

LAW, ETHICS AND HIV/AIDS IN SOUTH ASIA

A study of the legal and social environment of the
epidemic in Bangladesh, India, Nepal and Sri Lanka



United Nations Development Programme

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The research upon which this report is based was undertaken by The Institute of Law and Ethics in Medicine (TILEM), National Law School of India, Bangalore, India; Action Research Study on the Institutional Development of Human Rights in Bangladesh (IDHRB), Ministry of Law, Justice and Parliamentary Affairs and UNDP Bangladesh Country Office Joint Project, Dhaka, Bangladesh; Centre for Policy Alternatives (CPA), Colombo, Sri Lanka; and Forum for Women, Law and Development (FWLD), Kathmandu, Nepal, under the overall coordination and guidance of the UNDP Regional HIV and Development Programme for South and Southwest Asia.

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Foreword

We know that in South Asia the HIV epidemic is spreading within an environment of stigma, discrimination and denial. People living with HIV/AIDS (PLWHA) face serious rights violations. Many are tested without consent and their confidentiality is often breached, leading to harassment and rejection by families and communities. HIV positive people have lost their livelihoods and homes and some have been subjected to violent attacks. Children have been prevented from attending school and many PLWHA have been denied access to basic and life saving medical care.

The rights violations against PLWHA and vulnerable groups are part of a broader environment of social and gender inequality, marginalisation and discrimination in South Asia, which is providing perfect conditions for the epidemic to spread. For example, the vast majority of South Asian women remain economically and socially dependent on men, with limited power to make decisions over their own lives or to protect themselves from HIV. Likewise, vulnerable groups, such as sex workers, Men who have Sex with Men (MSM) or Injecting Drug Users (IDU), are often stigmatised, rejected by families and communities, and harassed by law enforcement authorities, making them less able to access the support and information needed to protect themselves and others.

Moreover, in South Asia there are currently over 200 million¹ people on the move in search of livelihoods. Many of these migrants move with little

information and end up living in hostile and lonely environments, without access to support systems and separated from their families. In such circumstances, their vulnerability to HIV is greatly increased. There are also many girls and women whose journey in search of greater livelihood options ends in trafficking for commercial sexual exploitation, making them vulnerable to both severe human rights abuses and HIV.

Recognising these complex factors that fuel the epidemic, what is required in South Asia is a comprehensive - and above all rights based-response. A response that seeks to build an environment where the rights of all members of society, especially the most vulnerable, are protected; where social space is created to talk openly about HIV and related issues; and where PLWHA and vulnerable groups are empowered to play a central role in responses.

Creating such an enabling environment involves action at legislative, policy and community level. Policies and laws are needed to empower marginalised groups and create a supportive framework for action, as well as to provide protection against discrimination. Policy makers in each sector must examine how best to protect the rights of PLWHA and vulnerable groups, addressing their diverse needs - as employees, family members, service users and residents. However, good laws and policies alone are not enough, as for people to realise their rights there must also be a supportive social and ethical environment. This means challenging the attitudes, norms and practices that disempower people and increase their vulnerability to HIV.

This study on which this report is based was

1 UNDP, 2002

commissioned to help enhance our understanding of the deep-rooted relationship between law, rights, the social and ethical environment, and HIV/AIDS vulnerability here in South Asia, as well as to provide actionable recommendations for legislative and policy reform. The findings have revealed a regional situation where significant human rights provisions exist, both in national constitutions and in ratified international conventions, but where there remains a serious disconnect between these provisions and people's experience at community level.

The findings of this study clearly demonstrate that both rights based policies and a shift in social

values and attitudes are urgently needed if we are to effectively address the epidemic in South Asia. With the development of new legislation and ground-breaking new rulings, as well as increasingly strong and vocal PLWHA and community groups, we are moving in the right direction. We hope that this report can serve as a tool for policy makers on this journey.



Dr. Maxine Olson
*UNDP Resident Representative &
UN Resident Coordinator*

Introduction

In the complex socio-economic context of South Asia, the challenges of developing effective national responses to HIV/AIDS are immense. Global experience of the epidemic, over the last two decades, has demonstrated that many elements contribute to an effective national response. Central among these is an appropriate legal framework that supports the rights and needs of all those affected by the epidemic, and provides a policy environment in which measures to prevent the spread of HIV can have maximum effect. Experience has also shown that inappropriate laws and legal practices can unintentionally increase HIV infection risks, particularly among vulnerable and legally marginalised populations.

In most countries - including much of South Asia - the initial response to HIV/AIDS has occurred within a legal framework of public health laws aimed at dealing with highly infectious diseases, such as typhoid and tuberculosis. These laws typically contain a range of provisions requiring compulsory testing and quarantine, disease notification to authorities, and restrictions on the movement of infected people. The rationale behind such laws is that coercive measures against infected people are the best way of preventing the spread of infectious disease, and that the individual rights of those infected are of lesser importance.

However, there has been an increasing realization that HIV is different from the diseases previously targeted by public health laws, and that a legal framework focused on identifying and controlling the behavior of infected individuals will not work. Unlike most other infectious diseases, HIV is

spread primarily through behavior that occurs in private and is not easily controlled by coercive means. Reducing its spread requires behavior change by both the infected and the uninfected. Such change cannot occur without a fundamental shift in the norms, values and attitudes that shape individual and collective behavior, enabling communities to openly address taboo issues around sexuality, gender, social inequality and HIV/AIDS. A response that involves using coercive measures against a few has not been found to deter others from unsafe behavior, but in fact creates an environment in which those vulnerable to HIV are discouraged from acknowledging their risk, avoid testing, and do not access available health care, information and counseling services.

The other important lesson from the first two decades of the epidemic has been that many of the major factors influencing the spread of HIV go far beyond the behaviour of individuals, and relate to structural factors within society that pose barriers to effective HIV care and prevention. For example, it is now widely accepted that the most pressing and important priorities for an effective national response to the HIV epidemic include; overcoming obstacles, such as illiteracy and homelessness, to the effective dissemination of information about HIV; assisting vulnerable groups, such as women, sex workers and those living in poverty, to protect themselves from HIV infection; providing affordable access to condoms and HIV therapies to everyone regardless of socioeconomic status; and overcoming stigma and discrimination towards PLWHA, in order to enable effective HIV/AIDS care and prevention work.

It is for this reason that the human rights dimensions of the HIV/AIDS epidemic have come to be emphasized in national and international responses. It is increasingly recognized that HIV/AIDS poses great challenges to the protection and fulfillment of human rights, impacting people's civil and political rights, as well as their economic, social and cultural rights. HIV/AIDS is the root of many violations, and marginalized groups are most vulnerable to infection. Therefore, recognition and protection of the rights and needs of PLWHA and vulnerable groups are essential to the creation of an "enabling environment" - an environment that supports initiatives to contain the spread of HIV/AIDS and address its impact on individuals and communities. In this regard, human rights protection can be seen as a critically important public health measure. However for rights to be meaningful and accessible at community level there must also be a transformation within the social and normative environment. This means developing a comprehensive response to HIV/AIDS that includes medical and public health interventions, strong human rights based legislation and policy and social transformation within communities and institutions.

The international community has embraced this approach to HIV/AIDS policy by recognising the importance of strong protection for the rights of PLWHA and the urgent need to address the social and economic vulnerabilities of marginalised groups. The *Declaration of Commitment on HIV/AIDS*, passed by the United Nations General Assembly Special Session (UNGASS) 25 - 27 June, 2001, noted that "some negative ... legal factors were hampering awareness, education, prevention, care, treatment and support efforts." The Declaration called on all countries to "enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups." The *Declaration of Commitment* also stressed the importance of respecting privacy and confidentiality, and highlighted the need to develop strategies to combat the stigma and social exclusion associated with HIV/AIDS. Noting the urgency of the epidemic, the Declaration

called on countries to initiate suggested reforms by no later than 2003.

In the context of the *Declaration of Commitment* and the need to create a supportive policy environment, many countries have considered how the law and legislative reform can contribute to an effective national response to the epidemic. Moving away from relying on the punitive function of the law, there has been an increasing focus on exploring how the law can be used constructively to reinforce other policy initiatives. For example, it has been recognised that legal protection against discrimination on the grounds of HIV status, sexuality or gender can create a more open environment for raising awareness, as well as assist vulnerable groups in dealing with the impact of HIV/AIDS. It has also been acknowledged that laws stipulating that HIV testing should take place only with free and informed consent, and that a person's HIV status should be kept confidential, are of central importance in encouraging individuals to undergo voluntary HIV counselling and testing. In addition, there has been concern to ensure that laws criminalising activities such as drug use and sex work do not impede harm reduction strategies to protect drug users and sex workers from HIV infection, or measures to provide the necessary treatment and care for those who are infected.

The studies that form the basis of this report have demonstrated that much remains to be done in this regard in South Asia. Far from having an "enabling environment" for the response to HIV/AIDS, there is still widespread ignorance across the region about the epidemic. Moreover the limited development within South Asia - with large pools of poverty, serious social and gender inequities, conflict and population displacement - heightens the region's vulnerability to the spread of HIV. Indeed, in South Asia, as elsewhere in the world, the HIV epidemic is bringing to the forefront the development gaps within societies, and is providing an urgent incentive for those gaps to be addressed.



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The Study

The Study

RATIONALE

Recognising the complex social, economic, legal and policy challenges posed by the HIV/AIDS epidemic in South Asia; the limited understanding of the legal and ethical environment of the epidemic in the region; and the lack of a systematic legal and policy framework to support a rights based response, in 2000, UNDP, together with its partners, launched a study across four South Asian countries.

The aims of this study were:

- To understand the practical impact of the HIV/AIDS epidemic on the lives of those affected, including the level of discrimination experienced and the extent to which the law or law enforcement practices are relevant.
- To identify factors shaping HIV vulnerabilities within the region, with a particular focus on attitudes and values relevant to sexuality and gender.
- To map existing laws, judicial decisions and law enforcement practices relevant to PLWHA or to the spread and impact of the epidemic, particularly among vulnerable groups.
- To identify priorities for law or legal policy reform in the South Asian region.

Civil society research organisations in Bangladesh, India, Nepal and Sri Lanka worked in collaboration on the study, with each partner undertaking research and analysis on the situation in their respective countries. The research was

coordinated by the lead partner in India, which provided ongoing capacity building and technical support to the other partner organisations throughout the research process. UNDP led and guided the study.

The partners involved in this study were:

- UNDP Regional Programme for HIV and Development, South and North East Asia, Delhi, India
- The Institute of Law and Ethics in Medicine (TILEM), National Law School of India, Bangalore, India
- Action Research Study on the Institutional Development of Human Rights in Bangladesh, Ministry of Law, Justice and Parliamentary Affairs and UNDP Bangladesh Country Office Joint Project, Dhaka, Bangladesh
- Centre for Policy Alternatives, Colombo, Sri Lanka
- Forum for Women, Law and Development, Kathmandu, Nepal

In 2001, a similar study was commissioned by UNDP in China². Although this used somewhat different methodology to the South Asia study, it also explored the legal and ethical environment of the epidemic, examining laws, policies and community level experiences. Some select findings from the study in China are presented in this report, in order to generate comparisons with the situation in South Asia.

