HIV/AIDS (Prevention and Control) Act, 2017: A Distant Dream

Dr. Deesha Khaire
Assistant Professor of Law, Gujarat National Law University,
Koba, Gandhinagar, Gujarat, India
Email - dkhaire@gnlu.ac.in

Abstract: *The General Assembly of United Nations, recalling and reaffirming its commitments on HIV/AIDS, has adopted the Declaration of Commitment on HIV/AIDS, 2001 to address the problems of HIV/AIDS in all its aspects and to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner. India being signatory to the aforesaid declaration finally passed the Act in 2017. The story of HIV/AIDS patients till now is the story of rights, of haves and have nots, of discrimination and stigma. The Indian judiciary in plethora of cases upheld the rights of HIV/AIDS patients/victims in one way or the other. The scenario with respect to the status of HIV/AIDS patients did not change for good even though India is a signatory to different international agreements, and the only ray of hope is that the Indian judiciary has set trends to uphold their rights. The passing of HIV/AIDS (Prevention and Control) ACT,2017 has raised the hopes of HIV/AIDS patients, and this research paper is an effort to answer the question whether the Act is comprehensive enough to cater the needs of HIV/AIDS.*

Key Words: *HIV/AIDS, Right to Health, Protection, Prevention and Control, Discrimination, Stigma, Commitment.*

1. INTRODUCTION

> *Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State.*
>
> *-Henry Sigerist*[i]

The HIV/AIDS pandemic is one of the most urgent threats to the global public health. The global statistics clearly indicates that 35.0 million people have died by AIDS-related illnesses and 76.1 million people have become infected since the start of the epidemic. It is to be noted that 36.7 million people globally were living with HIV, and 19.5 million people were accessing antiretroviral therapy in 2016. And 1.8 million people became newly infected with HIV in 2016.[ii] Growing inequalities and disparities of living standards between the worlds' richest and poorest are increasing as well which has posed a new concern for the human community.

When history reflects on the devastation caused by Acquired Immuno Deficiency Syndrome (AIDS) in the early 21st century, to what will our failure to curtail the spread of this preventable disease be attributed? Unlike the stories told of plagues, in which scientific ignorance about the spread of diseases seems more unfortunate than unjust, the story of AIDS will surely be a story about rights. The story of AIDS is about haves and have not's, and about discrimination, denial and indifference.

Human Immunodeficiency Virus (HIV) continues to spread throughout the world, shadowed by increasing challenges to human rights, at both national and international levels. In most of the world, discrimination jeopardizes equitable distribution of access to HIV-related goods for prevention and care, including necessary drugs for HIV/AIDS care and the development of vaccines to respond to the specific needs of all populations. As the number of people living with HIV and with AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more apparent, but also becoming increasingly diverse.

Since the twentieth century, there has been momentous advancement in health, such as in life expectancy and mortality rates, and medical progress that introduced hundreds of safe and effective medicines to cure infectious diseases. However, this does not mean the end of any possible health threats and efforts are still needed to further combat global health concerns. Indeed, diseases that were overcome in the developed nations are still gripping developing and poverty-stricken countries, and there is still a long way to go before the developing countries can reach the same level as the developed countries.

2. RESEARCH METHODOLOGY:

The author has relied upon doctrinal works for most of the inputs and theoretical deliverance of this paper. However, the suggestions have been formulated after conducting an empirical study the findings of which are not

produced in this paper as the subject matter is narrowed down to the 2017 Act. For the purpose of this research work, theoretical knowledge based on the provisions of the 2017 Act, the existing literature and the decisions of various judicial bodies of India are sufficient to draw the conclusions and suggest apt measures to the Government of India to improvise the provisions of the Act.

3. HEALTH AND RIGHT TO HEALTH: The Dividing Line

Given the centrality of health as a vital feature of the human condition, health has been recognized as a human right in numerous international documents[iii] and most of the civilized countries in the world are party to at least one human rights treaty or the other that deals with health-related rights. Although the terminology of right to health is commonly employed in national and international human rights dialogue, still, right to health as part of economic, social and cultural rights, is hardly ever put on the same platform of importance as civil and political rights.

The International Covenant on Economic, Social and Cultural Rights, 1966; the International Covenant on Civil and Political Rights, 1966; the UN Declaration on Elimination of All Forms of Discrimination Against Women, 1967; the Convention on the Elimination of All Forms of Discrimination Against Women, 1979; and the Convention on the Rights of the Child, 1989 have all been framed to protect apart from others the health care rights of women, children and other discriminated sections of the society. For more than fifty years, the World Health Organization (WHO) has been playing a laudable role at the international level with a view to ensure the availability of the highest standards of health care to people all over the world.

