Mainstreaming The Margins: A Review Of The Key Concerns In The HIV AIDS (Prevention And Control) Bill, 2012

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The AIDS epidemic sweeping the country presents difficult problems for law and policy makers. With social barriers being increasingly broken by instances of this disease, the problem of containing and reducing fresh outbreaks is further compounded. At the same time, considering the social stigma attached to AIDS and the rampant marginalisation that goes hand in hand with the same, the law must be geared to protect the interests of those afflicted. The HIV AIDS Bill, 2012 is an effort to combine these policy concerns in a holistic legislation. We have thematically structured our paper to address certain key concerns.

I. Introduction

The spread of HIV/AIDS is a curious case study. The HIV epidemic is distinct in the sense that the disease spreads through unique channels of transmission and remains asymptomatic for a considerable period of time before affecting the victim. Legislations aimed at regulating epidemics are confronted with the formidable problem of balancing the right of the general public to be protected from the disease and the constitutionally ordained rights of the affected individuals. This is true of the HIV/AIDS Bill 2012 as well. Apart from this, the social

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stigma and marginalisation associated with HIV/AIDS puts an onus on the policymakers to take into account the social dynamics of HIV AIDS regulation and to be sensitive towards the same. In this light, the authors have approached the analysis of the Bill in a thematic manner to address certain the key policy concerns. In the subsequent section the authors have looked at informed consent in the Bill in light of international standards on the same. In Part III, the authors have looked at whether the guarantees under the Bill are feasible in light of data available in the public domain. Part IV deals with provisions in the Bill which affect the groups which are at high risk of being afflicted with HIV/AIDS. Part V delves into how the provisions of the Bill deal with the issues related to matrimony such as partner notification. Part VI of the paper argues for a possible criminalisation of transmission along with mandatory testing in certain institutions where the risk of transmission is high. Part VII, contains a summary of findings and concluding remarks on the key issues discussed in the paper.

II. Informed Consent

The term "*Informed Consent*" first made an appearance in the 1950's, more than a decade after revelations of horrible medical experimentation on prisoners of war and civilians emerged after the Nuremberg trials.[1] The term was coined by a brilliant attorney by the name of Paul G. Gebhard, who in a 1957 medical malpractice case helped codify along with the California Appellate Court, the doctrine of Informed Consent. It was held that informed consent would "…require doctors to clearly disclose any possible risks as well as rewards of a proposed medical treatment or procedure".[2] However, with the passage of time there has been an *autonomy* driven shift of focus from the physician/researcher's obligation to divulge information to the *quality* of a patient's *understanding* and *consent*.[3]

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1 Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics, 77 (5th ed. 2001).

2 Paul G. Gebhard, *Lawyer Coined the Phrase 'Informed Consent'*, L.A.Times, Aug. 27, 1997, http://articles.latimes.com/1997/aug/27/news/mn-26326.

3 *See generally* Beauchamp & Childress, s*upra* note 1.

A. Informed Consent: An International Perspective

Informed Consent has become a pre-requisite in today's time with even the International Ethical Guidelines for Bio medical Research Involving Human Subjects prepared by the Council for International Organisations of Medical Sciences (CIOMS) in collaboration with the World Health Organization (WHO) recommending it. Guideline 4 of the document reads: *"For all biomedical research involving humans the investigator must obtain the voluntary informed consent of the prospective subject or, in the case of an individual who is not capable of giving informed consent, the permission of a legally authorized representative in accordance with applicable law. Waiver of informed consent is to be regarded as uncommon and exceptional, and must in all cases be approved by an ethical review committee."*[4]

The American Medical Association has provided a detailed analysis of Informed Consent under its Code of Medical Ethics.[5] The AMA believes that the physician is duty bound to divulge and deliberate with the patient:

1. His/her diagnosis;
2. "The nature and purpose of a proposed treatment or procedure";[6]
3. "The risks and benefits of a proposed treatment or procedure";[7]

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4 *International Ethical Guidelines for Biomedical Research Involving Human Subject International Ethical Guidelines for Biomedical Research Involving Human Subjects*, Council for International Organizations of Medical Sciences (CIOMS) 32, http://www.cioms.ch/publications/layout_guide2002.pdf (last visited Aug. 7, 2013).

5 Cl. 8.08, America Medical Association: Code of Medical Ethics available at https://ssl3.amaassn.org/apps/ecomm/PolicyFinderForm.pl?site=www.amaassn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/E-8.08.HTM(last visited Aug. 7, 2013).

6 *Informed Consent*, America Medical Association, http://www.ama-assn.org//ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page (last visited Aug. 7, 2013).

7 *Id.*

4. Alternatives to the treatment.
5. "The risks and benefits of undergoing the alternative procedure".[8]
6. And the risks and benefits if not undergoing any treatment or procedure.[9]

Furthermore, in the United States, inquiries regarding informed consent are decided on the basis of two broad questions. First, "whether a reasonable patient would have considered the information sufficient to make an informed decision"[10] and second whether the information provided would be sufficient to the reasonably prudent physician[11].[12]

The lawin UK however, is not codified, but has evolved through a plethora of case laws over the last 120 years.[13] However, legislations like *Adults with Incapacity (Scotland) Act, 2000*[14]*, Mental Health (Care and Treatment) (Scotland) Act, 2003*[15]*, The Mental Capacity Act, 2005*[16] also include the informed consent clause.

Beginning with the case of *Beatty v Cullingworth*[17]*,* where despite the absence of consent both the ovaries of a nurse were removed to

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8 *Id.*

9 *Id.*

10 *Id.*

11 *Id.*

12 *Id.*

13 *Consent to Medical Treatment in the UK, Appendix 1 - Key cases that have shaped consent law*, THE MEDICAL PROTECTION SOCIETY, http://www.medicalprotection.org/uk/booklets/guide-to-consent (last visited Aug. 7, 2013).

14 Adults with Incapacity (Scotland) Act, 2000, §6 available at http://www.legislation.gov.uk/asp/2000/4/contents(last visited Aug. 7, 2013).

15 *See generally* Mental Health (Care and treatment) (Scotland) Act, 2003 available at http://www.legislation.gov.uk/asp/2003/13/contents(last visited Aug. 7, 2013).

16 Mental Capacity Act, 2005, § 2 available at http://www.legislation.gov.uk/ukpga/2005/9/contents(last visited Aug. 7, 2013).

17 *See Beatty v. Cullingworth*, Br Med J 1896.

the case of *Hatcher v Black*[18], where the patient lost her voice despite being assured by the surgeons that there was no risk of such a possibility, the UK courts maintained a protective stance by ruling in favour of the medical practitioners.