This report summarises the findings of the

² "Law, Policies and Regulations concerning HIV/AIDS Prevention and Containment: an Assessment and Recommendations", UNDP, August 2003

studies undertaken in Bangladesh, India, Nepal and Sri Lanka, as well as some of the key points from the research in China, and highlights the main policy issues to emerge. It is evident that, while the legal frameworks differ markedly between the countries studied, common themes can be identified. For example, in relation to the lack of legal protection for PLWHA, or the need for laws that reflect a true understanding of effective public health approaches to the epidemic. The findings of these studies therefore offer important insights that can assist policy makers in the region to respond effectively to the challenges HIV/AIDS has thrown up.

METHODOLOGY

The research design involved three distinct elements, intended to illuminate the current situation for those working with or impacted by the epidemic, to examine practices and attitudes relating to gender and sexuality and their impact on HIV vulnerability, and to map all relevant laws and policies with potential to impact the epidemic

1. Legal Mapping

In order to understand the legal and policy environment in which the epidemic is spreading and in which responses to the epidemic are formulated and implemented, mappings were undertaken in each country of relevant legislation, case law and legal policy. This included laws and policies that relate directly to HIV, as well as those that more indirectly affect the spread of the epidemic, the responses to it, and the rights of PLWHA and other vulnerable and marginalised groups. For example in areas such as public health, privacy, anti-discrimination, employment, inheritance, family law and others. The mapping was intended to illuminate both strengths and gaps in the existing legal framework and thereby identify priorities for legal reform.

2. Stakeholder Consultations

The first element of the research was comprehensive stakeholder consultations. These were designed to gain an insight into the experiences, practices and attitudes of those constituencies in each country that are most immediately affected by

the HIV/AIDS epidemic, or that are involved in responses. The aim of these consultations was to provide an understanding of the values that shape the response to the epidemic, and of the realities of people's experiences in relation to HIV/AIDS - the social environment within which law and policy are implemented. Such an understanding allows for analysis of the relationship between the legal and policy framework and realities and practices on the ground.

Consultations were held with the following groups:

India: PLWHA, sex workers, doctors, nurses, hospital administrators, media, NGOs, policy makers (including judges), police, prison officials, trade unions, sexual minorities, activists on women's and children's issues, and students.

Bangladesh: Doctors, sex workers (female and male), MSM, hijras³, lawyers, judges, policy makers, government officials and NGOs.

Sri Lanka: Sex workers, doctors, health administrators, NGOs, officials in the justice and labour ministries.

Nepal: PLWHA, IDU, trafficking survivors, NGOs, media, and health professionals.

The consultations took a range of different forms, including interviews, dialogues and open discussions. They were structured to focus on the following areas:

- HIV/AIDS and its impact
- Discrimination and social issues related to the epidemic
- Legal, ethical and human rights concerns relating to HIV/AIDS
- The concerns of the stakeholders
- Suggestions for appropriate policy responses to HIV/AIDS.

3. Empirical Studies on Sexuality and HIV Vulnerability

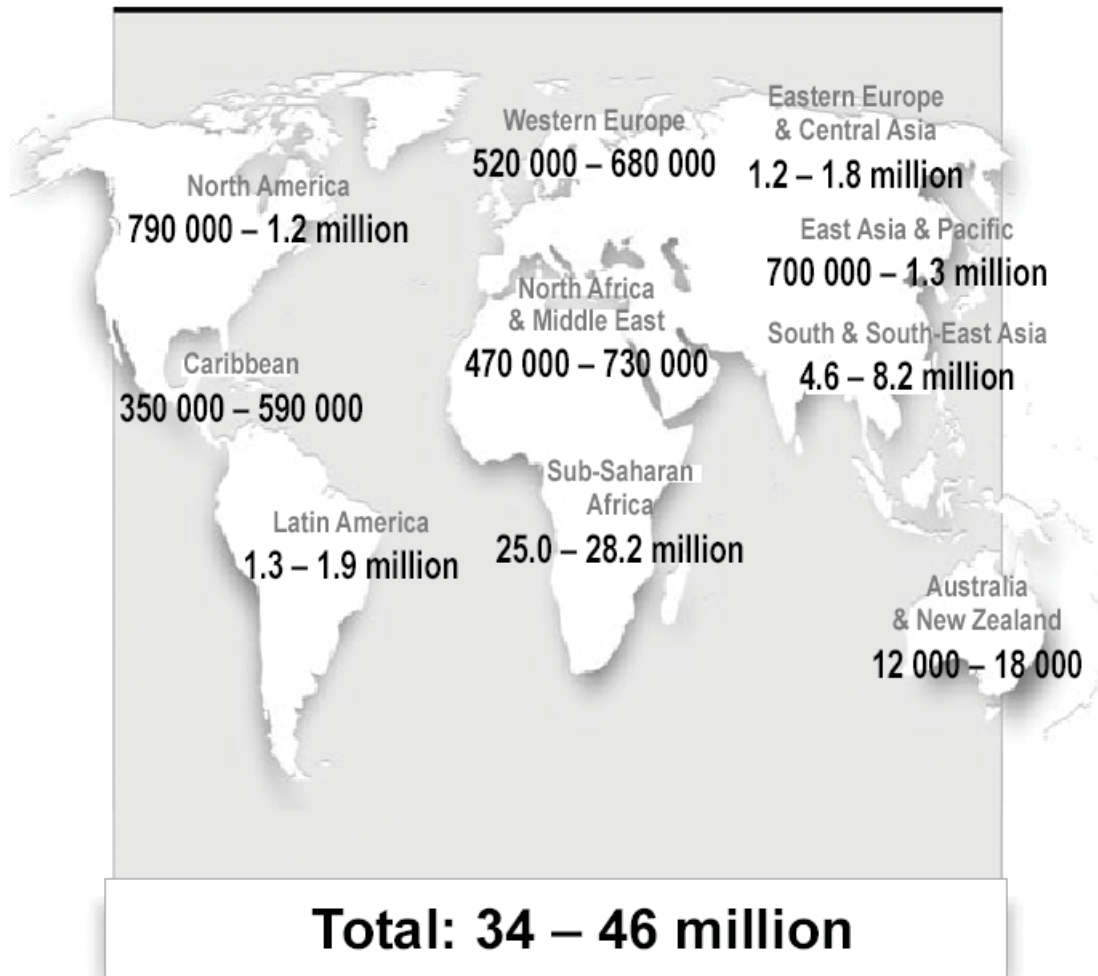
Empirical studies on sexuality and vulnerability to HIV/AIDS were undertaken in three countries: Bangladesh, Nepal and Sri Lanka. These studies used a range of methodologies, including questionnaires and surveys, to explore sexual values

³ A Hijra is defined within the South Asian culture as neither man nor woman. The word Hijra means hermaphrodite in Urdu but biologically the group consists of men and eunuchs. Hermaphrodites are today a minority within the community.

and practices and related HIV vulnerabilities of sample groups. Although the sample groups for these studies were relatively small, the findings were intended to complement the stakeholders' consultations by providing an insight into the normative environment - specifically, the prevailing

values in relation to sexuality and gender relations - within which the epidemic is spreading. An analysis of the empirical studies reveals close parallels with the concerns raised in many of the stakeholder consultations, particularly in relation to women's vulnerabilities.

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV/AIDS, END 2003



Source: UNAIDS, 2003

*The Findings:
Law And Legal
Policy*

The Findings: Law And Legal Policy

Existing legislation, case law and legal policy within South Asia are the key ingredients that shape the legal and policy environment in which the epidemic is spreading. These include laws and principles that relate directly to HIV, as well as those that affect the spread of the epidemic, the responses to it, and the rights of PLWHA and other vulnerable and marginalised populations.

It appears that very little legislation in the South Asian region refers specifically to HIV or AIDS. Even in the case of public health legislation, where one might have expected it to be amended to include HIV, this has not occurred. As a result, there is a great deal of legislation which pre-dates the HIV epidemic, but which now affects the legal rights of PLWHA, often with anomalous and undesirable consequences. There is also a vast array of penal provisions relating to sex between men, injecting drug use and sex work, which have an immediate and harmful impact on the spread of HIV, the efforts to contain it, and the rights of those affected.

HUMAN RIGHTS AND CONSTITUTIONAL PROTECTION

All four countries - India, Bangladesh, Nepal and Sri Lanka - have a written Constitution that recognizes a range of fundamental rights. These rights are potentially quite broad in their application to many of the issues that arise in the context of the HIV epidemic, but to date, these constitutional rights have very rarely been used to provide actual protection for those affected by HIV.

In India, the Constitution recognises the right of

all individuals to life, liberty, equality before the law and equal protection of the law. There is also constitutional protection of freedom of speech, freedom of movement, freedom of assembly, and freedom to settle in any part of the country. Not all these protections are absolute; some are subject to reasonable restrictions in particular circumstances.

In contrast with the other countries studied, the Indian Supreme Court has been active in interpreting and elaborating upon the rights laid down in the Constitution, often in the context of "public interest" test cases brought before it. Thus, constitutional rights have been interpreted to include, for example, a right to privacy, a right to health and medical assistance, a right to education, a right to life with dignity, a right to information and a right to protection from sexual harassment.

It is evident that the judicial recognition of this body of rights could be highly relevant to issues that arise in relation to the HIV epidemic. However, the experience with attempting to invoke constitutional rights in support of PLWHA in India has been mixed. In the decision of *Lucy D'Souza v. State of Goa* (AIR 1990 Bombay 355) for example, a challenge was mounted against a provision in the *Goa, Daman and Diu Public Health Act* of 1985 that permitted state authorities to isolate and detain a person with HIV indefinitely. The Bombay High Court held that although this was an infringement of an individual's right to liberty, that right had to give way to the public interest in such situations. Similarly, in *Vijaya v. Chairman and Managing Director, Singareni Collieries Ltd* (AIR 2001 A.P. 502), it was held that subjecting an individual to

compulsory HIV testing was not unconstitutional, even though it infringed the individual's right to privacy, because the State also had an obligation under the Constitution to take steps to improve public health.

In Bangladesh, the Constitution recognises the right to life, the right to privacy, the right to marry and the right to earn a livelihood. A separate equality clause prohibits unreasonable discrimination. The Nepalese Constitution guarantees a range of rights, including the right to personal liberty, the right to equality before the law and equal protection of the law, the right to information and the right to privacy. In both countries, the Constitution imposes some positive obligations on the government. In Nepal, the State is required under the Constitution to pursue policies to promote the interests of economically and socially disadvantaged groups. In Bangladesh, there is an obligation for the State to take effective measures to provide free education and to prevent sex work. However, it has been argued that the latter provision may be counter-productive in the context of the HIV epidemic, because it could be used to justify police crackdowns on sex workers.

