THE AIDS PREVENTION BILL OF 1989 : AN AGENDA FOR THE JOINT SELECT COMMITTEE

I Introduction

THE AIDS Prevention Bill of 1989[1] (hereinafter referred to as the Bill) introduced in the *Rajya Sabha* on 18 August, 1989 has been referred to the Joint Select Parliamentary Committee.[2] The committee is expected to make suggestions for redrafting the Bill.[3] This reference to the Parliamentary Committee has provided an opportunity to consider whether the Bill constitutes the kind of legislative intervention required to tackle the problem of AIDs.

II Objectives of the Bill

The Bill through the medium of medical practitioners, designated health authorities and surveillance centres, aims to prevent the spread of Human Immunodeficiency Virus (HIV) infection by singling out persons and groups who are "high risk". These persons are to be compulsorily tested and if required isolated and segregated.[4] Also on the basis of information furnished by the infected person the sources from where the infection was acquired and where it has been transmitted are to be traced.[5] On the touchstone of the constitution and human-rights these provisions are highly suspect. However without entering the constitutional/human rights controversy the query that we need to answer is will the Bill in its present form be able to fulfil its objective of prevention?

III Assessment of preventive strategy of the Bill

Epidemiological studies have documented only three modes of HIV transmission : (1) sexual intercourse (hetero-sexual or homosexual) (2) contact with blood, blood products or donated organs and semen. The vast majority of contacts with blood involve transfusion of unscreened blood or the use of unsterlized syringes and needles by HIV drug users or in other settings (3) Perinatal transmission-mother to child, mostly before and perhaps during or shortly after birth.

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1. *Gazette of India (Extra)* 18-8-1989 Part II, S. 2 at 43.
2. *The Hindustan Times,* 11 February 1991 at 5.
3. *Ibid.*
4. The Aids Prevention Bill 1989, cls. 5 and 6.
5. *Id.*, cl. 9(2).

(1) Preventing sexual transmission of HIV infection

To block the sexual transmission route, clause 6 of the Bill without expressly stating so (possibly because brothels and red light areas are illegal entities) permits the health authority to subject prostitutes and their customers to compulsory testing and if found positive to isolation and segregation.

Promiscous non safe sexual behaviour makes an individual susceptible to HIV infection. Though prostitutes and people who frequent them are one category of persons who indulge in such behaviour; they are surely not the only ones who do so. Also whilst certain cities may have certain specified areas wherein prostitutes live and prostitution in an organized form is practised, making implementation of the program outlined in clause 6 possible, this is not true of all cities. Further even cities wherein such areas are in existence prostitution is not confined to those locales alone. Hence whilst clause 6 may impede one route of sexual transmission it far from prevents HIV infection through sexual transmission. It is under inclusive in its ambit and necessarily so as

> no public authority has the capacity to impose and enforce norms pertaining to sexual practices nor does any country have the resources even if it had willingness to police sexual lives of all its population.[6]

In the absence of responsible behaviour of the entire population coercive procedures intending to modify the behaviour of some individuals or groups is not going to prevent the spread of HIV infection. Yet the discriminatory and stigmatising treatment meted out to the singled out group would cause others to stay as far away from the detection authorities as possible.

(2) Prevention of infection from blood, blood products

To prevent infection by this mode the Bill enjoins professional blood donors who know they are infected not to donate their blood, semen or organ.[7] It also required them to get themselves tested for HIV infection before making a donation.[8]

The professional blood donor is the most vulnerable link in the blood supply chain. To lay down the duty of performance and forbearance on him without laying down any such duties on manufacturers of blood products, blood banks, hospitals and laboratories is not only discriminatory but is asking for behaviour modification from the person who has the least capacity and no incentive to undertake it.

The professional blood donor sells his blood as a means of livelihood. If he is caught he is segregated but if he is not he continues to make whatever

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6. K. Tomasevski, "AIDs and Human Rights" *World Health Organization* (1990) (mimeo).

7. *Supra* note 4, cl. 10(1).

8. *Id.*, cl. 10 (2).

money he can from his activities. As has been reported once the more reputed institutions cease to accept donations from him he will go to the less reputed and lesser paying ones.[9] The only chance of eliminating this donor is if the duty to ensure that blood is HIV free is laid on manufacturers of blood products blood banks hospitals and laboratories and these institutions are held liable for the breach of this duty.[10]

Unsterlized needles can be a means of transmitting HIV infection. The Bill does not lay down any duty on medical personnel to only use sterlized syringes. Nor does it lay down that as far as possible the user of disposable syringes should be encouraged.

Intra-venous drug users can be susceptible to HIV infection if they share needles. Clause 4 of the Bill requires medical practitioners to report to the designated health authority their knowledge of the existence of a drug addict. Now all drug addicts are not IV drug users and all IV drug users do not share needles;[11] the Bill in again focussing on the group rather than the behaviour has made a classification which being overinclusive cannot be rationally related to its objective of preventing HIV infection.

(3) Perinatal transmission

No express provision has been made in the Bill with regard to perinatal infections though the Bill requires surveillance centres to identify infected persons amongst the general public or selected groups of persons.