Significant development were made in 1998 when the General Medical Council (GMC) published *Seeking Patients Counsel: The Ethical Considerations*[19], which laid down overtly, the information doctors are duty bound to disclose to the patients before proceeding to treatment.[20]

However, the major breakthrough for Informed Consent in U.K came through *Chester v Afshar*[21], wherein the House of Lords stressed upon the importance ensuring that patients were comprehensively informed, that they completely understood the information provided to them and that they had the time and freedom to make an intelligent choice.

Comparing HIV legislations in the US and UK with India is not possible for the simple fact that these countries do not have one. In both USA and UK, the informed consent guidelines are enshrined in medical practice as a standard principle to be followed or a duty to be imposed on the medical practitioner. Recently in India, the Consumer Protection Act has bought doctors under its purview making them liable for malpractice suits. The Indian Medical fraternity should take a leaf out of book of the US and UK medical code of conducts

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18 *See Hatcher v. Black*, The Times. 1954;*see generally* WaseemJerjes, JaspalMahil&TahwinderUpile, *English law for the surgeon II: Clinical negligence*, Head Neck Oncol. 2011; 3: 52.available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3259084/(last visited Aug. 7, 2013).

19 *Seeking Patients Counsel: The Ethical Considerations*, General Medical Council, http://www.gmc-uk.org/Seeking_patients_consent_The_ethical_considerations.pdf_25417085.pdf (last visited Aug 7, 2013).

20 *Id.*

21 *Chester v. Afshar,* [2004] 3 WLR 927; *see also Chester v Afshar [2004] 3 WLR 927*, E-law Resources, http://www.e-lawresources.co.uk/Chester-v-Afshar.php(last visited Aug. 7, 2013).

and ensure high standards when it comes to fulfilling the duty of informed consent. [22]

B. Informed Consent in the Bill

Chapter III of the HIV/Aids Bill deals with the concept of Informed Consent. Under this chapter, there are provisions that deal with informed consent required for HIV testing, treatment and research and the exceptions for informed consent. This chapter also deals with the question of who can consent in different situations.

The entire chapter on informed consent is based on the definition provided under section 2(q). Informed consent means "the consent given, specific to a proposed intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation and 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."[23]

According to the definition clause, informed consent not only means consent without fraud or misrepresentation but also includes the risks and benefits of any treatment that is to be done on the patient. The important element here is that section 2(q) mentions that the language in which information is to be given to the patient should be one that is understood by the patient. The definition of informed consent in the Bill is comparable with the existing standards of informed consent in the medical world.

Chapter III begins with the right to autonomy. Under section 7, every person has the right to bodily and psychological integrity including the right not to be subject to medical treatment, interventions or research without that person's informed consent.

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[22] Consumer Protection Act and Medical Profession - Model Form of Informed Consent, http://www.medindia.net/indian_health_act/consumer_protection_act_and_medical_profession_model_form_of_informed_consent.htm.

[23] HIV/AIDS Bill, 2012. http://164.100.24.219/BillsTexts/LSBillTexts/asintroduced/1579LS.pdf

The Bill requires specific, free and *informed consent* for HIV related testing, treatment and research. HIV *testing* must be accompanied by pre- and post-test counselling, HIV *treatment* may commence only after an explanation of risks, benefits and alternatives available while HIV *research* may take place only after the research subject is informed of aims, methods, sources of funding, possible conflicts of interest, institutional affiliations of the researcher, potential benefits and risks, possible discomfort and the right to withdraw consent.[24] This shows that the Bill makes a distinction between testing, treatment and research and allows for different standards of what can constitute informed consent.

Similarly, the Bill also recognises different ages at which informed consent can be given for HIV testing, research and treatment. For HIV- related tests and HIV related treatment, consent can be obtained from children above the age of 12 or if the child is between 12 and 16, and lacks the capacity to consent, as assessed by the healthcare provider, the parent, or legal or de facto guardian or the next friend. For HIV research, if the patient is under 18, then consent should be obtained from the parent, or legal or de factor guardian or the next friend.[25]

HIV testing can be conducted only for the voluntary determination of HIV status or if it is medically indicated and in the interest of the person being tested. Consent must be in writing however it can be taken verbally if it is recorded.[26] The Bill makes provision for proxy consent in the case of death, incapacity or emergency or for young persons.

The Bill also requires special attention to be given to women and young persons and for specific counselling regulations that will

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[24] *HIV/AIDS Bill, 2007*, LAWYERS COLLECTIVE (Nov. 23, 2010), http://www.lawyerscollective.org/hiv-and-law/draft-law.html.

[25] *THE HIV/AIDS BILL 2007 -A summary*, LAWYERS COLLECTIVE 15, http://www.lawyerscollective.org/files/HIV%20Bill%20-%20Chapter%20Summaries.pdf(last visited Aug. 7, 2013).

[26] *Id.* at 3.

create an atmosphere conducive to individual decision-making. Consent for HIV testing under the Bill is not required when it is ordered by courts, required for testing blood, organs, semen etc., or for surveillance.

The Bill guarantees the *confidentiality* of HIV-related information (including the HIV status of a person) and outlines the exceptions under which disclosure can be made - 'partner notification' and the 'duty to prevent transmission.' The Bill specifies the exact protocol for, and circumstances in which, a healthcare provider can notify the partner of an HIV-positive person about their status.[27]

The HIV/AIDS Bill recognises the right to privacy of all persons and accordingly guarantees the confidentiality of HIV-related information (including the HIV status of a person) and outlines the few exceptions where this information can be disclosed. A person cannot be compelled to disclose their status and persons to whom they may reveal it in confidence are bound not to reveal the information. The Bill requires informed consent for disclosure whether by a person or their proxy in the same way that consent is required for testing, treatment and research. Written consent is required in the case of fiduciary relationships such as healthcare provider-patient, lawyer-client, etc. Informed consent for disclosure is not required when it is necessary and in the best interest of a patient, if it is ordered by court, in the initiation of legal proceedings, or if it is in the form of statistical information or data.[28] It also prohibits the publication of HIV related information of a person without their informed consent.

The HIV/AIDS Bill thus helps avoid the social stigma associated with being diagnosed with/for HIV/AIDS by ensuring complete privacy for the patients. The Bill has taken a step forward

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[27] *Id.* at 4; *see also* National Coalition on HIV Aids Bill & Lawyers Collective,*The HIV/ AIDS Bill 2009- Leaflet for Parliamentarians*,LAWYERS COLLECTIVE, http://www.lawyerscollective.org/wp-content/uploads/2010/11/Parliamentarians.pdf (last visited Aug. 7, 2013).