In Sri Lanka, the Constitution also guarantees a range of rights. This includes an anti discrimination paragraph in article 12, "No citizen shall be discriminated against on the grounds of race, religion, language, caste, sex, political opinion, birth or any one of such grounds." However, since there is no right of judicial review of legislation passed by Parliament, the enforcement of these rights in practice is limited.

India is the only country to have passed legislation dealing specifically with disability discrimination, namely the *Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act*. However, "disability" is defined narrowly to cover only blindness, low vision, leprosy, hearing impairment, locomotor disability, mental retardation and mental illness, with the result that the legislation offers no protection to PLWHA.

In addition to constitutional human rights protection, all four countries have ratified the key international human rights conventions, including

the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW). Recent judgments of the Supreme Court of India have established that in the absence of specific legislation, the international treaties to which India is a signatory have the force of law. This offers a further avenue for protection of individual rights in the context of the HIV epidemic.

It would therefore seem that the legislative framework for effective human rights protection in the South Asian region is largely in place, to the extent that there is constitutional recognition of a wide range of individual rights and an acceptance of international treaty obligations. However, the existing constitutional rights have rarely been translated into legal protection on the ground. With the exception of India, there has been little judicial interpretation of existing constitutional rights, which would assist in giving them practical meaning and effect. The cost, delay and uncertainty associated with litigation are undoubtedly factors that further restrict access to justice in reality. As a result, there is clearly discordance between the human rights protection that exists in theory and the actual experience of individuals who suffer human rights abuses in the South Asian region.

PUBLIC HEALTH

All four countries have laws relating to public health, most of which pre-date the HIV epidemic (e.g. *Epidemic Diseases Act, 1897* (India), *Contagious Diseases Act, 1946* and *Quarantine and Prevention of Diseases Act, 1952* (Sri Lanka) and *Infectious Diseases Act, 1963* (Nepal)). They generally follow the model of listing a number of specified "infectious diseases", giving public health authorities a wide range of powers that can be used against people suffering from any of those diseases. Typically, these powers include mandatory case reporting, the right to compel testing and treatment, the isolation of infected individuals, and the right to enter and search premises.

Implicit in public health laws of this kind is the

assumption that in the case of infectious diseases, the rights of infected individuals must give way to the overriding interest of protecting public health. However, the diseases covered by this legislation are generally more contagious ones, such as cholera and tuberculosis. There is no existing model in South Asia for public health legislation that is targeted to the specific concerns associated with the HIV epidemic, which raises fundamentally different public health issues from other more readily transmissible and curable diseases.

This is perhaps reflected in the fact that in South Asia to date, the public health legislation described above has generally not been extended to cover HIV/AIDS. As a result, there is very little public health legislation that is applicable to the epidemic. However, there remains a concern that the existing legislation could very easily be amended in order to bring HIV/AIDS within its scope, giving public health authorities a wide range of punitive powers that could be used against PLWHA or those suspected to have HIV. In some cases that could occur simply by ministerial decree, without the need for any parliamentary debate.

Some of the countries studied also have other legislation that imposes restrictions on people suffering from specified "infectious diseases". For example, the Sri Lankan *Suburban Dairies and Laundries Act, 1952* prohibits people with an "infectious disease" from working in a dairy or a laundry. As with the public health legislation, the punitive effect of this legislation could be invoked against PLWHA merely by adding HIV infection to the list of applicable diseases.

ACCESS TO HEALTH CARE

Despite constitutional protection of the right to life and health, access to health care remains severely restricted in the South Asian region. This is another area where constitutional theory has not been translated into practice. The provision of health care is largely unregulated by legislation, and there are countless examples of PLWHA being denied treatment because of their status.

The Indian Supreme Court has held that failure on the part of a government to provide timely med-

ical treatment to a patient in need of such treatment amounts to a violation of the right to life (*Paschim Bengal Khet Mazdoor Society v. State of West Bengal*, AIR 1996 SC 2426). However, where a particular hospital was sued for charging exorbitantly and requiring patients to purchase imported medicines from private individuals, the court refused to intervene (*Subash Chandran v. State of AP*, AIR 2000 AP 272).

The affordability of medical care is assuming critical importance for PLWHA in the South Asian region who require anti-retroviral therapy. The existing law provides little or no direction on this question.

PRIVACY AND CONFIDENTIALITY

In the context of the HIV epidemic, effective confidentiality protection for HIV positive people is of central importance. In many cases, it is an essential first step in achieving an open acknowledgment of the risk of infection, encouraging voluntary testing and counselling, and reducing the discrimination experienced by PLWHA.

In Bangladesh and Nepal, the right to privacy is constitutionally guaranteed. In India, it has been derived from judicial interpretation of other constitutional rights. The extent to which the courts will be prepared to uphold the right to privacy of an HIV positive person has not been fully tested in any of the countries. However, as noted above, there has been a tendency in other test cases involving HIV and constitutional rights for the courts to permit significant encroachments on individual rights based on perceived public health considerations.

In India, Bangladesh and Sri Lanka, there are legal provisions that protect confidentiality in certain specific relationships (e.g. lawyer and client, husband and wife). All other relationships, including that between a doctor and patient, are governed by common law. In the absence of a specific provision that protects confidentiality in such circumstances, the existence of that right is open to interpretation.

In 1999, the Supreme Court of India addressed this issue in a case where a hospital had disclosed a patient's HIV status to his fiancée's family. The

patient challenged the hospital's action on the ground that the breach of confidentiality had irreparably damaged his right to marry, and sued for damages. The court at first instance held that HIV positive people did not have an absolute right to marry. Subsequently, the Supreme Court upheld the right to marry (*Mr. X v. Hospital Z*, 2002 SCCL.COM 701), but dismissed the claim arising from the breach of confidentiality (*Mr. X v. Hospital Z*, AIR 1999 SC PG 495).

The right to privacy and confidentiality is closely linked to the other contentious issue of compulsory HIV testing. Unlike other common law countries, such as the United States, Great Britain and Australia, where patient consent is required for any medical test or procedure, no such legal principle is recognised in South Asia. Accordingly, any challenge to compulsory HIV testing would probably need to rely upon an extension of the constitutional right to privacy.

In Nepal, the Supreme Court has been prepared to overturn an order made by a lower court for a woman to undergo testing to determine her virginity, on the basis that this was a particularly sensitive issue affecting the public image of the woman, and therefore infringed her right to privacy (*Annapurna Rana v. Kathmandu District Court*, writ no. 2187 of 2053). However, in India, in the decision of *Vijaya v. Singareni Collieries Ltd* (cited in more detail above), the court found that compulsory HIV testing could be justified where it was necessary for public health purposes. This demonstrates the limits of the constitutional right to privacy. In the absence of a clear judicial precedent, it

would seem that the existing legal protection against compulsory HIV testing is, at best, tenuous.

EMPLOYMENT

The Constitutions of India, Bangladesh and Nepal contain general prohibitions against discrimination in employment, but the precise circumstances in which such discrimination will be unlawful have not been clearly defined. As with other constitutional rights, perceived public health concerns could be relied upon to seek to justify discrimination against PLWHA in the workplace.

In some of the countries, there is legislation that permits a person's employment to be terminated if he or she is found to be suffering from an infectious disease or some other medical condition. (See, for example, the *Factories Act No. 12, 1976* (Sri Lanka) and the *Civil Service Act* (Nepal)).

In India, the question of whether an employer can lawfully terminate the employment of a person with HIV was considered by the Bombay High Court in *MX of Bombay, Indian inhabitant vs. M/s ZY* (AIR 1997 Bombay 406). The worker's services had been terminated by an insurance company when it was found that he had HIV. The company argued that his medical condition had led to a problem in the workplace, because other workers had refused to work with him. Ruling in favour of the worker, the court held where a worker has a contagious disease that could be transmitted by the normal activities of the workplace, his or her employment could reasonably be terminated. However, because the worker in this case was still

Bombay court upholds employment rights of PLWHA

On 16 January 2004, the Bombay High Court pronounced two judgements ordering public sector companies to employ HIV positive workers. In *X v State Bank of India*, a worker was denied employment on grounds of his HIV positive status, despite medical experts declaring him to be asymptomatic and fit to perform the job. The Court directed the respondent bank to employ the petitioner on first available vacancy and observed that "*Protection and dignity of the HIV infected persons is essential to the prevention and control of HIV/AIDS. Workers with HIV related illness should be treated the same as any other worker with an illness.*"

Source: Lawyers Collective, India

able to perform his normal job functions and did not pose any risk to fellow employees, it would be "arbitrary and unreasonable" to terminate his employment, and in breach of the equality clause in the Indian Constitution.

This judgment is an important one in establishing the right of people with HIV to continue to work without discrimination. It demonstrates the importance of having judges who are well-informed about HIV and understand its limited modes of transmission. The fact that the problem in this case arose because of the fears and prejudices of other employees also demonstrates the importance of maintaining confidentiality in relation to a person's HIV status, particularly in a confined environment, such as the workplace.

GENDER DISCRIMINATION AND FAMILY LAW

Despite the fact that all four countries have ratified the Convention for the Elimination of all forms of Discrimination against Women (CEDAW), there are still many legislative provisions throughout the region that discriminate against women. Since many of these relate to sexual relationships and family law, they reinforce the subordinate status of women within their families and communities, which in turn, intensifies women's vulnerability in the face of the HIV epidemic.

Many family laws within South Asia reflect deep-rooted cultural values related to the role of women and their inferior status within the community. The girl child is often considered to be a burden, is married at an early age and has little control over her own sexuality. In India, a married woman who has an extra-marital relationship can be found criminally liable for adultery, but there is no corresponding criminal offence for a married man. Divorce laws also discriminate against women. In Nepal, for example, a woman's extra-marital affair is ground for divorce, but not that of a man. Similarly, a woman suffering from an infectious venereal disease can be divorced by her husband but not vice versa. Married women generally have no legal protection against domestic violence, since marital rape is not recognised as a

Marital Rape Interpreted as a Crime

Interpreting marital rape as a crime, the Supreme Court of Nepal held that, ".....If an act is an offence by its very nature, it is unreasonable to say that it is not an offence merely because of difference in person committing the act. It will yield discriminatory results, if we interpret that an act committed to any other woman is an offence and is not an offence, if the same act is committed to one's own wife. There is no justification in differentiating between the women who are wives and other women. Such discriminatory practice is against the provisions of the Convention on the Elimination of All Forms of Discrimination against Women and letters and spirit of Articles 11(1), (2) and (3) of the Constitution of the Kingdom of Nepal. No law can be interpreted against provisions of the Constitution and treaties and international instruments to which Nepal is a party. Therefore, to exempt an offence of rape committed to one's wife by the husband is against recognised principles of justice....."

Source: Meera Dhungana for Forum for Women, Law and Development vs. HMG/Nepal, Supreme Court Bulletin, 2059 (2002), Vol. 5, p.13.

criminal offence anywhere in the region. However, a ground breaking judgment recently concluded that marital rape is in conflict with the international conventions signed by Nepal.

Women with HIV in South Asia often carry the blame for having infected their husbands and risk abandonment. Many inheritance laws also discriminate against women, in some cases by denying women any inheritance rights at all. For a woman, who may herself be sick as a result of her HIV infection, such laws can have devastating consequences.

