development corporation for women in order to help transgender people start self-help groups;
- Permanent identity cards, ration cards and the provision of a pension for transgender people above the age of 40 will be made. In addition, a separate transgenders' welfare board will be established at the district and state level, to implement welfare schemes for transgender people.

Another state which has been implementing progressive measures for transgender people since 2006 is the Government of Tamil Nadu, which issued an Order on Rehabilitation of Transgender people (Aravanis) stipulating various measures to be undertaken in this regard, including:

- A programme of counselling and sensitising by the Health Department;
- Family counselling by teachers, with the help of trained NGOs to be made mandatory so that children are not disowned by their families;
- Disciplinary action against schools or colleges discriminating against

transgender people with regard to admission;

- A detailed survey of the community in the state;
- Special vocational training and skill development training as well as small and petty loans to be arranged to those who have undergone skill training;
- Distribution of identity cards and ration cards.

Since this order various initiatives have been introduced, including hospitals in Tamil Nadu now offering sex reassignment surgery for free; issuance of new ration cards identifying Aravanis as a third gender; and the establishment of a special State Welfare Board to promote equality and security through welfare schemes.

#### Harm reduction in prison:

The Government of Manipur recently rolled out the state's first comprehensive HIV prevention, care and support programme at Sajiwa Central Prison. The prison intervention programme will be implemented jointly between the Manipur AIDS Control Society (MACS), the State Department of Prisons, the Manipur Network of Positive People (MNP+), in association with the United Nations Office on Drugs and Crime (UNODC). With special emphasis on behaviour change, the programme will introduce essential elements from the comprehensive package of HIV prevention services, including voluntary HIV counselling and testing; ART; prevention, diagnosis and treatment of viral hepatitis, STIs, tuberculosis; and

advocacy for Opioid Substitution Therapy (OST). It will also focus on capacity-building of prison officials in order to facilitate better understanding and delivery of HIV/AIDS prevention, treatment and care services in prison settings.<sup>246</sup>

#### Collaboration between law enforcement and pwud:

This is an example of a community friendly and successful targeted intervention (TI) programme being run with PWUD, in Kozikhode, Kerala for the last 12 years. The team leader of this TI, which was initiated by NACO, was an advocate who collaborated with the police and narcotics department and asked the Deputy Inspector General (DIG) of the area to become a contact point for the programme. There was a need to address the fact that many IDUs were fishermen who needed fresh needles when they returned from fishing at 3 a.m. in the morning. A system was worked out in collaboration with the authorities to hide clean needles and other equipment in some pre-selected places, from where the fishermen could pick them up at their convenience<sup>247</sup>.

Finally, it would be pertinent to note that the National AIDS Prevention and Control Policy of 2001 clearly recognises the impact of the criminalization of marginalized groups in their access to HIV prevention and treatment services. Recognising the importance of programmes to be based on human rights, the NAPCP states,

“Public health interest does not conflict with human rights. On the contrary, it has been recognised that when human rights are protected, fewer people become infected and those living with HIV/AIDS and their families can better cope with HIV/AIDS. Government recognises that without the protection of human rights of people, who are vulnerable and afflicted with HIV/AIDS, the response to HIV/AIDS epidemic will remain incomplete.”

Among the key responses of the government, the NAPCP states that the “[g]overnment will review and reform criminal laws and correctional system 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.”

Following the framework of NAPCP, the National AIDS Control Programme, Phase III (NACPIII) recognises that criminal laws create a significant deterrent in HIV programmes. Thus,

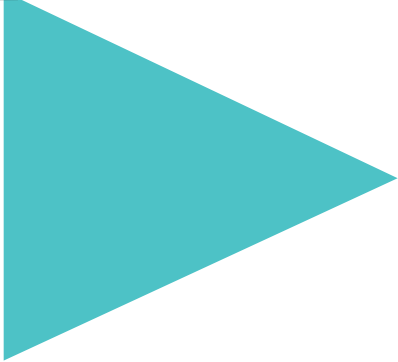
“criminal statutes such as Narcotic Drugs and Psychotropic Substances Act, Immoral Trafficking Prevention Act and section 377 of IPC continue to hamper implementation of targeted interventions with IDUs, sex workers and MSM.” Accordingly among the key activities under NACPIII is the constitution of “a Task Force to review existing laws and advocate for necessary amendments with

The Commission has found reason for hope. There are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights.