On the one hand the legislatures in India have tried to enforce the rights of the patients through various enactments like Indian Medical Council Act, 1956; Indian Nursing Council Act, 1947; Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994; The Medical Termination of Pregnancy Act, 1971; Transplantation of Human Organs Act, 1994; Medical Health Act, 1987; etc. On the other hand, the patients of HIV/AIDS are discriminated beyond recovery. It is very important to note that the Indian judiciary has brought right to health under Art. 21 of the Indian Constitution which is a Fundamental Right.[iv] Moreover, health has been given importance over religion or customary practices. Art. 47 is nothing but a duty casted upon the state to enact laws to improve public health.[v] But on the other hand, the legislations have proved to be inadequate when faced with new difficulties. For example, the Medical Termination of Pregnancy Act, 1971, is inadequate to answer the question of surrogate mother or termination of pregnancy after 20 weeks of pregnancy. Similarly, when it comes to the Rights of the HIV/AIDS patients, the present legal system is at a loss to answer all the questions.

As we all know the one global problem that has shaken the human race regardless of religions, regions, countries, races, gender and language is the well-known disease *'Acquired Immunodeficiency Syndrome'* (AIDS) the cause of which is *Human Immunodeficiency Virus* (HIV). Today HIV/AIDS is considered as a deadly disease and the victim of which is forced to undergo a lot of trauma because of the social stigma branded along with the disease. As various governments globally work for the elimination of such a disease a lot remained to be done for the victims of the disease; be it medical support or financial support or psychology support or legal support or all of them. The life situation of the victims of HIV/AIDS, although is short, is pathetic and getting deteriorated. The statistics reveal various unforeseen dangers to life of such victims and are alarming to world at large.

There are many factors outside the province of medicine that play a significant role in determining the quality of our lives like poverty, unemployment, malnutrition, deforestation, desertification, morality, crime, divorce, human unhappiness and so on.[vi] Out of all these, right to be healthy is the most important of all the rights. Without this right, no major change is possible and with this right in hand no change can remain impossible. Health is man's most precious possession; it influences all his activities; it shapes the destinies of people. Without it there can be no solid foundation for man's happiness.[vii] Health has always been a major concern for people throughout the ages. It is not at all a new concept, nor is it an asset of the modernized or Western world. Health has always been the intimate part of rights in the Indian society.

WHO defines health – as "a state of complete physical, mental and social well-being, not merely the absence disease or infirmity."[viii] There are many misconceptions about right to health, such as right to health is not the same as the right to be healthy, it is not only a programmatic goal to be attained in the long term and a country's difficult financial situation does not absolve it from having to take action to realize right to health.

Confronted with the controversies surrounding right to health, the Committee on Economic, Social and Cultural Rights issued a General Comment No. 14 that contributed to the discourse on the meaning of right to health. It states, "Health is a fundamental human right indispensable for the exercise of other rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[ix]

Consistent with the idea that most human rights are interrelated and interdependent, right to health is not confined to health care, but embraces a wide range of socio-economic conditions necessary for people to lead healthy lives, including the underlying determinants of health, for example, nutrition, housing, sanitation and water. The importance given to the "underlying determinants of health", that is, the factors and conditions which protect and promote right to health beyond health services, goods and facilities, show that right to health is dependent on, and

contributes to, the realization of many other human rights. These include right to food, water, an adequate standard of living, adequate housing, and freedom from discrimination, privacy, and access to information, participation, and the right to benefit from scientific progress and its applications.

It is arguable whether or not we necessarily need a clear definition of the word 'health' in order to understand right to health better. No doubt the attempts to define health are commendable because one also needs to assess the implications from the various concepts and definitions of health. However, rather than discussing a word as vague as 'health' in the abstract, the practical application of right to health should be considered. This is similar to attempt to define expressions like 'happiness' or 'life' or more specifically in this context right to life which according to international human rights documents is the essence of all human rights.

In sum, right to health does not mean right to be healthy, since being healthy is determined in part by health care, but also by genetic predisposition and social factors. The WHO definition seeks to capture the constructive connotations of health in everyday discourse, and suggests that there are ideals of health and not merely degrees of freedom from diseases.[x] It also has important conceptual and practical implications and it illustrates the interdependence and indivisibility of rights as they relate to health. The field of social epidemiology has excelled in establishing correlations between discrimination based on race, class or gender, denial of education and of decent working conditions, as well as other factors that contribute directly to increased rates of mortality and morbidity. Hence, these social determinants may also be defined in human rights terms as deprivation of health-related rights.[xi] This shows that rights relating to discrimination, autonomy, information, education and participation are a fundamental and indivisible part of the achievement of the highest attainable standard of health, just as the enjoyment of health is equally inseparable from that of other rights, whether categorized as civil and political or social, economic and cultural. [xii] Nonetheless, it is equally important to understand the implementation of right to health.