[28] *Id.* at 4.

by ensuring strict standards of compliance with respect to the informed consent clause. However, the true value of any legislation lies in its implementation and the Bill has a long way to go when it comes to *ensuring [emphasis supplied]* that it meets the very standards it wishes to set

III. Resource Analysis

Chapter V of the HIV/AIDS Bill 2012[29]guarantees "free of cost HIV-related prevention, care and support facilities, goods, measures, services and information, including centers providing voluntary testing and counseling services in every sub-district in accordance with the Regulations".[30] It also guarantees free of cost treatment wherein treatment would include: "health facilities, goods, measures, services and information for the curative and palliative care of HIV/AIDS and related opportunistic infections and conditions including:

(i) Counseling;

(ii) The effective and monitored use of medicines for opportunistic infections;

(iii) Post exposure prophylaxis;

(iv) Anti-retroviral therapy;

(v) Nutritional supplements;

(vi) Measures for the prevention of mother-to-child transmission;

(vii) Infant milk substitutes; and

(viii) Other safe and effective medicines, diagnostics and related technologies"[31]

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[29] THE HIV/AIDS BILL, 2007 *available at* http://www.lawyerscollective.org/files/Final%20HIV%20Bill%202007.pdf (last visited Aug. 7, 2013).

[30] *Id.* at Cl. 17.

[31] *Id.* at Cl. 17.

Not restricted to just these, Bill also obligates Government to take effective legislative, administrative and fiscal measures which include: ensuring the use of all options to promote access to healthcare including provision of travel subsidies for HIV-positive persons to facilitate access to treatment; introducing tax incentives and exemptions on HIV-related treatment in order to promote its affordability, accessibility and availability; ensuring that the pricing of medication, diagnostics and related technologies pursuant to any statute, regulation or order is fixed in a manner that is transparent, accountable and open to public scrutiny and that promotes its affordability, accessibility and availability.'[32]

Bill seeks to provide counseling services and testing centers, in every sub district. There are more than 640[33] districts in the country and 5924[34] sub districts as per 2011 census. For counseling services and testing centers in these 5924 sub districts, certain amount of infrastructure like testing machines, human resource, and laboratory facilities will certainly be required. And hence, arises the need of analyzing the adequacy of resources for implementing the promises of the legislative scheme.

A. Number of Patients

As per National Aids Control Organization (NACO's) Annual Report, 2012-2013[35], the total number of HIV/AIDS patients in India was- 20.89 lakhs till 2011. 6,10,490 eligible patients were availing government services. Out of these, 6,04,987 were on first line

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[32] *Id.* at Cl. 19.

[33] *Census 2011 Provisional Population Totals*, Ministry of Home Affairs (Mar. 31, 2011), http://censusindia.gov.in/2011-prov-results/data_files/india/pov_popu_total_presentation_2011.pdf.

[34] *Id.*

[35] *See generally Annual Report 2012-2013*, National Aids Control Organization (NACO) available at http://www.naco.gov.in/upload/Publication/Annual%20Report/Annual%20report%202012-13_English.pdf (last visited Aug. 7, 2013).

treatment and 5503[36] on second line treatment. Anti-Retroviral Treatment for AIDS is conducted in two stages. First line treatment is the basic level of treatment and is administered to all the patients. Those who fail to show any sign of improvement post First Line Treatment, are subjected to Second Line Treatment.[37] According to NACO's National Guidelines on Second-line ART for adults and adolescents 2011[38], 2-3% patients (as per survey conducted in 2006) show negligible improvement to First Line Treatment and hence go through Second Line Treatment.

B. Cost of Treatment

As per a newspaper report[39], cost of First Line treatment is Rs. 5000/- per person and for Second Line Treatment, it is Rs. 29,000/- per person. Multiplying the costs with the number of patients undergoing such treatment we get the estimated expenditure:

20.89 lakhs *5000 = 1044.5 crores

+ (3% of 20.89 lakhs*29000) = 181.743 crores

1044.5 +181.743 crores = 1226.243 crores per year.

NACP works in phases of five year terms. Currently, NACP 1V (2012-2017) is functional. However, for the sake of calculation we will take into consideration, the figures from NACP III (2007-2012).

Since NACP works in 5 year term phases, for the sake of convenience, we shall make our calculations in the similar pattern.

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36 *Id.* at 53.

37 *Id.*

38 *National Guidelines on Second-line ART for adults and adolescents 2011*, National Aids Control Organization (NACO) *available at*http://www.naco.gov.in/upload/Care%20&%20Treatment/NACO%20guidelines%20for%20second%20line%20ART%20April%202011.pdf (last visited Aug. 9, 2013).

39 Sanchita Sharma, *AIDS treatment is cheapest in India*, Hindustan Times (Dec. 2, 2011), http://www.hindustantimes.com/India-news/NewDelhi/AIDS-treatment-is-cheapest-in-India/Article1-776764.aspx.

Hence, the estimated cost of treatment, as calculated above, 1226.243 which is for 1 year shall now be multiplied by 5 to give us the estimate cost of treatment for 20.89 lakhs patients for 5 years.

1226.243*5= Rs. 6131.215 Crores

C. NACP III Budget and Expenditure

As per NACO's Annual Report of 2012-2013, the budget approved for NACP III from Government was Rs. 8,023 crores out of which surprisingly, NACO ended up utilizing **just** Rs. 1152.62 crores. Not just 7/8th of the budget but also a large proportion of funding from global sources remained un-utilized.[40] Where on one hand the estimated expenditure at the beginning of NACP III was Rs. 11,585 crores, at the end of the phase, the total amount spent was just Rs. 6237 crores with which supposedly, NACO achieved its stated objectives of: providing prevention, care and treatment, which would essentially mean conducting tests on public at large, awareness campaigns, distributing condoms, providing ART Treatment, medicines, access to safe blood, and other procurements.[41]

As per NACO's report, total expenditure of Rs. 6237 crores[42] has been incurred over 5 years from which it is claimed that 6,10,490 patients have availed the services. In that case for 20.89 lakhs patients the expenditure that could be estimated at Rs.21, 342.02 crores.

a. *Calculation*

Rs. 6237 crores for 610,490 patients;

For 20.89 lakhs it would be: 20.89*6237/610490= Rs. 21,342 crores.

To this, if we add the treatment cost calculated earlier in the paper, since from the objectives of NACP III, it isn't clear if all the

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40 Annual Report, *supra* note 33 at 100.

41 Annual Report, *supra* note 33 at viii-x.

42 Annual Report, *supra* note 33 at 100.

patients were provided with ART treatment, hence the Rs. 6237 crore expenditure incurred in NACP III might be excluding 'Treatment cost'.