It had been stated earlier that the provisions of the Bill do infringe a number of human-rights. However this objection was kept in abeyance to determine whether the Bill whilst infringing human rights fulfils its public health motivations. Our examination demonstrates that the Bill fails to do so as instead of identifying and outlawing behaviour which could cause HIV infection it concentrates on identifying HIV infected persons. As high risk behaviour can be indulged in by persons other than high risk groups even the most successful outlawing of high risk groups will not prevent the spread of HIV infection.

IV An alternative preventive strategy

The Bill operates on the premise that all persons who are HIV infected cannot be expected to behave responsibly hence the only option for purposes 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

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9. See Bachi J. Karkaria "Aids You could be the Next Victim", *The Illustrated Weekly of India* 45 (7-1-1990).

10. For the necessity of holding these entities responsible, see, Shalini D'Souza "Prostitution and Aids" *Social Action* 405 (1990).

11. See on the over inclusiveness of the definition, Siddhartha Gautam "The Aids Prevention Bill, 1989: Protection or Prosecution?" *Lawyers Collective* 7 (Oct 1989).

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 coercive 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.[12]

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.

Studies in other countries have shown[13] that voluntary cooperation for HIV testing can only be achieved if the norm of confidentiality is respected and the HIV positive persons are not subjected to discriminatory and stigmatization measures.

These studies bring home the fact that for the purposes of preventing the spread of HIV infection and AIDs, recognition to human rights is not a concession rather human-rights based policy can be the only means of achieving public health objectives.[14]

The coercive/policing sanctions though inappropriate for modifying individual behaviour have immense potential for altering institutional behaviour *i.e.*, to compel blood manufacturers, blood banks, hospitals, laboratories to adopt practices which would clean up the blood supply.[15]

V Agenda before the Joint Select Committee

The Bill in consonance with a number of legislations adopted the world over is a knee-jerk reaction to the AIDs scare.[16] All these legislations followed the public health model adopted for infectious and communicable diseases. However, it was soon found out that coercive measures

12. See *supra* note 6.

13. H.F. Hull *et al* "Comparison of HIV Antibody Prevalence in Patients Consenting and Declining HIV-Antibody Testing in an Std Clinic", 260 (7) *JAMA* 935 (19-8-1988); E.J. Fordyce "Mandatory Reporting of Human Immunodeficiency Virus Testing Would Deter Blacks and Hispanics from being Tested" 262 (3) *JAMA* 349 (21-7-1989); "Mandatory HIV Reporting Testing Deterrent" *CDC AIDS Weekly* 8, 27-3-1989 and G Ohi *et al* "Notificatilon of HIV Carriers : Possible Effects on Uptake of AIDS Testing," *The Lancet* 947 (22-10-1988).

14. See, *supra* note 6.

15. See, appendix.

16. K. Tomasevski "Survey of National Aids Legislation" World Health Organization (July 1990) (Mimeo).

were counter productive in the realm of individual behaviour modification. Consequently a number of legislations providing for compulsory screening, notification, isolation and segregation were either amended or withdrawn.[17] Also as the linkage between anti-discriminatory practices and AIDs prevention came to be appreciated a number of statutes providing for informed consensual testing, full confidentiality and non discrimination came to be enacted.[18]

The Joint Select Committee has been enjoined to redraft the Bill. It is suggested that this redrafting should be substantive in nature[19] and the coercive policing measures adopted by the Bill should be replaced by promotive facilitative measures.

It is hoped that the committee will adopt an activist perspective and bring the Indian law in tune with international thinking and the World Health Organisation's (WHO) global programme on AIDs. As the AIDs scourge is a late entrant in our country, we are in the fortunate position of being able to benefit from the experience of others.

VI Suggestions for amendments

Clause 4 of the Bill could be a directive to medical practitioners to inform people with high risk behaviour of dangers of HIV infection and advice them to seek the confidential testing and treatment facilities made available by the designated health authority.

Clause 5: In the light of the amendments made in clause 4, it should be deleted.

Clause 6 should be modified to lay down that the designated health authority will provide facilities and make arrangements for persons wishing to undergo the test.

Clause 6(2) should be added laying down that the confidentiality of all persons undergoing the test shall be respected.

Clause 6(3) should lay down the sanctions for breach of confidentiality.

Clause 7 should be amended to read that the Designated Health Authority whilst respecting the confidentiality of the HIV positive or AIDs patient shall provide to them the services listed in clauses 7(a) to (e).

Clause 9(1) should be amended to read that every surveillance centre shall conduct clinical or laboratory tests or shall cause such tests to be conducted for the purposes of detecting, determining or monitoring the rate of HIV infection through unlinked sample testing.

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17. *Ibid.*
18. *Ibid.*
19. For suggestions on possible amendments to the Bill see, section VI *infra.*

Clause 9(2) should be replaced by a provision empowering surveillance centres to carry out unlinked testing of blood samples procured for other purposes.

Clause 10(1) should be amended to shift the responsibility of ensuring that blood is not HIV infected on the manufacturers of blood products, blood banks, hospitals and laboratories.

Clause 10(2) should lay down the sanctions against the abovementioned bodies for breach of their responsibility.

Clause 12(2)(a) should be deleted in view of the amendments suggested above.

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