To some such an approach may seem a paradox—the AIDS paradox. But compelling evidence shows that it is the way to reduce the toll of HIV.

246. <http://www.unodc.org/southasia/en/frontpage/2010/december/north-east-india---hiv-and-aids-prevention-in-prisons-takes-a-significant-stride.html>

247. Delegates reporting at Delhi Consultation.



different ministries, legislators, judiciary, civil society etc” and advocacy for the speedy adoption of the HIV/AIDS Bill.

The National AIDS Programme envisages creating an enabling environment where the people involved in risky behaviour are encouraged not to conceal information so that they can be provided total access to the services of such preventive efforts, as it recognises the adverse impact that criminalization has had on health. This was well demonstrated in the Naz Foundation case that dealt with the issues of Section 377 of the Indian Penal Code and where the National AIDS Control Organisation prevention information and services.

The Global HIV Law Commission, in its 2012 Report<sup>248</sup> stated<sup>249</sup> :

- 123 countries have legislation to outlaw discrimination based on HIV; 112 legally protect at least some populations based on their vulnerability to HIV. But these laws are often ignored, laxly enforced or aggressively flouted.
- In over 60 countries it is a crime to expose another person to HIV or to transmit it, especially through sex. At least 600 individuals living with HIV in 24 countries have been convicted under HIV-specific or general criminal laws (due to underreporting, these estimates are conservative). Such laws do not increase safer sex practices. Instead, they discourage people from getting tested or treated, in fear of being prosecuted for

passing HIV to lovers or children.

- Women and girls make up half of the global population of people living with HIV. Laws and legally condoned customs — from genital mutilation to denial of property rights — produce profound gender inequality; domestic violence also robs women and girls of personal power. These factors undermine women’s and girls’ ability to protect themselves from HIV infection and cope with its consequences.

It called upon the countries to outlaw all forms of discrimination and violence directed against those who are vulnerable to or living with HIV or are perceived to be HIV-positive<sup>250</sup>:

- To ensure that existing human rights commitments and constitutional guarantees are enforced.
- Repeal punitive laws and enact laws that facilitate and enable effective responses to HIV prevention, care and treatment services for all who need them.
- Enact no laws that explicitly criminalise HIV transmission, exposure or non-disclosure of HIV status, which are counterproductive.
- Work with the guardians of customary and religious law to promote traditions and religious practice that promote rights and acceptance of diversity and that protect privacy.
- Decriminalise private and consensual adult sexual behaviours, including same-sex sexual acts.

---

248. <http://www.hivlawcommission.org/resources/report/Executive-Summary-GCHL-EN.pdf>

249. “HIV and the Law: Risks, Rights & Health” is the Commission’s flagship publication. Released in July 2012, the report presents public health, human rights and legal analysis and makes recommendations for law and policy makers, civil society, development partners and private sector actors involved in crafting a sustainable global response to HIV.

250. <http://www.hivlawcommission.org/resources/report/Executive-Summary-GCHL-EN.pdf>

- Prosecute the perpetrators of sexual violence, including marital rape and rape related to conflict, whether perpetrated against females, males, or transgender people.

The report said that countries must ensure that their national HIV policies, strategies, plans and programmes include effective, targeted action to support enabling legal environments, with attention to formal law, law enforcement and access to justice. Every country must repeal punitive laws and enact protective laws to protect and promote human rights, improve delivery of and access to HIV prevention and treatment, and increase the cost-effectiveness of these efforts.