Adding treatment cost to Rs. 21,342 crores we get the estimated total cost of expenditure once the bill comes into action= Rs. (21,342 + 6131.21) crores = Rs. 27,473 crores.

However, there are few factors which are likely to cause variation to the estimations; due to the limited information available as a result of which precise expenditure cannot be calculated. Some of these factors are listed below.

D. Other Factors

Other factors include:

1. The unaccounted infrastructure, maintenance, procurement and other costs;

2. An increase in the number of patients: 1.16 lakhs among adults and 14,500 among children each year which will increase the expenditure on treatment;

3. Reliability of NACO Report, on the basis of which calculations above have been carried out. Reliability is under question since, the estimates released by NACO in its Annual Report 2012-2013, indicate that an estimated 20.89 lakhs people are HIV positive in the country, whereas in contrast in 2005, NACO reported 52.1 lakhs HIV positive individuals. It is highly difficult to believe how can the figures of 52.1 lakhs[43] of reported HIV patients decrease by more than 50% in 7 years considering that each year new HIV patients add in the statistics.

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[43] *Draft Report on Independent Evaluation of National AIDS Control Programme*, National Aids Control Organization (NACO) 11 *available at*http://www.naco.gov.in/upload/Finance/Draft%20Report%20on%20Independent%20Evaluation%20of%20NACP.pdf (last visited Aug. 9, 2013).

Conclusion: With this resource analysis, the authors intend to give a reality check to the Government and raise questions of financial feasibility and whether in terms of manpower; the Government is equipped to meet the promises made in the bill. Moreover, the most startling fact is the expenditure estimated in 'Financial Memorandum'[44] of HIV AIDS Bill 2012, where it has been stated that if the bill is enacted; the non-recurring expenditure is likely to be Rs. 100 crores whereas recurring expenditure would come up to Rs. 500 per annum. As per the calculations above which are based on Government's official reports estimate expenditure should be between Rs. 21,342 crores - Rs. 27,473. Well, the significant discrepancy in the estimates put a big question mark on adequacy of resources. However, the under-utilized Government and Global funding if put to proper utilization for treatment, infrastructure and training, can help us win the battle against AIDS.

IV. High Risk Groups

While the adult prevalence[45] of HIV infection in India is low and was estimated to be 0.27% in 2011,[46] certain regions and populations show disproportionately high HIV levels.[47] Sub-population which show a disproportionately high prevalence of HIV are called High Risk Groups (hereinafter HRGs).The National AIDS Control Program-III (hereinafter NACP-III) classifies HRGs into three categories. Core HRGs comprise the first category and are populations which are most vulnerable to the risk of acquiring an HIV infection.

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44 Cl. 52,*supra* note 23.

45 *HIV prevalence among adults aged 15-49 years (%)*, Health statistics and health information systems: World Health Organisation, http://www.who.int/healthinfo/statistics/indhivprevalence/en/ (last visited Aug. 7, 2013).

46 *See Technical Report India HIV Estimates 2012*, National AIDS Control Organisation (NACO) xvi, http://www.nacoonline.org/upload/Surveillance/Reports%20&%20Publication/Technical%20Report%20-%20India%20HIV%20Estimates%202012.pdf (last visited Aug. 7, 2013).

47 *See generally HIV Sentinel Surveillance 2010-11: A Technical Brief*, National AIDS Control Organization (NACO), http://aidsdatahub.org/dmdocuments/HSS_2010-11_Technical_Brief_30_Nov_12.pdf (last visited Aug. 7, 2013).

Female Commercial Sex Workers (hereinafter FSW), Men who have Sex with Men (hereinafter MSM) and Injectable Drug Users (hereinafter IDUs) fall under this category. Bridge Populations form the second category and are individuals who have sexual partners in both core HRGs and the general population. Such populations are responsible for transmitting HIV from core HRGs to the general population. Clients of sex workers, truck drivers and male migrants are examples of bridge populations. The third category consists of "risk groups in rural areas, HIV affected children, youth (15 to 19 years of age) and women."[48] Under its scheme the NACP-III gave the highest priority to the sub-populations which had the highest risk of contracting HIV.[49] In light of the enormous implications of having a high HIV prevalence amongst core HRGs, it becomes necessary to review the extent of protection provided to such groups under the HIV AIDS Bill.

A. Legalising Targeted Interventions

HIV infection spreads outwards from the core HRGs, to the bridge populations and then to the general population. "Given this pattern of epidemic transmission, it is most effective and efficient to target prevention to the [core] HRG members to keep their HIV prevalence as low as possible, and to reduce transmission from them to the bridge population."[50] The NACP-III adopts a policy of providing

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48 *See generally Targeted Interventions under NACP III: Operational Guidelines Volume 1 Core High Risk Groups*, National AIDS Control Organization (NACO),http://www.iapsmgc.org/userfiles/3TARGETED_INTERVENTION_FOR_HIGH_RISK_GROUP.pdf (last visited Aug. 7, 2013).

49 *NACP-III: Policy Priorities and Thrust Areas*, National AIDS Control Organisation (NACO), http://www.nacoonline.org/NACO/National_AIDS_Control_ Program/Programme_Priorities_and_Thrust_Areas.html (last visited Aug. 7, 2013). "Sub-populations that have the highest risk of exposure to HIV will receive the highest priority in the intervention programmes. These would include sex workers, men-who-have-sex-with-men and injecting drug users. Second high priority in the intervention programmes is accorded to long-distance truckers, prisoners, migrants (including refugees) and street children.".

50 NACO, *supra* note 48 at 7.

'targeted interventions' (TIs) to core HRGs with the objective of controlling HIV levels in such groups and reducing the chances of transmission of the infection to other groups. Targeted interventions are packages which "…enhance accessibility of high risk groups to key HIV prevention services and improve their health seeking behaviour, thereby reducing their vulnerability and risk to acquire Sexually Transmitted Infections (STI) and HIV infections. TIs provide services, such as behaviour change communication, condom promotion and clean needle and syringe for people who inject drugs, STI care, referrals for HIV and Syphilis testing and linkages with Anti-Retroviral Treatment."[51]

They are generally implemented through NGOs and Community based organisations and follow a community based approach. While the NACP-III deems TIs to be effective and efficient solutions for controlling the spread of HIV in core HRGs, the operation of such initiatives can be impeded by legal and regulatory regimes. Thus not only are such initiatives open to challenge under provisions of Indian Penal Code like "…abetment of an offence, criminal conspiracy, common intention, sale, distribution of 'obscene' material, printing of grossly indecent material, sale of obscene objects to young persons and obscene acts and songs",[52] they can also be challenged under provisions of special enactments like IMTP[53] and NDPS[54] Acts which apply to core HRGs. The HIV AIDS Bill contains a most significant provision, section 21 which specifically protects the promotion of risk reduction strategies (or targeted interventions) from being hampered by the operation of criminal or civil laws. Strategies for risk reduction are initiatives which minimise "a person's risk of

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51 *Supra* note 33.