The Committee for the Elimination of all forms of Discrimination against Women, which oversees the implementation of CEDAW, has issued specific

guidance on HIV/AIDS and the actions that countries should take in order to give effect to the principles underpinning CEDAW in their response to the HIV epidemic. For instance, States are required to take steps to:

- avoid stigmatising women as "vectors of disease," regardless of the source of infection
- avoid placing the blame for HIV transmission and other sexually transmitted diseases on female sex workers
- support women's efforts to get their partners to use condoms
- empower women to enable them to make their own sexual choices

There is little evidence in South Asia of effective measures to address these concerns. Some hope has arisen in Nepal with the eleventh amendment to the Country Code eliminating various discriminatory legal provisions against women and securing women's property rights, right to abortion, rights in marriage, divorce and adoption and increasing punishment for sexual offences against women. However, with discrimination against women firmly entrenched in cultural norms as well as legislation throughout the region, it is clear that significant legal reform is required in order to achieve even minimal compliance with human rights obligations under international law.

POLICE POWERS AND PUBLIC SECURITY

The enforcement of penal provisions related to sex between men, drug use and sex work, as well as other criminal law provisions that could be used to punish actual or suspected HIV transmission, puts the police at the forefront of much of the legal response to the HIV epidemic in the region. A consistent theme is a concern about police harassment of PLWHA and vulnerable populations, such as sex workers. The extent to which the exercise of police powers is restrained by law, therefore, becomes highly relevant to the protection of individual rights in the context of the epidemic.

In some of the countries of the region, there is constitutional protection that extends, either explicitly or by judicial interpretation, to protection

against arbitrary detention. However, these constitutional rights are not reflected in actual procedural safeguards to restrain abuse of power by police. Under the Bangladesh *Criminal Procedure Code*, for example, police have the power to arrest and detain any person on mere suspicion of having committed an offence. The arbitrary exercise of authority by police was severely criticised by the Bangladesh Supreme Court in *Blast v. Bangladesh* (4 BCL 600). The court recommended that a code of conduct be drawn up for law enforcement agencies to emphasise their role in protecting citizens in need.

Police are also given a large measure of discretion under public security laws to take action against individuals or groups, who they perceive to be acting contrary to the interests of public security or public order. In India, the *Delhi Police Act* permits the police to prohibit certain acts in public places on the ground of maintaining public order and decency, and has been used to prevent public demonstrations by sexual minorities. In Nepal, under the *Public Security Act*, a local authority has the power to confine a person to living in a particular place if it is thought that the person may disturb the interests of the general public. Moreover, in all four countries, constitutional rights such as freedom of expression and movement and the right to work can be restricted on grounds of public security and public order. This limits the human rights protection available to groups such as sex workers and sexual minorities.

MEN WHO HAVE SEX WITH MEN (MSM)

In all four countries, certain sexual practices, including anal sex between men, are criminal offences carrying a substantial prison term. Although there have not been many instances where consenting adults have been charged under these provisions, the law is often abused by the police and others to harass, blackmail, and extort bribes from MSM.

Criminal provisions of this kind, which discriminate on grounds of sexual orientation, are susceptible to challenge on the basis that they breach the International Covenant on Civil and Political Rights, and possibly also under constitutional

Legal reform in Sri Lanka

In the 1990s, a bill was introduced to decriminalise homosexuality in Sri Lanka, in an effort to overturn previous legislation that criminalised sexual relationships between two males. However, opposition to the bill was voiced by some Muslim and Catholic MPs, who stated that homosexuality was not recognised by their faiths. As a result, the sponsors withdrew the bill, fearing that it would spark a damaging debate on religion and ethnicity and create further polarisation in an already divided country. After the bill, aimed at decriminalising homosexuality, was withdrawn, it was pointed out that the wording of the existing "anti-homosexual" provision referred only to "man", and that this was discriminatory. Therefore, the word "person" was used to replace "man", resulting in legislation that criminalises both men and women for same sex sexual activity. In this way, the introduction of a bill aimed at decriminalising homosexual conduct between men ultimately resulted in a widening of the scope of the original law.

An anomaly of the legislative process in Sri Lanka means that there is a constitutional bar on judicial review of legislation. This makes it impossible for any legislation, such as the laws against homosexuality, to be challenged in the courts on the grounds that it - or provisions within it - violates the national Constitution.

Source: Centre for Policy Alternatives, Sri Lanka

equality rights. In India, the validity of the law criminalising sodomy has been challenged in court, although the result of this challenge is not yet known. In Sri Lanka, there was also an attempt to abolish such a law, which ironically resulted in a worsening of the situation.

DRUG USE

Harsh criminal penalties apply to drug use throughout the South Asian region. (See, for

example, *Narcotics Drugs and Psychotropic Substances Act, 1985* (India), *Narcotics Control Act, 1990* (Bangladesh) and *Narcotics Drugs (Control) Act, 1976* (Nepal)). These laws create a large range of offences related to the manufacture, supply, possession and use of illicit drugs, many of which are punishable by prison terms of several years or, in extreme cases, by the death penalty.

There are provisions in some drug laws (e.g. India and Bangladesh) which seek to encourage drug users to undergo treatment and rehabilitation. The Indian legislation provides that the consumption of prohibited drugs is not an offence if the person is willing to undergo rehabilitation. However, apart from these very limited provisions, drug users in the region remain highly vulnerable to criminal prosecution. It is a particular concern that the possession of small quantities of drugs for self-consumption remains a criminal offence in most places, making it extremely difficult to introduce effective needle and syringe exchange programmes.

SEX WORK

All the countries of the region have criminal offences applicable to sex work, ranging from trafficking and brothel-keeping to soliciting and seducing. (See *Immoral Traffic (Prevention) Act, 1956*, India, *Suppression of Immoral Traffic Act*, Bangladesh, and *Country Code*, Nepal). Although sex work itself is not unlawful in any of the countries studied, the law still provides considerable scope for police harassment and arrest of sex workers. In practice, the mere possession of condoms is often sufficient to evoke such harassment.

In addition to provisions in the various criminal codes and laws on immoral trafficking, there is legislation dealing with order in public places that can be used against sex workers. In Sri Lanka, under the *Vagrancy Act 1978*, a sex worker who is considered to be behaving in an indecent manner in a public place is deemed to be an "idle and disorderly person," and is liable to imprisonment. In Nepal, the *Public Offences and Punishment Act* permits the police to charge sex workers for causing public offence. However, the situation there is changing,

Nepal Supreme Court 's Interpretation on Sex Work as Profession

No. 7 of the Chapter on Rape of the Country Code provided that in cases where a sex worker is raped, the maximum penalty for the rapist on conviction would be a fine of up to Rs. 500. This provision of punishment was highly discriminatory against sex workers, in comparison to a maximum penalty of ten years imprisonment and a half share of the culprit's property to the woman raped, in cases where the woman is not a sex worker.

This provision was challenged in the Supreme Court, with the demand that the existing provision be declared discriminatory and unconstitutional. The Court, in its final decree, stated that sex work is also like any other profession and no discrimination could be made on the basis of sex work. The Court held that "...Prostitution, in some countries is legalised. However, prostitution is a profession or occupation irrespective of whether or not it is legal..." The court declared the existing legal provision null and void.

Source: *Writ No. 56/2058, Date of decision: 2059.1.19 B.S. (May 2, 2002)*, Publication of Judgments relating to Human Rights (Special issue) Supreme Court 2059(2002), pp. 144-151

as proved by the abolition of discrimination against sex workers with regard to rape.

The law in India and Bangladesh recognises the concept of "protective custody", whereby individuals can be detained in corrective institutions or welfare homes, ostensibly for their own protection. There have been many reports of sex workers being detained on this basis, with few procedural safeguards and no effective right of appeal. Moreover, by drawing an analogy with prisoners who can be compelled to undergo medical examinations, the courts in India have held that sex workers under "protective custody" can be subjected to compulsory HIV testing.

MIGRANT WORKERS

Migrant workers account for a significant proportion of the population in all the countries of South Asia. Many are economically disadvantaged and move between countries in search of better livelihood opportunities. There are significant numbers of people travelling from South Asia to countries in the Persian Gulf and back again, as well as an influx of workers moving within South Asia in search of employment.

There are several laws in the region that regulate the movement of migrant workers. These include the *Emigration Act 1983* in India, under which the

authorities can prohibit the emigration of any person to a specified country on the grounds of preventing an outbreak of disease, and the *Emigration Ordinance 1982* and the *Foreigners Act 1946* in Bangladesh. The Nepalese *Immigration Rules* permit a foreigner's visa to be cancelled if he or she is diagnosed as having an infectious disease.

Migrant workers have few legal rights in these circumstances. In the four countries studied, constitutional rights generally apply only to citizens, and are not enforceable by foreigners. Migrant workers are therefore left extremely vulnerable to discriminatory practices. It should be noted in this context that the United Nations Convention on the Protection of the Rights of Migrant Workers, currently only ratified by Bangladesh within South Asia, requires States to provide migrant workers with the same access to education, housing and health services as is available to nationals.

PRISONERS

India, Bangladesh and Nepal all have legislation governing the administration of the country's prisons. In view of the numerous reports of police detention of people with HIV, as well as the many criminal offences associated with

behaviours such as injecting drug use and sex between men, the laws relating to the management of prisons also assume some significance in the context of the HIV epidemic.

The Bangladesh *Prisoners Act 1900* contains various provisions about medical treatment for prisoners, but nothing specifically relating to infectious disease. In Nepal, the Prisons Act provides for sick prisoners to be segregated, and

there are reports of HIV positive inmates being kept separately. Compulsory HIV testing of prisoners is commonplace throughout the region, contrary to Article 7 of the ICCPR and the WHO Guidelines on HIV Infection and AIDS in Prisons. Moreover, neither the relevant legislation nor prison policies in the region acknowledge the need for any measures to prevent HIV transmission in prisons.

Legal Reform in India

In India, The National AIDS Control Organisation (NACO), together with MP Kapil Sibal, has commissioned the NGO Lawyers Collective to draft HIV/AIDS legislation to be presented in Parliament. The aim is to create a comprehensive law which protects the rights of PLWHA and vulnerable groups. The process began with research and preparation of background information, including an examination of other countries laws and policies on HIV/AIDS, on the basis of which draft legislation has been formulated. Some of the key measures being proposed in the draft legislation include procedures for HIV testing, counselling and referral, maintenance of confidentiality and permissibility of disclosure of HIV status, standards of care for HIV/AIDS related treatment, non-discrimination, safe working environment for health care workers and risk reduction measures to protect vulnerable communities.

A first draft of the legislation is presently undergoing a comprehensive consultation process. The consultations enable different stakeholders to articulate their concerns about the legislation and provide crucial feedback and inputs to make the draft law more effective and relevant to the needs of institutions and communities. The extent to which communities will embrace the legislation, and institutions will comply and implement the law, depends partly on the support generated through the consultation process.