On the 18 July 2016 at Durban, South Africa,

four years after the Global Commission on HIV and the Law released its report on the impact of laws, policies and practices on those living with and most vulnerable to HIV, the UNDP and the participating world is taking stock of its recommendations made in 2012 and to see how much progress has been made. The report titled, AIDS 2016 - Risks, rights and health: Taking stock of the Global Commission on HIV and the Law. The work will look at how the HIV response has combined a human rights approach when dealing with the problems and recommendations faced by the people living with and affected by HIV.

### Sustainable Development Goals - SDGS

At a UN Summit (25-27 September 2015), 193 Member States of the United Nations adopted the new sustainable development agenda entitled "Transforming Our World: 2030 Agenda for Sustainable Development." It officially came into effect on 1 January 2016, and will run through 2030. The 2030 Agenda sets forth "a plan of action for people, planet and prosperity". It seeks to strengthen universal peace in larger freedom. And it heralds a universal pledge that no one will be left behind. The 2030 Agenda consists of a Declaration, 17 Sustainable Development Goals (SDGs)<sup>251</sup> and 169 targets, a section on means of implementation and renewed global partnership, and a framework for review and follow-up. The deadline for the SDGs is 2030. The SDGs are integrated and indivisible and balance the three dimensions of sustainable development: the economic, social and environmental. The SDGs build on the success of the Millennium Development Goals (MDGs) and aim to go further to end all forms of poverty. The new Goals are unique in that they call for action by all countries, poor, rich and middle-income to promote prosperity while protecting the planet. They recognize that ending poverty must go hand-in-hand with strategies that build economic growth and addresses a range of social needs including education, health, social protection,

"Just as our vision behind the Agenda 2030 is lofty, our goals are comprehensive. It gives priority to the problems that have endured through the past decades. And, it reflects our evolving understanding of the social, economic and environmental linkages that define our lives."

Prime Minister Mr. Narendra Modi's statement at the UN Summit for the adoption of Post-2015 Development Agenda

251. <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>

and job opportunities, while tackling climate change and environmental protection.

While the SDGs are not legally binding, governments are expected to take ownership and establish national frameworks for the achievement of the 17 Goals. Countries have the primary responsibility for follow-up and review of the progress made in implementing the Goals, which will require quality, accessible and timely data collection. Regional follow-up and review will be based on national-level analyses and contribute to follow-up and review at the global level<sup>252</sup>.

In India, the NITI Aayog has been entrusted with the role to co-ordinate 'Transforming our world: the 2030 Agenda for Sustainable Development' (called as SDGs). Moving ahead from the Millennium Development Goals (MDGs), SDGs have been evolved through a long inclusive process for achievement during 2016-2030. The SDGs cover 17 goals and 169 related targets resolved in the UN Summit meet 25-27 September 2015, in which India was represented at the level of Hon'ble Prime Minister. These SDGs will stimulate, align and accomplish action over the 15-year period in areas of critical importance for the humanity and the planet.<sup>253</sup> At a recent National Conference of Chief Secretaries and Planning Secretaries of States and Union Territories, held on 27th July 2016, some key messages looked at

were: 5 critical elements to ensure robust localisation of SDGs: Develop Vision for the State that is economically sound, socially inclusive and environmentally sustainable. For example: In Assam, Haryana and Odisha – based on SDGs, inter-departmental thematic working groups have been formed.

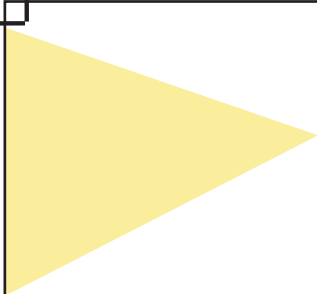
Prepare integrated implementation plans. For example: Analysis shows that more than half of the SDG targets make an explicit reference to at least another goal which may facilitate cross-sector integration of thinking, policy and implementation.