52 United Nations Office on Drug and Crime, Regional Office for South Asia, *Legal and Policy concerns relating to IDU harm reduction in SAARC countries* 57, http://www.unodc.org/pdf/india/publications/legal_policy_book_140807.pdf (last visited Aug. 7, 2013).

53 Immoral Traffic Prevention Act, 1956, no. 104 of 1956 [Dec.,30, 1956].

54 Narcotic Drugs and Psychotropic Substances Act, 1985, no. 61 of 1985 [Sept., 16, 1985].

exposure to HIV or mitigate the adverse impacts related to HIV/AIDS."[55] The Bill states in clear terms that a strategy for risk reduction cannot in "any manner, be prohibited, impeded, restricted or prevented and shall not amount to a criminal offence or attract civil liability."[56] Such a provision grants legal protections to NGO's and Community Based Organizations (CBO's) who take active steps to regulate the spread of HIV AIDs in HRGs and rectifies a long-standing legal lacuna.

B. Ensuring Adequate Representation

The HIV AIDS bill envisages the creation of HIV AIDS authorities at the National, State and District levels. These authorities are given a wide mandate under the bill to formulate the HIV policy and to implement nationwide HIV prevention measures. It is desirable that all stake holders are provided adequate representation in such bodies and that the interests of all vulnerable populations are considered during policy formulation. Not only are Core HRGs most vulnerable to HIV/AIDS, they also represent a section of the society which is rarely represented in policy making. The HIV AIDS Bill contains provisions which can be used to allow members from the Core HRGs to actively participate in the day to day functioning of HIV AIDS Authorities. The bill coins the expression "protected person" and defines such person as one who is: (i) HIV-positive; or (ii) actually, or perceived to be, associated with an HIV-positive person; or (iii) actually, or perceived to be, at risk of exposure to HIV infection; or (iv) actually or perceived to be, a member of a group actually or perceived to be, vulnerable to HIV/AIDS.[57] Protected persons are entitled to special benefits under the scheme of the bill and are eligible for social security[58] and insurance schemes,[59] rights of residence[60] etc.

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55 Cl. 21, Bill, 2012, *supra* note 23.

56 Cl. 21, Bill, 2012, *supra* note 23.

57 Cl. 2(v), Bill, 2012, *supra* note 23.

58 Cl. 22, Bill, 2012, *supra* note 23.

59 Cl. 22, Bill, 2012, *supra* note 23.

60 Cl. 70, Bill, 2012, *supra* note 23.

It is apparent that this provision is wide enough to include core HRG in its ambit. Section 39 of the bill deals with the constitution of HIV Authorities. The sub-sections of section 39 which deal with the constitution of National/State District HIV/AIDS Authority declare that such authorities shall include certain members "nominated by the appropriate government representing HIV-positive persons, other protected persons, healthcare providers, women, non-governmental organisations working in the field of HIV/AIDS or any other interest which, in the opinion of the Central Government, ought to be represented."[61] Considering the fact that interests of core HRGs are usually represented by community based organization and NGOs, the inclusion of such provisions in the Bill might go a long way to ensure adequate representation of such groups in policy making process.

C. Seeking Across the Board Legislative Reforms

The HIV AIDS Bill correctly recognises that protection to core HRGs cannot be ensured by enacting a single legislation. Rather what is required are across the board reforms and significant amendments to the laws that apply to such groups. The laws applicable to Core HRGs like FSW, IDU and MSM are often punitive in nature and impose criminal sanctions on such groups. This moves the activities of such groups underground in high risk environments thereby increasing the chance of HIV.

Consider for instance the Narcotic Drugs and Psychotropic Substances Act, 1985. This act criminalises the use, possession and trade of narcotic and psychotropic substances and is the law that applies to IDUs. Under the legislation, the act of consuming a prohibited substance is a crime and entails a term in a correctional home. It has been argued that provisions which criminalise consumption of narcotic substances should altogether be deleted as they are counterproductive and increase the chances of a person of acquiring an HIV infection. "Punishment in a correctional home is

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[61] Cl. 39, Bill, 2012, *supra* note 23.

not an appropriate sanction to drug dependence. It has to be understood that once a person becomes dependent on drugs, s/he cannot give up without medical help….Punishment is also not an appropriate sanction for experimental or occasional use of drugs. First time or occasional users will benefit more from education on the harms of continued use, rather than prosecution and jail."[62] Furthermore correctional homes are high risk environments. There is a greater chance of IDUs contracting HIV due to sharing of HIV infected drug paraphernalia between inmates. Thus, the incarceration of IDUs is in fact counterproductive towards controlling drug use and preventing HIV spread.

The HIV AIDS Bill 2012 recognises the need to ensure that existing legal framework does not hamper the operation India's HIV/AIDS programme. To this effect it requires the HIV AIDS authorities to review existing laws and policies and advice the government regarding the changes needed to the same.[63] Furthermore the bill requires the appropriate government to "enact, review and amend legislation to promote the rights of protected persons and to establish a legislative framework in consonance with the objectives of this Act."[64] The problem with such a provision is that it is merely prescriptive in nature; more of a directive than a mandatory legal obligation on the State. This is evident from its language and content. Furthermore, the provisions are directed at the 'appropriate government' which only has a limited capacity of causing legislative reform. This anomaly effectively reduces the scope of protection available under this act for protecting core HRGs. It is thus evident without a wider legislative reform, it is particularly difficult to assert and protect of the rights of the core HRGs. The protection provided by the HIV AIDS Bill to core HRGs is thus at best a very limited one.

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62 *See generally* Lawyers Collective, *Submissions to the Standing Committee on Finance on the Narcotic Drugs and Psychotropic Substances (Amendment) Bill, 2011*,http://www.lawyerscollective.org/files/Submission%20on%20NDPS%20Amendment% 20Bill,%202011.pdf (last visited Aug. 7, 2013).