Consultations have taken place with PLWHA, vulnerable groups, health care providers and representatives from the workplace. In spring 2004 the draft legislation is being discussed at six regional consultations across the country, with participation from civil society and local government. In addition, national level consultations with women's and children's organisations will also take place. After the consultations the draft legislation will be finalized and the draft posted on the internet for further comments before submission to the government. By the time the proposed legislation is submitted to the government over 900 people will have been directly involved in consultation meetings, raising their concerns and providing inputs.

Source: Legislating an Epidemic: HIV/AIDS in India; Lawyers Collective, 2003

*The Findings:
The Social
Environment of
HIV/AIDS in
South Asia*

The Findings: The Social Environment of HIV/AIDS in South Asia

PEOPLE LIVING WITH HIV/AIDS

Numerous examples emerged from all four countries of stigma, discrimination and human rights violations towards PLWHA. HIV positive people reported that being open about their status made them vulnerable to discrimination in every sphere, often with disastrous consequences for their families. In particular, the stigma associated with the epidemic - and the prevailing social perception that HIV infection is the "wages of sin" - distressed and angered HIV positive people.

Specific concerns were raised by PLWHA about arbitrary arrest, security of employment, lack of support for those who are seriously ill, and access to education for HIV positive children. PLWHA were unanimous in opposing the mandatory testing of groups such as migrant workers, sex workers and prisoners, stressing that such tests violated basic human rights. HIV positive people also voiced concern about intrusive media reports that "exposed them to public view," with extremely negative consequences for them and their families.

The denial of medical care is a pervasive problem for PLWHA, due to discriminatory practices by health professionals, as well as the prohibitively high cost of anti-retroviral treatments (ARVs). PLWHA wanted governments to subsidise the cost of HIV drugs, and to introduce appropriate reforms in their national health policies to provide more equitable access to health care.

PLWHA stressed that HIV positive people should be more actively involved in working with decision-makers to shape the direction of National AIDS

Programmes. They also articulated the need for education programmes to sensitise police officials, religious leaders, and women and youth leaders on HIV/AIDS issues.

It is clear that the discrimination faced by PLWHA affects their basic right to health in various ways. The stigma associated with HIV infection inhibits them from disclosing their health status and seeking medical attention, while the discriminatory treatment they receive in hospitals results in many PLWHA being denied access to even the most rudimentary health care. Moreover, the emotional and psychological consequences of stigma are profound. Popular misconceptions about the risks of HIV transmission from casual contact remain widespread, even among health professionals, leading to alienation and a fundamental loss of dignity for PLWHA in the South Asian region.

WOMEN LIVING WITH HIV/AIDS

A constituency that faces particularly harsh discrimination is women living with HIV/AIDS. Even in instances where women have been infected by their spouses, they report being harassed by their in-laws and denied their right to maintenance and inheritance. A particular concern of women living with HIV is that their interests are consistently marginalised and that their vulnerability to HIV infection was never properly understood or addressed. As a consequence, they stressed, the number of women with HIV is growing rapidly, and most of these women face severe discrimination.

HIV positive women were critical of media reports that sensationalized the epidemic, created misinformed fears about the risk of infection, and identified HIV positive people without their consent. Apart from constituting an invasion of privacy, such reports had the effect of stigmatising them further within their communities.

The abuse of police powers to harass PLWHA was another area of concern for women. It emerged that laws giving police sweeping powers to make arbitrary arrests typically became instruments of harassment. Apart from violating people's rights under the International Covenant on Civil and Political Rights, such harassment had the effect of making the identity of people living with HIV known within their community, exposing them to social stigmatisation and discrimination.

Income poverty is directly linked to social marginalisation and stigmatisation, and it emerged that women bear the brunt of both. In South Asia, women are disproportionately represented among the poor and typically have less access to resources and services - including health care - making the impact of HIV infection on them much more severe. In the case of women living in poverty, their struggle for daily survival takes precedence over concerns about HIV, and often limits their capacity to take measures to protect themselves against the risk of HIV.

SEX WORKERS

Sex workers are one of the social groups least protected by law, most harassed by law enforcement agencies and most seriously discriminated against within their communities. Therefore, they experience some of the worst forms of abuse and violations of human rights. The experiences of sex workers - as a community with a vital stake in every aspect of the debate relating to HIV/AIDS - can offer important insights to inform HIV policy and legal reform.

Sex workers reported widespread, and often unlawful, harassment at the hands of the police and other law enforcement agencies and argued for the urgent decriminalisation of sex work. They stressed that, as long as soliciting or prostitution

Eviction of Sex Workers in Bangladesh

In July 1999, local officials evicted numerous sex workers from the brothel in Tanbazar (a Bangladeshi river port town of Narayangang). The sex workers sought compensation and took to the streets of Dhaka in protest, demanding rehabilitation and claiming back their houses. The president of the Sex Workers Network in Bangladesh protested that the sex workers were evicted even though they were operating legally and paid taxes on the brothel property. In a landmark judgment in 2000, after the case was filed by over 100 sex workers and human rights organisations, the Bangladesh High Court ruled that the eviction of sex workers from the brothel was unlawful, as the brothel was registered.

Source: Human Development Report - HIV/AIDS and Development in South Asia 2003

remain criminal offences, sex workers will be vulnerable to abuse and harassment, making it difficult for them to participate in measures to raise awareness about HIV and reduce their own vulnerability to infection.

Sex workers from Bangladesh pointed out that, in their country, police have sweeping powers under criminal law to search anyone, and mere possession of condoms invites harassment on trumped-up charges of soliciting. They called for training for the police force on issues of human rights and gender sensitivity. Bangladeshi sex workers also reported that some voluntary organisations that provide legal aid to socially disadvantaged groups refuse to extend the service to sex workers.

Sri Lankan sex workers identified a need for more responses aimed at raising HIV/AIDS awareness among sex workers and providing legal aid services and alternative employment opportunities. In Nepal and India, sex workers called for severe punishment for those responsible for trafficking in women. Sex workers in India have also set up self regulatory boards that among other tasks guard

against the entry of minors or women forced into their profession. Sex workers expressed concern at denial of medical treatment to sex workers, even in state-funded public hospitals.

Across the region, sex workers emphasised the importance of education to raise awareness about HIV and encourage their clients to use condoms. However, they pointed out that the distribution of videos, films or other information to promote condom use can invite prosecution under existing obscenity laws and stressed the need to amend such laws.

It emerged that even sex workers who are well informed about HIV and its modes of transmission are often powerless to compel condom use, despite their awareness of the infection risks. Sex workers' intense distrust of the police and other law enforcement authorities is a reflection of the harassment they face and of the skewed nature of laws that penalise sex workers and leave them without legal protection or defence. Accordingly, HIV policies that target sex workers as a source of infection fail to understand the extreme vulnerability of this population, and the extent to which the hostile social and legal environment prevents sex workers from taking measures to protect themselves and others from infection.

SEXUAL MINORITIES

Consultations were undertaken in Bangladesh and India with two distinct sexual minorities - men who have sex with men and hijras. Both these groups reported being severely discriminated against because of their sexuality and sexual behaviour. Both Bangladesh and India have similar provisions in their penal code that criminalise "non penile-vaginal intercourse" which includes anal sex and provide for up to 10 years imprisonment. Stakeholders wanted a repeal of this legal provision, as well as other provisions of the Code of Criminal Procedure, the Vagrancy Act, and similar laws, which are often abused by the police to bring unfounded charges against MSM.

Due to the fear of rejection by families and social discrimination if their sexual orientation were discovered, it was reported that many MSM end up

marrying women, sometimes with disastrous consequences for both parties. The stakeholders pointed out the injustice of having to hide their sexual identities in this way, and called for efforts to sensitise the community, especially the police and law enforcement authorities, to accept sexual diversity.

The use of criminal provisions against men who have sex with men goes against a recommendation of the UN Human Rights Committee⁴ that rejects discrimination on the basis of sexual orientation. Legal provisions of this kind inhibit sexual minorities from acknowledging the HIV infection risks associated with their sexual behaviour, accessing appropriate sexual health information and services, and taking steps to protect themselves and others.

Hijras reported experiencing severe discrimination on account of their gender identity and sexual behaviour, including rejection by families and police harassment. Although cross-dressing men are found all over the world, in South Asia they represent a well established sub-population with their own distinctive culture and customs. Hijras have traditionally earned their living by singing and dancing at weddings and other festive occasions. However, they are becoming increasingly socially marginalised and most reported supplementing the earnings from their traditional activities by begging or selling sex. It was reported that there is a high prevalence of STDs among hijras, indicating that this population are particularly vulnerable to HIV.

COMMUNITY AND NON-GOVERNMENTAL ORGANISATIONS

In South Asia there are a vast range of civil society stakeholders that have a role to play in addressing issues of HIV/AIDS, law and ethics. Although they may not be directly affected by the epidemic, these civil society groups have the potential to shape responses or act as "opinion-makers," influencing the social attitudes towards the epidemic, PLWHA and vulnerable populations. The stakeholders involved in the consultations covered a diverse range of interests, and included representatives of non-governmental organisations, the legal profession, and

⁴ UN Human Rights Committee's comments to Article 26

activists working on behalf of marginalised populations (women, children, migrants etc), among others.

There were sharp differences of opinion among the civil society stakeholders as to what constitutes an appropriate policy response to the HIV epidemic. Many expressed a reluctance to accept alternative sexual behaviours and argued that what was required was a stricter moral stand against such behaviours. This group advocated for responses that would discourage any form of sexual expression other than heterosexual sex within marriage, and called for further studies on the social and cultural factors that make people "vulnerable" to alternative sexual behaviours.

Others argued that responses based on moralizing would simply lead to groups such as sex workers and men who have sex with men becoming further marginalised. They emphasised the importance of openness and acceptance in matters relating to sexual behavior, and pointed out how rejection of alternative sexual behaviours - including the imposition of criminal sanctions in some countries in the region - resulted in greater discrimination against vulnerable groups, thereby hampering HIV prevention efforts.

Another key issue that emerged concerned migrant workers coming to countries in the region, or returning to the region after working abroad. Many of the civil society stakeholders believed that there should be mandatory HIV testing for all migrant workers entering or re-entering the country, with the establishment of special testing facilities at ports and airports. However, NGOs and activists working on HIV issues vehemently opposed any form of mandatory testing. They pointed to the serious personal consequences of requiring HIV testing for migrant workers, who are already economically disadvantaged and socially isolated as a result of dislocation from their families. The desire to single out migrant workers for mandatory testing suggests that many people in South Asia are still under the misapprehension that HIV is a virus that comes primarily from outside the region, rather than one that is present in their own communities.

The contrasting views expressed by civil society stakeholders demonstrate the challenge of fostering a response to the epidemic based on non-discrimination and respect for individual rights. It appears that there are widespread and deeply-held values

within the region relating to sexuality and HIV, which can obstruct open discussion of HIV and prevent the general population from acknowledging their HIV vulnerabilities and their shared responsibility for preventing the spread of the epidemic.