States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international customary law[xiii] and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights. The Committee on Economic, Social and Cultural Rights has also stressed that States have a *core minimum obligation* to ensure the satisfaction of minimum essential levels of each of the rights under the Covenant. While these essential levels are, to some extent, resource-dependent, they should be given priority by the State in its efforts to realize the rights under the Covenant.

The Economic, Social and Cultural Rights Committee, in its General Comment No.3, was of the view that "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party." [xiv] The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights further reaffirmed that "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, violating the ICESCR." [xv] There were endeavours to define the core content of some specific economic, social and cultural rights and it raises the question as to what level of health individuals should minimally have so that they could lead a dignified life and be able to operate adequately in society.

At the 1977 World Health Assembly, the WHO initiated the Global Strategy for Health for All by the Year 2000, which states, "There is a health baseline below which no individuals in any country should find themselves." [xvi] In the interpretation of this goal by governments and the WHO, it is intended that all people in all countries should have a level of health that enable them to work productively and participate actively in the social life of the community in which they live. [xvii] This concept and vision of Health for all was perhaps an attempt to restore the definition of health as construed in the WHO constitution to its original purpose.

Giving a sketch of the status of the HIV/AIDS victims at this juncture is very important. Right to health and availability of qualitative health services are issues that are relevant all over the world. Hence, these issues also form topics of debate at various international levels. The United Nations, in particular, has played an active role in adopting various resolutions to safeguard the interests of individuals in ensuring their health and well-being.

As discussed above, many international conventions have been framed to protect apart from others the health care rights of women, children and other discriminated sections of the society. WHO is playing laudable role and several international agencies have also lent support to public participation in health care. [xviii] But then, the issue is how far these international obligations, agreements, treaties and covenants bind the Indian State and its nationals? To what extent can these instruments be invoked and relied upon in Indian Courts?

Chief Justice Sikri in ***Keshavananda Bharati* v. *State of Kerala***, [xix] observed that, in view of Art. 51, the Supreme Court must interpret the language of the Constitution, if not intractable, in the light of the United Nations Charter and the solemn declaration subscribed to by India. According to the Supreme Court, the executive is qua the State, competent to represent the State in all matters international and may by an agreement, convention or treaties incur obligation, which in international law are binding on the State. But the obligations arising under the agreement or treaty are not by their own binding upon Indian nationals. The making of law is necessary when the treaty or agreement operates to restrict the rights of citizens or other or modifies the laws of the State. If the rights of citizens or

others, which are justiciable, are not affected, no legislative measure is needed to give effect to the agreement or treaty. [xx]

The term Right to Health is nowhere mentioned in the Indian Constitution yet the Supreme Court has interpreted it as a fundamental right under Right to Life enshrined in Article 21. It is a significant view of the Supreme Court that first it interpreted Right to Health under Part IV, i.e., Directive Principles of State Policy and noted that it is the duty of the State to look after the health of the people at large. In its wider interpretation of Article 21, it was held by the Supreme Court that, Right to Health is a part and parcel of Right to Life and therefore one of fundamental rights provided under Indian Constitution. In the real sense, the court has played a pivotal role in imposing positive obligations on authorities to maintain and improve public health.

Till the early 1980s, the judicial response to health related issues in India was essentially centered on cases of medical negligence or entitlements of employees under the Workmen's Compensation and ESI Acts. Apart from this, there were a few cases concerning drugs and other related issues. The second branches of litigation concerning employees are cases regarding government servants. A large number of these cases pertain to the rights of government employees to reimbursement of medical expenses incurred in private health care sector. At around this time patients started approaching the courts in matters concerning medical negligence. They were required to file suits in the district courts, which were highly time consuming, expensive and in many cases resulted in failure. The law followed in these matters was the English common law (judge made law) concerning torts and more particularly negligence. Though the legal tools to fight against medical negligence have always been available, the procedural tools were highly inadequate. So the cases were few. This situation changed dramatically from the mid-1980s with the passage of the Consumer Protection Act and a consequent decision of the Supreme Court held that medical services except those providing totally free medical services were covered under the Act.

4. JUDICIAL JURISPRUDENCE OF RIGHT TO HEALTH:

The classification of rights in the international scenario took place only in 1966 after UDHR of 1948 in the form of the International Covenants. Right to life has been incorporated under the Civil and Political right which includes right to health. However, various State parties have adopted the provisions of the Covenants in their own ways giving effect to right to life and right to health. [xxi]

In ***Paschim Banga Khet Mazdoor Samity and others*** **v.** ***State of West Bengal***, [xxii] the Indian Supreme Court addressed the Constitutional duty of government-owned hospitals to provide emergency medical treatment to someone who was seriously ill. The plaintiff suffered serious head injuries and brain hemorrhage after falling off a train. He was turned away by various hospitals because the hospitals had inadequate medical facilities or did not have a vacant bed to accommodate him. Consequently, he had to seek treatment at a private hospital and incurred costly expenditure for it.