63 Cl. 50(3)(e), Bill, 2012, *supra* note 23.

64 Cl. 66, Bill, 2012, *supra* note 23.

V. Matrimony in the HIV/AIDS Bill

A. Definition of Domestic Relationship and Partner

The Bill per se, does not define matrimony. Instead it offers a broad all-encompassing definition of what constitutes a domestic relationship under section 2 (g). Under the Bill, a domestic relationship refers to a relationship between two or more persons who live together or alternatively, who have lived together at one point of time in a shared household. It specifies that a person can be related through consanguinity i.e. blood relations or through adoption. Alternatively, one can be said to be in a domestic relationship through marriage or in a relationship in the nature of marriage. It also states that those who live together as members of a joint family can also be construed to be in a domestic relationship. This definition must be read in conjunction with section 2 (s) that defines what is meant by a partner. It states that a partner is a spouse and includes a person with whom another person has a relationship in the nature of marriage reflecting the forward-looking nature of the Bill.

B. Transmission of HIV/AIDS

It has been scientifically proven that HIV/AIDS can be transmitted through three primary methods: sexual contact, exposure to infected body fluids or tissues and from mother to child during pregnancy, delivery or breast feeding. Explanation II to Section 2 (y) has elaborated on what constitutes "circumstances which constitute significant risk of transmitting or contracting HIV infection". These include sexual intercourse through vaginal, anal or oral sexual modes wherein an uninfected person is exposed to the blood, blood products, semen or vaginal secretions of a HIV positive person. This provision also states that a child in the womb of the mother is also at significant risk of transfusion. Alternatively, the child can be exposed to the virus by consumption of the HIV positive mother's breast milk.

C. Partner Notification

Thereby, as the partner is at significant risk of being exposed to the deleterious effects of HIV virus, the law has a provision wherein

the said partner is notified of the significant others' health condition. Section 13 covers the law regarding partner notification. It states the circumstances under which a health care provider can inform the partner of a HIV/AIDS victim of the said spouses' HIV positive status. However, it is to be noted that this can be done when the victim is directly under the aforementioned physician's or counsellor's care. There are several other safety mechanisms that have been instituted to protect the right to privacy of the victim which has been specifically carved out under section 11 of the bill. The health care provider must have a bona fide belief that the significant other of the victim is at a substantial risk of falling prey to the virus as well. The health care provider must then counsel the victim to inform such partner. If even after taking this step the health care provider is not satisfied that the HIV positive person will inform such partner, then the health care provider will first issue a warning of his intent to communicate the status of the HIV positive person to the spouse. Then, the health care provider will inform the partner of the HIV positive person through a personal counselling session. If all such precautions are taken, then no civil liability or criminal sanction will vest upon the heath care provider for revealing the status of the HIV positive person to his or her spouse. It is also to be noted that the health care provider will not have any obligations to identify or locate the partner of the HIV positive person.

D. Duty to Prevent Transmission

It is also to be noted that under section 14 every person who is aware of his HIV-positive status and who has undergone counselling and/or is aware of the dangerous nature of HIV and the manner in which it is transmitted, shall take all reasonable precautions in order to prevent the transmission of the virus to others. Thus, before the HIV positive person engages in any sexual contact, he must inform the other person of such fact.

E. Exemption from Partner notification and Duty to Prevent Transmission

It is important to note that the law makes a special exemption for both partner notification and upon the duty to prevent transmission.

The wordings of the exception are identical in both sections. The exception states that there exists no duty to prevent transmission if there is a reasonable apprehension that such measures and precautions might result in violence, abandonment or actions which may have a severe negative impact upon the physical and mental health of the HIV positive person. The law also factors in that such a disclosure might have a negative impact upon the children of the HIV positive person or anyone who is close to them. This exemption has been made applicable to women who are inflicted with the HIV virus.

F. Registration of Marriage

Sections 71 and 72 of the bill refer to the procedural aspects of matrimony for a person who is inflicted with HIV. Section 72 states that before a person is lawfully wedded to a HIV positive person, the prospective groom or bride must first receive HIV related information, Education and Communication ('IEC'). Section 2 (l) has defined HIV related information to mean any information related to any private information connected to the testing, treatment and research related information regarding the status and identity of such person. However, for the purpose of the current sections, the explanation accompanying section 72 states that this includes information relating to sexual health, contraception, condom usage, sexuality, methods of transmission of HIV and about voluntary HIV testing. In order to get married to a HIV positive person, the healthy spouse must first receive such IEC through a one-on-one interactive counselling session. Section 71 states that the marriage will not be registered unless the registering officer is satisfied that such criterion regarding IEC have been properly satisfied. The same section also states that if an existing marriage is not solemnised in accordance with the provisions of the bill within two years from the commencement of such legislation, then the woman has an option of declaring such marriage as voidable. However, all marriages that take place between an HIV positive person and a spouse after the commencement of the act should be registered in accordance with the provisions of such legislation.

G. Motherhood and HIV/AIDS

Such IEC must also be given to a HIV positive pregnant woman under section 73. This provision gives the HIV positive woman the right to decide whether she wants to keep the child or not. She also has the option of deciding whether or not to undertake HIV related treatment and in other matters which affect her health and pregnancy. The law explicitly states that no woman who is pregnant can be subjected to a forced sterilisation or an abortion. In case of the aforementioned section, IEC refers to information regarding the pros and cons of feeding breast milk vis-a-vis infant milk substitutes. The woman will be given appropriate counselling with regard to the same and ultimately the woman's decision will be given paramount importance.

H. Dissolution of Marriage and Maintenance

Section 71 provides that if the marriage is struck down as void, then all rights and obligations of the legitimacy of the children, who would have otherwise been legitimate had the marriage not been dissolved, shall be as such they would have been had the marriage been dissolved under the applicable law pertaining to marriage. This is also applicable in case of rights related to property and even with regard to maintenance. Section 84 of the Act speaks of maintenance. It states that in case the court passes any order of maintenance, then the court has to factor in the medical costs of HIV related treatment that may be incurred by the applicant.

I. Right to Residence

In addition to providing a specific provision for maintenance, the draft legislation also provides a specific right of residence that can be availed of by women and all children below the age of eighteen, irrespective of their gender. Section 70 states that every such protected person has the right to reside in a shared household and the right not to be excluded from the shared household or any part of it and the right to enjoy and use the facilities of such shared household in a non-discriminatory manner. For the purposes of this section, an accompanying explanation states that a shared household is one in

which a person lives or has lived at any point of a domestic relationship either singly or jointly. This includes a household which can be rented or owned, either singly or jointly. It also refers to a household wherein such a person jointly or singly has any right, title, interest or even equity. The definition is broad enough to include within its ambit the household which may belong to a joint family of which either person is a member of irrespective of whether such person has any right, title or interest in such shared household.