HEALTH PROFESSIONALS AND HOSPITAL ADMINISTRATORS

Health professionals and hospital administrators face a variety of difficult ethical and legal issues related to HIV. Issues of confidentiality arise when a patient tests for HIV; then there is the question of what measures are appropriate to guard against the risk of HIV transmission to a health service provider. Hospitals must decide how to respond when an employee refuses to treat someone with HIV, or when employees themselves test positive for HIV. These issues all require careful consideration and debate.

Health professionals and hospital administrators expressed a number of differing and inconsistent views on these issues. Health professionals acknowledged the importance of protecting a patient's right to confidentiality in relation to HIV, but argued that this should not prevent full disclosure of a patient's HIV status to all treating health professionals. Indeed, the prevailing view was that mandatory HIV testing for patients was desirable for the protection of health professionals and other patients, although there is no recognised scientific basis for such a policy.

There was no clear agreement on the steps a hospital should take if a health care professional is diagnosed as HIV positive. However, doctors felt that as their work put them at risk, they required an economic "safety net" in case of infection. Stakeholders also expressed that there is great need for HIV orientation and awareness programmes for the medical community.

Significantly, health professionals and hospital administrators did not raise the issue of whether there was discrimination against PLWHA in the provision of health care, despite the many incidences of severe discrimination and denial of access reported by PLWHA. This suggests a lack of awareness and understanding among health care professionals of the discriminatory attitudes and

practices within their sector.

MEDIA

Stakeholders from the media were deeply divided over the issues of confidentiality for PLWHA. While some argued that the identity of an HIV positive person should not be disclosed in media reports without their consent, others felt it was the "duty" of the media to disclose the identity of PLWHA in the public interest.

It emerged that the media in South Asia, like much of the general public, are largely ignorant about the basic facts of HIV transmission. As a result, media reports perpetuate the misconception that HIV positive people pose a risk to those around them, both in their homes and workplaces, and in the community in general. It is clear that as long as this message continues to be communicated by the media, discrimination against PLWHA will remain widespread, and it will be difficult to implement policies that respond to the HIV epidemic in an open and non-judgmental way.

CONCLUSION

A picture of serious and widespread human rights abuses against PLWHA in South Asia emerged from the stakeholder consultations. These included examples of testing without consent, denial of

medical care, breach of confidentiality, police harassment, discrimination in the workplace and denial of inheritance. There was also substantial evidence of discriminatory practices against marginalised populations, including women, migrant workers, sex workers and sexual minorities, which further increased their vulnerability to HIV infection. Moreover, it emerged that in some cases these practices are encouraged or reinforced by inappropriate or discriminatory laws.

Another issue of serious concern emerging from the consultations is the level of ignorance and misunderstanding about HIV and its modes of transmission, even among groups such as health professionals and journalists, who would be expected to have access to correct information. The existence of widespread ignorance about the virus, twenty years into the epidemic, is a demonstration of the challenges faced by policymakers in the region seeking to implement effective policies on HIV.

The stakeholders' concerns indicate that, while education to generate awareness about HIV is critically important, there is also a pressing need for legal protection of the rights of PLWHA and vulnerable groups in South Asia. It would seem that despite existing constitutional guarantees of rights and freedoms, there has been limited progress in making these rights a reality for certain populations.

Best Practice Legislation in Asia

In the **Philippines**, the *Philippine AIDS Prevention and Control Act, 1998* enacted a package of reforms that:

- Provides formal legal recognition that all people with HIV are entitled to full protection of their human rights and civil liberties
- Places a positive obligation on the government to promote HIV education and awareness
- Requires basic health services to be available to people with HIV in all government hospitals
- Outlaws discrimination against people with HIV in the workplace, in schools, in health care, and in the provision of credit and loan services
- Requires medical confidentiality to be respected
- States that the government must seek to eradicate conditions that aggravate the spread of HIV, including poverty, gender inequality, marginalisation and ignorance

In **Cambodia**, the *Law on Prevention and Combat against the spread of HIV/AIDS* in 2002:

- Prohibits discrimination against people with HIV, and establishes legal confidentiality protection in relation to a person's HIV status
- Prohibits HIV testing without consent in the absence of a court order
- Provides PLWHA freedom of movement and residence
- Prohibits the refusal of health care on the basis of HIV infection
- Requires the government to encourage the involvement of people with HIV in public HIV awareness campaigns

Source: "Law, Policies and Regulations concerning HIV/AIDS Prevention and Containment: an Assessment and Recommendations", UNDP, August, 2003

*The Findings:
Sexuality and
HIV/AIDS
Vulnerability
in South Asia*

The Findings: Sexuality and HIV/AIDS Vulnerability in South Asia

Within South Asia, sexuality in general - and personal sexual practices in particular - remain highly taboo topics that are difficult for people to discuss. For women especially, strong cultural pressures inhibit them from speaking openly about their sexual practices or desires, particularly in the areas of alternative sexuality, multiple partners and extra-marital relationships. However, the study on sexuality and vulnerability did identify some of the common practices and prevailing values within the region - in relation to sexuality and gender - that shape the normative environment in which the epidemic is spreading.

There appears to be extremely low level of awareness about how HIV is spread, with what little information is available drawn largely from media reports. Many people were of the opinion that people with HIV should be segregated, while others believed that sharing a meal with an HIV positive person posed a risk of transmission. This almost total lack of information and awareness about HIV fosters an atmosphere of fear, discrimination and stigmatisation towards PLWHA.

Women reported that they were unable to insist on protection during sexual intercourse. If a woman wanted her partner to use a condom, it was perceived as a sign of mistrust of her partner and a denial of the man's right to full sexual gratification. Women had little or no control over when, where and how they had sex with their partners, even within marriage. Many women felt that sexual

intercourse was a responsibility and duty towards their partners. In Nepal, women who refused to have sexual intercourse reported being beaten, or having their partner threaten to enter a second marriage or extra-marital relationships.

In Sri Lanka, women reported that their vulnerability to rape and sexual exploitation increased in conflict affected areas. Sex workers, in particular, were extremely vulnerable, as customers demanded unprotected sex. Women in Sri Lanka said the legal framework did not provide them any redress or equality before law and they described many experiences of discrimination and harassment at the hands of the police.

Religious beliefs also appear to have a great influence on sexuality and sexual values. In the study in Bangladesh, a significant number of respondents considered sexuality as sinful and sexual intercourse to be "unethical" or "immoral".

Open discussion of sexuality, especially female sexuality, is impossible in much of the region. Stereotypical views of women's sexuality dictate that "chaste women" should be ignorant of matters relating to sexuality and act passively in sexual interactions. Consequently, there is a lack of understanding of individual sexual needs and desires, even within the institution of marriage. This makes it very difficult for women to be informed about ways to reduce their risk of infection. Even when they are reasonably well informed, it is difficult for them to be proactive in negotiating safer sex.

*South Asia
in Perspective:
The Experience
in China*

South Asia in Perspective: The Experience in China

At the same time as the mapping exercise was being carried out in the four South Asian countries, the UNDP office in China supported a similar study to identify critical ethical and human rights issues associated with the HIV epidemic in China, and to assess the adequacy and appropriateness of the existing legal framework in China for addressing these issues. Despite widely differing political and cultural environments, there are some useful parallels to be drawn between the experience in China and South Asia, as well as some significant contrasts. Many of the same concerns about discrimination were voiced by PLWHA and other vulnerable populations in China. However, the Chinese legislative response to date has been quite different.

The interviews and focus groups conducted in China were not as extensive as the stakeholder consultations in South Asia. However, input was received from people with HIV, intravenous drug users, sex workers, health professionals and provincial government officials. This research revealed many examples of discriminatory practices in relation to HIV positive people and those considered to be at risk. This included PLWHA and their families being refused medical care, losing their jobs, and having their HIV status revealed to others without their consent. Ignorance and lack of understanding about HIV, even among health care workers, was seen to compound the atmosphere of hostility experienced by PLWHA, in turn leading to feelings of exclusion, alienation and helplessness to act in the face of the HIV epidemic.

A particular problem identified in China, in

common with South Asia, was that police raids on sex workers and injecting drug users have made it extremely difficult to conduct effective HIV prevention activities among these populations. In one instance, a planned program for the free distribution of condoms in hotels did not proceed because of fear that the police would consider this to be unlawful encouragement of sex work. In another case, an HIV prevention program for sex workers was hampered when a police raid forced the sex workers to re-locate to another district. However, there are increasing moves by Chinese authorities to ensure that HIV prevention work, and particularly condom promotion, is no longer restricted by such law enforcement activities. The general lack of understanding of HIV and its modes of transmission among sex workers was another disturbing finding, in contrast with the position in South Asia.

Lack of access to medical services was another problem commonly reported by PLWHA in China. Many hospitals and health professionals were afraid to accept HIV positive people. If they were admitted to hospital, they were often kept in isolation or subjected to other discriminatory measures, which were neither necessary nor justifiable in order to prevent disease transmission.

The subordinate position of women is another factor China has in common with countries in the South Asian region. Discriminatory marriage laws and limited education and employment opportunities render Chinese women particularly vulnerable to HIV. Although China is a signatory to CEDAW, significant gender inequality still exists both in law

and in practice.

Notwithstanding these similarities in the underlying problems identified in both China and South Asia, the legislative response to date has been very different. Whereas there is very little legislation in South Asia that applies specifically to HIV, there has been a great deal of legislation passed in China in response to the HIV epidemic, at national, provincial and municipal levels. This is perhaps due to the tradition of strong government intervention in China, which emphasises government control from above, and gives little recognition to private or individual interests as opposed to the interests of the collectivity or the state.

In the area of infectious diseases, Chinese laws generally conform to the traditional public health model that seeks to target and manage infected individuals. HIV and AIDS have been brought under the cover of many pre-existing infectious diseases laws in China, giving government officials wide-ranging punitive powers to act against PLWHA and those considered to be at risk. There are provisions, for example, that have the effect of requiring all people with HIV to be quarantined, and that prevent them from working or getting married. Other laws provide for compulsory HIV testing of sex workers, drug users, "people suspected of having AIDS," and their families. Punitive policies are pursued against sex workers and drug users, in particular, with long periods of detention often enforced.

Many of these laws are inconsistent with the policies endorsed by China in its "Mid to Long Term Program for AIDS Prevention and Care (1998 to 2010)". This strategy emphasises the importance of not discriminating against PLWHA and their families in relation to work, study, medical care and participation in social activities. However, there are clearly tensions between the stated principles underpinning China's national HIV strategy and the existing legislation and law enforcement practices.

The priorities for appropriate HIV law reform in China are therefore somewhat different from South Asia, due to the need to advocate for the repeal of many existing punitive laws on HIV, that obstruct effective HIV policy responses. Nonetheless, there is a shared need to encourage the introduction of a legal framework that protects the rights of PLWHA

and vulnerable groups, consistent with international human rights standards.

