2. EXTRACTS FROM WRITINGS ON THE AIDS PREVENTION BILL 1989

M.P.S.Menon, The AIDS Prevention Bill, 1989,
13 D.L.R. 109(1991).

The Bill is the brain child of the Director General of the Indian Council of Medical Research and the Head of the Department of Medicine and Immunology, All India Institute of Medical Sciences, New Delhi. Significantly, the Director General, ICMR had come out with a drastic advice of introducing a Bill in the Parliament to prevent sex relationship between Indians and foreigners and to evolve a mechanism to observe and prevent such relationship. Needless to say that this mad idea died before it saw the light of the day. The present Bill does not contain any such provision. The estimated prevalence of HIV infection in India is low (one in 3500). 3950 zero positive individuals were detected in India from October, 1985 to October, 1990 (ICMR) out of which, 2539 were males and 1411 were females. Sexually promiscuous people were the majority of those infected . Intravenus drug users were the second highest group. The third biggest group consisted of the blood donors (660 during the same period). 482 foreigners tested positive in India. The total number of people tested during this period was 6 lakhs. Only high risk groups were included in this study. During this period, 57 AIDS patients were detected till October, 1990. Compared to the data available from the United States, Europe, Africa and other countries, the above figure is insignificant at present. In some of these countries, AIDS has become a very important cause of death, especially in women and children. The situation in India is different. Among the infectious diseases, tuberculosis, gastro-intestinal disorders such as dysentery and diarrhoea are the major killers in this country. The reported incidence of tuberculosis in India is 75 per hundred thousand and mortality rate 20 per hundred thousand. About 5,00,000 children die of diarrhial diseases every year. We have a very large population of infectious leprosy patients (4 million out of 60 million). There is no exact data relating to sexually transmitted diseases in this country such as syphilis, etc. Although the Government of India at different stages introduced various legislations and methods to control these diseases, they totally failed not only in eradicating but also in containing these diseases.

It is not intended here to minimise the possibility of future risk the population of India may have to face. Certainly, the Indian public should be made aware of the risk they face from exposure to this deadly disease and they should be educated to take all preventive methods. By introducing a law to arrest, isolate or keep people in asylum is not the right step in this direction. On the contrary, it may be counter-productive. We have the Lepers Act, 1898 which gives powers to the police and municipal authorities and citizens of India to arrest and incarcerate the hapless leprosy patients. This obselete legislation has only helped to make the suffering leprosy patients to go underground and lead a subterranean life (as envisaged by George Orwell in 1984) . It has also probably helped to perpetuate this disease. The introduction of the AIDS Prevention Bill permitting some authorities to arrest, isolate or quarantine the HIV positive non diseased and diseased Indians is bound to meet the same fate.

What is needed is to educate the public regarding AIDS and to help the sufferers medically, socially and economically so that they may lead useful life till their death and also help in preventing the further spread of the disease to others, instead of squandering the scarce resources of the country on wasteful expenditure such as seminars, conferences, setting up of apex bodies, etc. Most of the leprosy and tuberculosis centres at the village level in India do not have even the cheap essential drugs. They also do not have the required manpower to record the incidence of the diseases or educate the public about them.

Amita Dhanda, Compassion not Coercion, XVII (4)
Health for the Millions, 24 (August, 1991)

Legislation for modification of human behaviour has primarily relied on measures of exclusion backed by coercive sanctions. Some of the measures adopted by law to exclude the diseased from the healthy include notification of diseases requiring their compulsory reporting and the subsequent quarantine of the afflicted; restrictions on travel from affected to non affected areas; prohibition on frequenting of public places and segregation in institutions. These mesures have been used for diseases such as leprosy, small pox, plague, yellow fever and mental illness. A number of these mechanisms were introduced during periods when there was no cure for these diseases. Hence this resort to physical exclusion.

The success of these measures in preventive terms requires assessment but their stigmatising effect (especially for leprosy and mental illness) is well known. The effect of a stigma is such that even today when cures for these diseases have been found, people are unwilling to seek treatment for fear of discovery as a strong social resistance to the rehabilitation and integration of the cured continues.