J. Sexual Assault and HIV/AIDS

One of the most important aspects of the draft legislations is that it takes into account that HIV/AIDS can be transmitted through the process of sexual assault. The explanation accompanying section 74 defines sexual assault for the purpose of this bill to mean any non-consensual contact with sexual purposes including an offence under section 376 A, B, C, D and section 377 of the Indian Penal Code. This explanation takes a further step and states that this is regardless whether or not such an act is recognised as a crime by the law for the time being in force and whether or not it is reported to the police. Another explanation, Explanation II, specifically clarifies that for the purpose of this bill, sexual assault includes non-consensual sexual contact by a man with his wife.

K. Relationships in the Nature of Marriage

The draft bill in many aspects has been extremely progressive with regard to matrimony. The bill has accorded a broad meaning to what is meant by a 'domestic relationship' as it brings within its ambit relationships in the nature of marriage. The Apex Court first recognised the validity of live in relationships in an observation in *Khushboo v Kanniamal*.[65] The Court remarked that if two adult people consent to live together it does not amount to an offence. This view was again reiterated in the case of *D Velusamy v D Patchiammal*[66] and reference was made to

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[65] *See S. Khushboo v. Kanniammal&Anrs.*, AIR 2010 SC 3196 (India).

[66] *See D. Velusamy v D. Patchaiammal*, (2010) 10 SCC 469 (India).

the provisions of the Domestic Violence Act, 2005 which recognises live in relationships to an extent. Thus, the bill takes cognizance of live in relationships. This is a step in the right direction as it widens the scope of those who claim rights arising out of this current bill.

L. Implicit Recognition Given to Homosexuality

Section 74 of the Bill talks about sexual assault protocols, states in its accompanying explanation that for the purpose of this bill it recognizes section 377 as sexual assault, regardless of what the position of the penal law on the same is. This was done in order to ensure that protection was granted to victims of sodomy, in case HIV/AIDS was transmitted through anal sexual intercourse. Given the recent amendments to the Penal Code, take cognizance of anal sexual intercourse as rape, this provision of the bill serves to reiterate the same.

However, it must be taken note that homosexuals are not vilified in the course of the bill. Upon looking into the Statement of Objects, it is clear that the drafters of the bill were not oblivious to the fact that one of most affected demographics is that of the LGBT community. It is stated by the legislators, that homosexuals are six to eight times more likely to be inflicted with HIV/AIDS in contrast to the general populace. Thus, they have taken proactive steps in order to ensure that the LGBT community is brought as a beneficiary within the bill. Though not explicitly stated, this is brought to light with the help of illustrations in the bill. The illustration to section 21 states that, members of civil society that engage in propagation of sexual health information, education and counselling for "men who have sex with other men" will not be held criminally or civilly liable. Thus, though there is no explicit mention of homosexuality, it can be inferred that relationships in the 'nature of marriage' can be extended to mean homosexual relationships as well. This can be done by creative judicial construction of the existing law.

M. Recognition of Marital Rape

As highlighted in the previous section, the Criminal (Amendment) Act, 2013 has brought in a plethora of changes to the

existing rape law. However, sadly despite all the changes that were made, the Indian Penal Code still distinguishes between rape and marital rape. It criminalises non-consensual sexual intercourse as per section 375. However by means of an exception this section excludes criminal sanction to the rape, if both parties are married and above fifteen years of age.[67] The inclusion of this provision becomes relevant as HIV positive parties may out of vengeance, inflict and transmit the virus to their spouses. However, as marital rape does not constitute an offence, the perpetrators of the crime would get away scot free. Thus, it becomes pertinent for the legislation to recognize marital rape. Thereby, one of the most commendable features of the draft bill is that it recognizes marital rape within the ambit of sexual assault under section 74.

N. Possible Misuse of Right to Residence

Further, the bill is replete with special provisions for women. Section 3 (4) of the bill in particular clearly states that the act attempts to eradicate discrimination and inequalities particularly those brought about by patriarchy. Another instance where special rights have been carved out for women is under section 70, which provides right to residence. Though primarily this right was provided in order to ensure that a HIV positive woman is not to left to fend for herself, it creates scope for possible misuse against the members of the shared household. The HIV positive person can invoke this provision of the law and force herself upon people who genuinely dislike her, regardless of the discrimination meted out to her on the basis of her health condition. Similarly, if a child has been ousted out of the paternal house for indulging in narcotic activities, the father of the aforementioned child will be forced to retake the child against his will, as per this law. Thus, rules need to be formulated in order to prevent such misuse. Alternatively, the law can provide for adequate shelter facilities for those inflicted with HIV/AIDS. This will also serve the dual purpose of ensuring that such persons are given adequate and timely medical care and attention.

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[67] Indian Penal Code, 1860, § 375. (Exception: Sexual intercourse by a man with his own wife, the wife not being under fifteen years of age, is not rape).

O. Domestic Violence and Partner Notification

As per the Bill, the privacy of the individual is sought to be protected as far as possible. This includes prevention of disclosure of the condition of the individual to the spouse of the patient by the health care provider.[68] The health care provider may inform the partner of a HIV positive spouse only if the health care provider bona-fide and reasonably believes that the partner is at a significant risk of transmission of HIV.[69] However, a proviso to the section provides that the health care provider shall not inform the partner, especially in case of women, if he harbours reasonable apprehension that such information will result in violence, abandonment or actions with a severe negative effect on the physical and mental safety of the HIV inflicted person, their children or someone close to them.[70]

This provision for partner notification must be read in conjugation with section 14 which imposes a duty to prevent transmission.[71] This section stipulates that every person who is HIV

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[68] Cl. 13, Bill, 2012, *supra* note 23. (A healthcare provider who is a physician or a counsellor may inform the partner of a person under their indirection care of such persons HIV-positive status only when:(a) the healthcare provider bona fide and reasonably believes that the partner is at significant risk of transmission of HIV from such person; and

(b) the HIV positive person has been counselled to inform such partner, and (c) the healthcare provider is satisfied that the HIV positive person will not inform such partner; and(d) the healthcare provider has informed the HIV positive person of the intention to disclose the HIV positive status to such partner; and(e) such disclosure to the partner is made in person and with appropriate counselling or referrals for counselling).

[69] Cl. 13, Bill, 2012, *supra* note 23.

[70] Cl. 13, Bill, 2012, *supra* note 23. (Exception: The healthcare provider shall not inform a partner, particularly in the case of women, where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental safety of the HIV positive person, their children or someone who is close to them).