HIV/STD measures in Zhejiang

In March 2004, a measure was issued in Zhejiang province in Eastern China, aimed at protecting the rights of PLWHA. This regulation stipulates that PLWHA have the right to receive treatment at medical institutes appointed by the local health administration and that those PLWHA who have purchased basic health insurance should have the costs of their diagnosis and treatment covered by this health insurance. In addressing employment issues, the measure stipulates that an employer cannot revoke the contract of an employee based on their HIV positive status. However, it also states that if it is not appropriate for an HIV positive employee to continue in their current work, their employer should arrange other suitable work for them, within one month of being informed of their HIV positive status by the health administration. In addition, the employer must maintain the confidentiality of the employee's HIV positive status.

This measure highlights some of the difficult policy and legislative issues that authorities in China - and elsewhere in Asia - are grappling with. The measure recognises the rights of PLWHA to medical care, to work and contribute to society, as well as to some level of confidentiality and freedom from discrimination. However, it also suggests that if medical authorities inform an employer of an employee's HIV positive status, the employer is then permitted to change the nature of that person's job based on their status. This throws up some fundamental concerns related to confidentiality and discrimination. As countries move forward in recognizing and protecting the rights of PLWHA, it is inevitable that such concerns will continue to arise, and solutions will need to be identified that are relevant and workable within each local context.

Source: UNDP, 2004

Involving Sex Workers in Condom Promotion

The strong commitment to HIV/AIDS by the highest levels of the Chinese government has created new opportunities for the Chinese response to the epidemic. Although sex work remains illegal in China, there is an increasing recognition of the vulnerabilities of sex workers to HIV and the importance of working in partnership with them to contain the epidemic.

For example, in Wuhan City, a ground breaking, multi-sectoral pilot programme was undertaken between October 2001 to May 2003 to promote 100 percent condom use among sex workers and their clients. During the programme, sex workers and entertainment establishment owners met regularly with public security and local government authorities, and outreach activities were undertaken to inform and support sex workers in using condoms. One of the most striking outcomes reported by the programme was that public security authorities were convinced that such 100 percent condom use programmes - implemented together with sex workers and entertainment establishment owners - were a vital element of an effective response to HIV/AIDS.

Source: Wuhan 100% CUP Office

*Priorities for
HIV/AIDS Law
and Policy in
South Asia*

Priorities for HIV/AIDS Law and Policy in South Asia

This study has provided important insights into the factors influencing the spread of HIV in the South Asian region and the social, cultural and legal determinants of vulnerability to the epidemic. Many obstacles to an effective understanding of the epidemic have been identified, as have many attitudes and beliefs which prevent individuals and communities from implementing the changes which are necessary to avoid the further spread of HIV and to address its profound social impact.

These include:

- widespread lack of understanding of how HIV is spread, leading to misplaced fear about the extent to which PLWHA pose a threat to others
- a tendency to blame PLWHA for having been responsible for the spread of the epidemic, without acknowledging sources of vulnerability that are beyond individual control
- a view of the epidemic based on perceived "risk groups" (e.g. sex workers, men who have sex with men etc.), which prevents acknowledgment of risk within communities as a whole and intensifies discrimination and stigmatisation against the so-called risk groups
- a failure to respect the dignity and needs of those already affected by the epidemic, through denial of health care and social support, breaches of privacy, loss of employment and, in some instances, police harassment
- the existence of deep-rooted gender inequality and power imbalances in sexual

relationships, which severely constrain the capacity of individuals to protect themselves and others from HIV

The fact that many of these attitudes and misconceptions apparently persist at all levels of society in South Asia, including among health professionals, law enforcement agencies and the judiciary, emphasises the extent of the change required. Without a fundamental shift in the values that shape the public perception of the HIV epidemic, it is difficult to achieve an HIV policy framework that is effective in promoting a non-discriminatory and rights-based response.

In this context, it is important to explore the extent to which legal policy and legislative reform can contribute to the changes that are required for an effective policy response. The review of existing HIV laws in the four South Asian countries undertaken for this project has highlighted the areas where the law has shaped - or, in some cases, not shaped - the response to the epidemic to date. It is striking that in all four countries studied, there is an almost complete absence of HIV-specific laws. The South Asian experience in this regard is in sharp contrast with that in China, where many laws have been enacted or amended to cover HIV. In particular, public health laws focussing on identifying infected individuals and controlling their behaviour have been a strong feature of China's legislative response to the epidemic.

But despite the absence of HIV specific laws in South Asia, there are many ways in which the law has had an important influence on the spread of HIV and on the everyday experience of those

affected by the epidemic. Laws that criminalise behaviours such as sex work, homosexuality and injecting drug use have a real and immediate impact on efforts to reduce HIV transmission among those groups. The subordinate position of women is reinforced by discriminatory laws in the areas of family law and inheritance. The lack of clear legal protection against mandatory HIV testing or unauthorised disclosure of a person's HIV status permits these rights abuses to continue, largely unchecked.

Even where the law does offer protection in the form of constitutional rights, there is clearly a significant gap between the letter of the law and the practical enforcement of legal rights. There are many reasons for this, including lack of public awareness about legal rights, lack of affordable access to legal representation and other disincentives to taking legal action, such as media publicity and fear of further discrimination. Moreover, because there are few judicial precedents in the region for human rights litigation in the area of HIV (with the possible exception of India), it is difficult to be confident as to the outcome of any test cases that might be brought. This is an illustration of how the implementation of the law can be as important for effective legal policy on HIV as the content of the laws themselves.

So, what lessons can be learned from the current state of HIV law and legal policy in South Asia to guide the development of an effective legal policy response to the epidemic? At the outset, it is important to emphasise that overcoming discrimination and rights abuses against PLWHA and other vulnerable groups obviously requires far more than any programme of legal reform could reasonably expect to achieve. Reducing discriminatory practices is not primarily a matter of legislative reform. Rather, it involves nurturing understanding about HIV and the sources of individual and community vulnerability to the epidemic, and overcoming stigmatising views of the epidemic that seek only to blame those affected. Efforts to generate this more complex understanding of the epidemic must always be at the forefront of the policy response, and must occur regardless of the legal policy agenda.

Nonetheless, it is also important for policymak-

ers to appreciate the many different ways in which the law and legislative reform can support and reinforce the values and policies that underpin an effective national strategy on HIV. Conversely, laws which reflect and encourage discriminatory practices and sources of vulnerability to HIV, such as gender inequality, can actively impede other policy initiatives. When seen in this light, the development of a careful and considered legal policy on HIV, backed up by appropriate legislative reform, is an important element of an effective HIV policy response. A clear and consistent legal policy in this area would give weight and legitimacy to the principle of non-discrimination and the need to protect the dignity and needs of all those affected by the epidemic. It would also provide practical legal remedies for people who experience rights abuses, and guide judicial pronouncements in the important area of human rights and HIV.

The fact that there is, in effect, a legal vacuum in respect of legislation governing HIV in South Asia provides an opportunity for constructive law reform in response to the epidemic. The results of the stakeholder consultations, the empirical studies on sexuality and the legal mapping exercise, when viewed together, highlight a number of areas where more appropriate legal policy is required. These include the following:

Effective human rights and anti-discrimination protection. While all four countries in the region have constitutions that enshrine a range of rights, and have signed up to the key international human rights instruments, legal protection against discrimination remains limited in practice. Consideration could be given to enacting legislation that provides specific protection against HIV-related discrimination, by way of more detailed elaboration of existing constitutional rights. Legislation of this kind would establish the principles that should govern the application of human rights law to HIV and avoid uncertainties of judicial interpretation. HIV awareness programmes for the judiciary could also be beneficial in this regard.

Legal awareness and access to legal services. Among the reasons why existing constitutional rights protection in South Asia is not

utilised as fully as possible would seem to be a lack of awareness of existing laws and how they might apply in the context of the HIV epidemic, and a lack of affordable access to legal representation. Practical initiatives to address this by promoting a greater understanding of existing human rights laws and providing access to legal advocacy services could have immediate and positive consequences for those who suffer HIV-related discrimination.

Review of relevant criminal laws. The legal mapping exercise provided many examples of provisions in the criminal laws of all four countries that impose criminal sanctions on a range of practices relevant to the spread of HIV. These include punitive provisions related to sex work, injecting drug use and sex between men. The stakeholder consultations demonstrated how these laws are counter-productive in achieving an effective response to the HIV epidemic. In addition to increasing the stigmatisation already experienced by those groups, the criminalisation of these behaviours provides scope for police harassment and obstructs efforts to support and encourage safer sexual and drug using practices. There is an urgent need to bring the criminal law into harmony with an effective HIV strategy, whether by selective de-criminalisation of certain conduct or by negotiation and cooperation with law enforcement agencies. Inappropriate exercise of police powers, which many of the stakeholders reported taking place against groups such as sex workers, is another concern that must be addressed in this regard.

Use of public health powers. Although there is currently very little public health legislation in the South Asian region that applies specifically to HIV, concern has been expressed that existing public health legislation could easily be amended to cover HIV. This would authorise the use of a range of public health powers against people with HIV or those suspected of being infected, including compulsory testing and detention. The fact that there is no model in the region for public health legislation appropriate to HIV, based on principles of non-discrimination, confidentiality and empowerment for voluntary behaviour

change, is a further concern. It is important that these principles be clearly affirmed as part of the legal policy response to HIV to guard against the inappropriate use in the future of existing public health laws.

Gender Inequality. Both the stakeholder consultations and the empirical studies on sexuality made clear that the subordinate position of women in South Asia makes them acutely vulnerable to HIV as well as other forms of rights abuses. They often have little control over their own sexuality and sexual relationships, by reason of their low social status and lack of financial independence. They cannot compel their partners to adopt safer sexual practices, and yet risk being blamed if their husband becomes infected. The inferior position of women in many parts of South Asia is reinforced by discriminatory laws in areas such as family law and inheritance. While legislative reform of these provisions is unlikely by itself to change the cultural values that underpin them, it can provide an important basis for other measures to address the subordinate status of women, giving them the means and power to protect themselves against HIV.

The role of legal policy guidelines. All the governments in the four countries have formulated policies on HIV/AIDS. However, in specific areas, such as health care, employment and prisons, there has been little done to develop policies and protocols addressing the issues thrown up by the epidemic. As a result, there are a number of difficult policy issues that are yet to be adequately addressed in most countries in the South Asian region. These include, for example, disclosure of a person's HIV status to health care workers, access to condoms and clean injecting equipment within prisons, and guidance for employers on HIV in the workplace. While these issues involve questions of law and could be addressed by legislation, other means of establishing policy in such areas should not be overlooked. In particular, consideration could be given to initiating a process of consultation and debate to develop policy guidelines on specific topics. This process would allow greater flexibility than a purely legislative approach and would permit a range of

considerations, both legal and non-legal, to be taken into account.

It is clear that much remains to be done in South Asia to develop a consistent and coherent legal policy response to the HIV epidemic. It is equally clear, in light of the widespread discrimination that accompanies the epidemic in the region, that the development of an appropriate legal policy must be a priority for the government in each of the four countries studied.