Shalini D'Souza, Prostitution and AIDS,
Social Action, 405 (October-December, 1990)

The centre-piece of the Bill, as of the entire testing and AIDS prevention strategy, is the notion of "high-risk groups" - an epidemiological concept which has functioned to isolate and condemn patients, rather than to educate, protect and treat them.

There are no bio-medical or physiological factors which make some groups rather than others more prone to HIV infection.

For instance , the drug user who does not take drugs intravenously, or the intra venuous drug user who does ot share needles, are both wrongly assumed to be at greater risk than, let's say the non-drug user receiving an injection with unsterilised equipment at a local clinic.

Amita Dhanda, The AIDS Prevention Bill of 1989: An
Agenda for the Joint Select Committee, 33(1) JILI, 98 (1991).

The Bill operates on the premise that all persons who are HIV infected cannot be expected to behave responsibly hence the only option for purpose of prevention is to force them to modify their behaviour. The coercive policing preventive strategy could have been experimented with if the "high risk group" premise of the Bill could have resulted in the formulation of an adequate preventive strategy. As it stands it has been demonstrated that the protection accorded on the basis of "high risk groups" is most inadequate and incomplete. To modify "high risk behaviour" of all persons on the basis of a coercise policing regime will be impossible of implementation especially considering the private nature of the "high risk behaviour" . Further a coercive/policing policy will need continuous enforcement; it can never become self sustaining. The social and financial costs of such a policy for modifying high risk behaviour will be prohibitive.

The only policy choice remaining open to modify individual "high risk behaviour" is individual responsible behaviour. A coercive policy negates individual choice but it also abjures individual responsibility. A recognition of individual responsibility necessarily requires a respect for individual autonomy, dignity and privacy. Informed individual cooperation can be elicted through persuasion not coercion. A preventive strategy demanding individual responsible behaviour will necessarily have to depend upon facilitative and promotive legal measures.

Siddhartha Gautam, The AIDS Prevention Bill, 1989:
Protection or Prosecution, The Lawyers, 7 (October, 1989).

The Government has failed miserably in the one area where it could have most effectively controlled the transmission of the HIV virus - through contaminated blood and blood products and the use of unsterilised hypodermic needles. The Bill places the entire burden on the private citizen, threatening to prosecute blood donors if they know that they are infected and making it their responsibility to get tested every time they give blood [Sections 10(1) and 10(2)]. Hospitals, blood banks and large pharmaceutical companies manufacturing blood products are far better equipped to meet prescribed screening norms and rules and should be the ones held criminally responsible for failure to do so, rather than the poor professional donor who might be ignorant or illiterate. From the way in which these institutions are completely let off the hook by the proposed legislation, it would appear that what is at stake is not the survival of people with AIDS and those who might become infected, but rather the survival and protection of testing centers, high-salaried health bureaucrats, multinational companies manufacturing blood products, blood banks and government hospitals.

The AIDs Prevention Bill, 1989, No.54-55, Manushi, 56(1989)

The Bill does not provide any safeguards or guarantees to AIDS victims. It does not guarantee provision of medical care or drugs like AZT to those who cannot afford to pay for them. it does not propose to penalise employers who throw out AIDS infected employees or educational institutions who expel AIDS affected students or house owners who refuse to rent accommodation to AIDS victims. The inhumanity of the Bill is evident in its bypassing of all the questions related to the AIDS patient's survival and dignity.

The only real effects of the Bill are likely to be, first, an increase of powers wielded by the central government which, under section 12, is empowered to make all the specific rules for implementation of the Bill; and, second, a proliferation of bureaucracy, as indicated in the financial memorandum attached to the Bill, which proposes to spend a pitiful 255 lakhs on combating AIDS. Out of this 100 lakhs is to be spent on salaries of counsellors" and a meagre Rs.155 lakhs on health education, treatment and social support to AIDS victims.

We hope all those working in the field of health and all concerned citizens will campaign for the withdrawal of this ill informed and inhuman Bill.