[71] Cl. 14, Bill, 2012, *supra* note 23. (Every person who is HIV positive, is aware of such statues and has been counselled in accordance with this Act, or is aware of the nature of HIV and how it is transmitted, shall take all reasonable measures and

positive and is aware of such status and has prior knowledge of how HIV is transmitted should take all reasonable precautions to ensure that the virus doesn't spread.[72] This section too is accompanied with an exception that states that in case there is a reasonable apprehension of violence, the partner has no duty to prevent transmission.[73]

However, this appears to be inequitable as the rights of the healthy spouse are infringed upon at the cost of protecting the HIV patient. Just because there is a reasonable apprehension in the mind of the HIV positive patient, it doesn't entail non-disclosure of such dangerous information. Instead, an alternative solution ought to be obtained wherein neither parties' rights are compromised.

VI. Criminalisation and Mandatory testing

A. Criminalisation Of Transmission.

Section 14 of the Bill imposes a duty on a HIV/AIDS afflicted person to take reasonable care to prevent the transmission of the virus. Such duty includes precautions in the nature of contraceptives and informing the sexual partners of the same. In the opinion of the authors a mere duty with no penal consequences is not in consonance with the objectives of reduction in transmission laid down at the outset of the Bill. While nature of HIV/AIDS is not exactly susceptible to a Typhoid Mary[74] situation, there have been incidents relating to

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precautions to prevent the transmission of HIV to others which may include adopting strategies for the reduction of risk or informing in advance any sexual contact or person with whom needles are shared of that fact).

72 Cl. 14, Bill, 2012, *supra* note 23.

73 Cl. 14, Bill, 2012, *supra* note 23. (Exception: There shall be no duty to prevent transmission, particularly in the case of women, where there is a reasonable apprehension that the measures and precautions may result in violence, abandonment or actions which may have severe negative effect on the physical and mental health and safety of the HIV positive person, their children or someone who is close to them.).

74 *Typhoid Mary*, Encyclopaedia Britannica, http://www.britannica.com/EBchecked/topic/611790/Typhoid-http://www.britannica.com/EBchecked/

individuals with communicable diseases not taking adequate care to prevent transmission. Attention may be drawn to the Nawshaun Williams incident in New York in 1996 where a young African-American male knowingly infected 16 females which interestingly led to criminalisation of transmission in New York.[75] While it is of paramount importance that right of those affected should be protected, it should not be at the expense of the health and the right of the sexual partner tobe informed. It should also be noted that HIV/AIDS is asymptomatic for a long time after the initial infection and as such the onus should be on the person who knows that he/she is HIV positive to take adequate precautions.

In light of the above, the authors would propose that withholding of information of HIV/AIDS status from sexual partners, irrespective of precautions taken, should amount to an offence. The essential ingredients of such an offence would be knowledge of HIV status, non-disclosure of the same to the sexual partner and transmitting the virus intentionally or through reckless action. Knowingly infecting others is a crime in most countries such as United States, United Kingdom, Australia, Germany, Netherlands, and Finland among others and hence the dereliction of duty in Section 14 should attract penal consequences.

B. Mandatory Testing In High Risk Institutions

Section 75 of the Bill gives individuals who are in the 'care and custody' of the State a right to be protected against HIV/AIDS. It is in pursuance of the same that the authors propose mandatory testing and quarantine of infected individuals in certain high risk institutes which are run by the State such as prisons.

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topic/611790/Typhoid-Mary (last visited Aug.7, 2013). (Mary Mallon, the first asymptomatic carrier of the typhoid pathogen was responsible for the deaths of over 50 people and numerous typhoid outbreaks.).

[75]Richard Perez-Pena, *Two Births Lengthen List In One-Man H.I.V. Spree*, N.Y.Times,Jan. 29, 1998, http://www.nytimes.com/1998/01/29/nyregion/two-births-lengthen-list-in-one-man-hiv-spree.html?ref=nushawnjwilliams.

Quarantine generally can be justified when combating communicable diseases under two circumstances: A) when the disease is highly contagious B) when the disease is contagious for a short period of time (like swine flu/bird flu). Even though HIV/AIDS falls under neither category, the nature of the disease dictates that rights of those in the custody of the State be adequately protected. (This right is a constitutional right and is expressly recognised in Section 75 of the Bill)

Even then, institutions such as prisons are uniquely placed because conventional preventive measures would not be effective in such cases. High risk behaviour such as intravenous drug use and unprotected sex is difficult to control and regulate in prisons. As such, mandatory testing of the inmates at the time of entry and at periodic intervals is a must and the individuals diagnosed with the same must be segregated. Prison quarantine and testing have found wide acceptance in foreign jurisdictions. General involuntary quarantine is followed in Sweden, Finland, China, Cuba and Malaysia which is not economically feasible in our country and throws up difficult questions of privacy. Universal mandatory testing has been rejected by both the United States and the United Kingdom but both countries have accepted that it can be used for specific groups of people who are at high risk such in prisons and hospitals.[76]

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[76] *See generally La Rocca v. Dalshiem,* 120 Misc. 2d 697, 467 N.Y.S.2d 302 (N.Y. Sup. Ct. 1983); *See also Cordero v. Coughlin*, 607 F.Supp. 9, (S.D.N.Y.1984). (The US Supreme Court has held quarantine of prisoners to constitutionally valid in these two cases); *See also* The Public Health (Infectious Diseases) Regulations, 1988, available at http://www.legislation.gov.uk/uksi/1988/1546/contents/made (last visited Aug. 7, 2013)United Kingdom has provisions for mandatory testing of patients under 'exceptional circumstances' and if need arises for involuntary detention. This provision seems to have been framed for epidemic like situations and evidence suggests that till now, it has been used sparingly even in the absence of constitutional protection of individual rights. Prison quarantine has been upheld by the courts in cases).

VII. Suggested Changes

Firstly, the holistic and complementary changes in existing legislation with regards to the high risk groups must be made mandatory and not merely prescriptive. Clauses which cast a more direct obligation upon the legislature to amend existing laws into being complementary with the present Bill are required. Secondly, possible misuse of the right to residence must be pre-empted. Thirdly, the rights of the healthy spouse must be given adequate protection and to that effect the proviso allowing non-disclosure in anticipation of violence must be reframed. Fourthly, transmission of the AIDS virus or any action which increases the risk of transmission in any form should be made a criminal offence which includes but is not restricted to malpractices in blood banks and blood donation schemes, unprotected sexual intercourse with knowledge of being afflicted with HIV/AIDS. Fifthly, testing of new-borns and in high risk institutions such as hospitals, prisons and risk groups such as sex workers should be made mandatory. The aforesaid changes would go a long way in upholding the right of the general public to be protected from the disease and protecting the constitutionally ordained rights of the affected individuals