However, there is good reason for optimism. There is no doubt that the vibrant and vocal civil society that exists in South Asia provides an ideal environment to express and explore the complex issues raised by the HIV epidemic. Moreover, the increasing empowerment and involvement in responses by PLWHA and affected communities -

sex workers, IDU, MSM, women's groups and others - can ensure that the concerns and needs of these groups are heard and addressed. There are also promising policy and legal initiatives emerging in each of the countries, including the formulation of new laws, ground breaking rulings, and inclusive HIV policies and programmes.

This study has highlighted the close relationship between norm and values, social and economic inequalities, and law and policy, in relation to the HIV epidemic. It has also demonstrated that these elements must be understood and addressed in a holistic manner by policy makers, legislators, judiciary, law enforcement agencies and communities alike, if the countries of South Asia are to build the truly comprehensive and rights based response that is needed to contain the HIV epidemic.

INTERNATIONAL DECLARATIONS, GUIDELINES AND CONVENANTS

UNGASS Declaration of Commitment on HIV/AIDS, United Nations

Millennium Declaration & Millennium Development Goals, United Nations

International Guidelines on HIV/AIDS and Human Rights, OHCHR/UNAIDS

International Covenant on Civil and Political Rights (ICCPR), United Nations

International Covenant on Economic, Social and Cultural Rights (ICESCR), United Nations

Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW), United Nations

Convention on the Protection of the Rights of Migrant Workers and Members of their family (not yet in force), United Nations

Convention Against Trans-National Organised Crime (Including Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children), United Nations

KEY TEST CASES AND NATIONAL LEGISLATION

INDIA

Cases:

Lucy D'souza v. State of Goa (AIR 1990 Bombay 355)
Vijaya v. Chairman and Managing Director, Singareni Collieries Ltd. (AIR 2001 AP 502)
Paschim Bengal Khet Mazdoor Society v. State of West Bengal (AIR 1996 SC 2426)
Subash Chandran v. State of AP (AIR 2000 AP 272)
Mr. X v. Hospital Z (2002 SCCL.COM 701)
Mr. X v. Hospital Z (AIR 1999 SC PG 495)
MX of Bombay, India inhabitant v. M/s ZY (AIR 1997 Bombay 406)

Laws:

Persons with Disabilities Act
Epidemic Diseases Act
Delhi Police Act
Narcotics Drugs and Psychotropic Substances Act
Immoral Traffic (Prevention) Act
Emigration Act

SRI LANKA

Laws:

Contentious Diseases Act
Quarantine and Prevention of Diseases Act
Suburban Dairies and Laundries Act
Factories Act No. 12
Vagrancy Act

NEPAL

Cases:

Annapurna Rana v. Kathmandu District Court (Writ no. 2187 of 2053)
Meera Dhungana for FWLD v. HMG/Nepal (Supreme Court Bullitin, 2059 [2002], vol. 5, p. 13)
Publication of Judgements Related to Human Rights (Special issue, Supreme Court 2059 [2002], p. 144-151)

Laws:

Infectious Diseases Act
Civil Service Act
Public Security Act
Narcotics Drugs (Control) Act
Country Code
Public Offences and Punishment Act
Immigration Rules
Prisoners Act

BANGLADESH

Cases:

Blast v. Bangladesh (4 BLC 600)

Laws:

Code of Criminal Procedure
Vagrancy Act
Narcotics Drugs Act
Suppression of Immoral Traffic Act
Emigration Ordinance
Foreigners Act
Prisoners Act

Annexures

Annexure 1: HIV and Development in the Countries Studied

BANGLADESH

The first incidences of HIV appeared in Bangladesh during the late 1980s and early 1990s. Infection rates currently remain low, with national prevalence under 1%. However, despite this low prevalence, Bangladesh has high vulnerability factors, including widespread sex work and injecting drug use, large mobile populations, serious poverty and gender inequality. Moreover, there is evidence of very low condom use, extensive needle sharing by IDU and very little knowledge among the general population on the basic facts of HIV/AIDS. In light of these vulnerability factors, there is increasing concern that the epidemic could spread to the general population in a similar manner to that seen in several neighbouring countries (Myanmar, Thailand, parts of India).

BANGLADESH 2003	
Population (millions)	140.4
Sex ratio (females per 1000 males)	933
Total fertility rate	3.5
Maternal mortality rate (per 100,000 live births)	400
Literacy rate (%)	40.8
Population below income poverty line \$1 per day (%)	33.7
Life expectancy	61.4
HIV prevalence among adults (%)	<0.1
Total estimated number of PLWHA	13,000

Source: UNAIDS 2003 estimates, UNDP Human Development Report 2003

CHINA

HIV was first reported in China in 1985. Until 1993 the spread of the epidemic remained limited and was mostly confined to vulnerable groups, such as IDU, sex workers and a small number of migrant labourers. However, after 1994, an increasing number of HIV infections were reported among injecting drug users and commercial plasma donors and the number of PLWHA grew rapidly.

Although China's national prevalence rates remain less than 0.1%, these figures conceal the fact that there are serious, concentrated epidemics among vulnerable populations in a number of regions. Available evidence suggests that injecting drug use is increasing (with a high proportion of drug users sharing ne-

dles and syringes), and that condom use remains low among sex workers, MSM and other vulnerable groups. HIV is increasingly being spread through sexual intercourse and it is feared that it is now reaching further into the general population. The infection rate rose by 17% in the first half of 2002 alone, and 31 provinces (autonomous regions and municipalities) are now affected.

CHINA 2003	
Population (millions)	1285.2
Sex ratio (females per 1000 males)	-
Total fertility rate	1.8
Maternal mortality rate (per 100,000 live births)	55
Literacy rate (%)	83.5
Population below income poverty line \$1 per day (%)	4.6
Life expectancy	71
HIV prevalence among adults (%)	<0.1
Total estimated number of PLWHA	850,000

Source: UNAIDS 2003 estimates, UNDP Human Development Report 2003

INDIA

Since the first case of HIV was reported in Chennai in 1986 HIV has spread rapidly within India, with incidences of infection reported from almost all states and union territories. The infection rate is estimated to be 0.8 percent among the general adult population, with much higher prevalence within vulnerable populations and worst affected states. For example, in Maharashtra, prevalence is 60% among Mumbai's sex workers and over 2% among women attending ante-natal clinics (a common proxy indicator for prevalence in the adult population). The epidemic is slowly moving beyond its initial focus among sex workers, with sub-epidemics evolving in a number of populations and regions. The last four years have seen a broadening of the epidemic across the southern and western states of India, as well as the continued concentration of HIV among drug users in the North Eastern states.

INDIA 2003	
Population (millions)	1027
Sex ratio (females per 1000 males)	933
Total fertility rate	3
Maternal mortality rate (per 100,000 live births)	540
Literacy rate (%)	65.38
Population below income poverty line \$1 per day (%)	28.6
Life expectancy	63.9
HIV prevalence among adults (%)	<0.8
Total estimated number of PLWHA	4,580,000

Source: UNAIDS 2003 estimates, UNDP Human Development Report 2003

NEPAL

The first cases of HIV were reported in Nepal in 1988. Although surveillance is patchy, the limited data indicates that HIV prevalence is currently around 0.5 percent in the general population. However, this low prevalence among the general population masks a concentrated epidemic, with prevalence rates among injecting drug users at around 40.4% nationwide, and 68% in the Kathmandu Valley (NCASC, 2000; FHI, 2002), as well as 17.3% among sex workers in the Kathmandu valley (SACTS/FHI, 2000). The limited development, socio-economic inequalities and ongoing conflict in Nepal make the country highly vulnerable to the spread of HIV/AIDS. There are many people migrating without adequate information or support, and there is also a serious problem of trafficking of women for commercial sexual exploitation. In addition, drug use is increasing in Nepal and sex work is also widespread with little outreach to sex workers.

NEPAL 2003	
Population (millions)	24.1
Sex ratio (females per 1000 males)	-
Total fertility rate	4.3
Maternal mortality rate (per 100,000 live births)	540
Literacy rate (%)	-
Population below income poverty line \$1 per day (%)	42
Life expectancy	59.9
HIV prevalence among adults (%)	0.5%
Total estimated number of PLWHA	58,000

Source: UNAIDS 2003 estimates, UNDP Human Development Report 2003

SRI LANKA

The first case of HIV in Sri Lanka was reported in 1987 and prevalence rates in the country still remain very low, with approximately 4,800 people living with HIV/AIDS, and prevalence among sex workers estimated to be under 1%. Nonetheless, the country is considered vulnerable due to a range of factors. These include a growing number of sex workers, particularly where armed forces are stationed and along major transportation routes; low use of condoms; high and growing number of STDs; high levels of mobility; displacement of populations and sexual violence due to conflict; and the particular vulnerability of young women working in the Free Trade Zone areas.

SRI LANKA 2003	
Population (millions)	19
Sex ratio (females per 1000 males)	-
Total fertility rate	2
Maternal mortality rate (per 100,000 live births)	90
Literacy rate (%)	90%
Population below income poverty line \$1 per day (%)	25
Life expectancy	72.6
HIV prevalence among adults (%)	<0.1
Total estimated number of PLWHA	4,800

Source: UNAIDS 2003 estimates, UNDP Human Development Report 2003

Annexure 2: Resources

Legislating an Epidemic: HIV/AIDS in India; Lawyers Collective, 2003
Law, Policies, and Regulations Concerning HIV/AIDS Prevention and Containment: An Assessment and Recommendations - China; UNDP, 2003
Regional Human Development Report - HIV/AIDS and Development in South Asia; UNDP, 2003
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Handbook for Legislators on HIV/AIDS, Law and Human Rights; UNAIDS/IPU, 1999
Health Care: Policy, Ethics and Law; TILEM, National Law School of India, 2000
HIV/AIDS Testing: In Search of Policy - Interface of Law, Ethics and Medicine; TILEM, National Law School of India, 2000
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Law and Health: An Introduction to Systems; TILEM, National Law School of India, 1999
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AIDS - Law and Humanity; The Indian Law Institute New Delhi, 1995
HIV/AIDS Law and Law Reform: Asia Pacific; UNDP 1995
HIV/AIDS Law and Human Rights; UNDP 1995
Recommendations on Sri Lankan Law, Ethics and HIV/AIDS; CPA, 1995
Law, Ethics and HIV: Proceedings of the UNDP Inter-country Consultation; UNDP, 1993

UNDP is the UN's global development network, advocating for change and connecting countries, knowledge, experience and resources to help people build a better life. HIV/AIDS is one of its top organisational priorities, integrating it into its broader efforts to support effective governance and poverty reduction. UNDP has been one of the most outspoken advocates for a multi-sectoral response to HIV/AIDS since the late 1980s.

The UNDP Regional HIV and Development Programme covers 13 countries in South and North East Asia. The programme addresses the development and trans-border challenges of HIV/AIDS in the region and supports integrated and rights based responses that promote gender equality, sustainable livelihoods and community participation. Focus areas of work include: Policy Advocacy and Outreach, Mobility and HIV/AIDS, Capacity Development and Greater Involvement of People Living with HIV/AIDS and Human Rights.

www.YouandAIDS.org

The HIV/AIDS Portal for Asia Pacific



United Nations Development Programme