Ensuring adequate finance for SDGs. For example: States are now responsible for 57% of the spending, which accounts for 16 percent of GDP. Of this, nearly 74% of the funds are untied (compared to an average of 57% during the 13th Finance Commission period), allowing more flexibility to states. Also, global SDG financing gap: USD 2.5 trillion per year (UNCTAD, 2014). Invest in upgraded, coordinated and integrated institutions and capacities at the local level. For example: Out of the 17 SDGs, 15 are directly related to activities carried out by local governments in India (SDG 14 on marine resources and SDG 17 on global partnerships are the two not directly relevant). Invest in SDG monitoring to help invisible become visible.

252. <http://www.un.org/sustainabledevelopment/development-agenda/>

253. <http://niti.gov.in/content/universal-game-changer>





For example: In our assessment and rich experience of institutionalizing human development, a relatively small increase in support for capacity development at local levels and statistics can go a long way to developing a robust system for implementation and monitoring the SDGs.

In a recent article published in May 2016, titled, "Towards sustainable development" authored by Mr. Henk Bekedam, the WHO Representative for India, the author states <sup>254</sup>:

"India can progress towards sustainable development in health if it follows the following five steps.

First, health must be high on the National and State agenda, as it is the cornerstone for economic growth of the nation. This requires high political commitment and collective long-term efforts by ministries beyond the Ministry of Health to invest in health. The proposal in India's draft National Health Policy 2015 to raise public health expenditure to 2.5 % of the GDP by 2020 is commendable. Second, India should invest in public health and finish the MDG agenda through further improvements in maternal and child health, confronting neglected tropical diseases, eliminating malaria, and increasing the fight against tuberculosis. For all these challenges, it is clear what needs to be done; programmes and interventions need to be taken to

scale, with a central emphasis on equity and quality of services.

Third, accelerate the implementation of universal health coverage. UHC is important to prevent people slipping into poverty due to ill health and to ensure everyone in need has access to good quality health services. To complement tax revenue based health financing, incremental expansion of prepayment and risk pooling mechanisms such as Social Health Insurance are worth considering. UHC is at the core of SDGs and in the interest of people and governments.

Fourth, build robust health system in all aspects and strengthen both the rural and urban components, with comprehensive primary health care at its centre. Given the magnitude of the private sector in India, more effective engagement with private healthcare providers is vital. Appropriate contracting modality, which is an important feature under the Social Health Insurance or RSSY, can be worked out and private sector can be instrumental in complementing the public sector as demonstrated by different country experiences, including Thailand and Philippines. Finally, develop a strong system for monitoring, evaluation and accountability. It is absolutely essential to regularly review and analyse the progress made for feeding into policy decisions and revising strategies based on the challenges. In conclusion, the SDGs have the potential to create a world where no one is left behind.

---

254. <http://www.thehindu.com/sci-tech/health/sdgs-big-agenda-big-opportunities-for-india/article8570010.ece>

The SDGS also make it possible to achieve what the WHO constitution mandates: attainment by all peoples of the highest possible level of health.

“It has been observed that laws permit or prohibit specific behaviours but in doing so, it shapes various aspects of the country not just the people but its economy, politics and society making a tangible difference in the lives of its citizens, becoming the bridge between vulnerability and empowerment as well as help build safeguards against HIV. It has also been observed that in many countries and societies, archaic laws, some steeped in cultural dimensions, have challenged any progress made by its State to safeguard the rights of its citizens exacerbating vulnerability amongst the most disenfranchised. But it has also been seen that when people and the courts come together, or people and governments come together and begin a discussion on safe guarding the fundamental rights of equality and access to the highest standards of health, this constructive dialogue often controversial to start with, leads way to progressive reform. Transgender rights and health rights, specifically those on HIV in India are such remarkable examples. It may never be a quick process but when countries take the time and take action to strengthen the human rights enshrined in their Constitution, like

India did, it survives as one of the best ways to strengthen the foundations of justice and challenge stigma and discrimination at its very heart.

Laws then, create a sense not of fear but of protection, of strength not stigma and of support not discrimination and the legal and social environment around good health and HIV reflects all of these positive surroundings.