The Court held that the provision of adequate medical facilities of the people is an essential part of the obligations undertaken by the Government in a welfare state and this obligation is discharged by running hospitals and health centers that provides medical care to the person to avail those facilities. [xxiii] Article 21 of the Indian Constitution imposes an obligation on the State to safeguard the right to life of every person; therefore, denial of timely medical treatment necessary to a person in need of such treatment would constitute a direct violation of this right. The Court recognized that financial resources are needed for providing these facilities, but the State could not avoid its Constitutional obligation based on financial constraints. Accordingly, the State was ordered to compensate the Plaintiff for the loss suffered.

This case illustrates the innovation used by courts in dealing with the different areas of economic and social rights. By explaining right to health as forming an integral part of the right to life, the Court was able to provide substantive protection to right to health as well as to show the indivisibility of civil/political and economic/social/cultural rights.

5. PUBLIC INTEREST LITIGATION AND RIGHT TO HEALTH

Plethora of cases arising out of Public Interest Litigations (PILs) have been filed in order to secure proper health services. Many judgments pronounced in these cases have had a profound effect as they have resulted in effective policy making and better execution of services. PILs have been filed on a wide array of health issues involving fundamental right to health, right to food, reproductive rights, rights of workers to occupational health and safety, right to clean environment, right to adequate drugs, medical negligence, right against medical malpractice, right to emergency health care, HIV/Aids and public health care. [xxiv]

Different countries tried, exploring the possibility of implementing the international or Constitutional right to health through their domestic judicial systems. [xxv] Compared to other human rights especially civil and political rights, courts are generally more reluctant to found their decisions just on the basis of right to health. Although the ratio for the number of judgments where right to health is justiciable is considerably less, there is increasing recognition of right to health and the role governments have in protecting the right of health of their people.

6. Role of Indian Judiciary on Rights of HIV/AIDS Patients:

With reference to issue of HIV/AIDS patients/victims the Indian courts have taken a more informed approach, which have helped in reducing discrimination. Right from stopping people being kept under captivity, to stopping discrimination on the basis of the disease and safeguarding the employment of the affected people and to the policy on drugs required for the HIV positive people, the courts have issued important judgments, clearly highlighting the apathy of the government and the discriminatory policies adopted and to point to the large amount of work that still needs to be done in this area. [xxvi]

Though the Supreme Court in a series of judgments has declared right to health and health care to be a fundamental right, it has not been given due recognition by the State. What is also quite unfortunate is that in a country where poor and marginalized are more in number and these people cannot afford paid services in any government and private hospitals, the state should have develop novel health insurance policies at a nominal rate.

7. The HIV/AIDS (Prevention and Control) Act, 2017: An Overview

Even after six decades of independence no effective steps have been taken to implement the Constitutional obligation upon the State to secure the health and strength of people. It has rightly been said that nutrition, health and education are the three inputs accepted as significant for the development of human resources. But these sectors get adequate attention only when community becomes affluent to meet the heavy expenditure involved in each. To this end the Government was expected to formulate legislation, it is finally on 20th April, 2017 the legislation was passed for protection and control of HIV/AIDS disease, clearly indicating the apathy on the part of government to pass law on this subject as it was first introduced in 2005, reintroduced in 2007, 2010 and 2014 finally getting assent in 2017.

The Act seeks to prevent and control the spread of HIV and AIDS, prohibits discrimination on various grounds which include the denial, termination, discontinuation or unfair treatment with regard to: (i) employment, (ii) educational establishments, (iii) health care services, (iv) residing or renting property, (v) standing for public or private office, and (vi) provision of insurance (unless based on actuarial studies), [xxvii] provides for informed consent[xxviii] and confidentiality with regard to their treatment, [xxix] places obligations on establishments to safeguard their rights, [xxx] and creates mechanisms for redressing their complaints, [xxxi] the role of Central and State government is also mentioned, [xxxii] it discusses about guardianship and court proceedings, too.

8. FINDINGS:

The HIV/AIDS (Prevention and Control) Act, 2017 has certain lacunas or shortcomings. At one place the Act tried to recognize lot of rights to HIV/AIDS patients but on other hand the contentious clause 'as far as possible" [xxxiii] dilutes it from being legal right as it only obliges the government to take measure to provide the services as to diagnostic facilities, ART therapy and opportunistic, clearly indicating that it does not make this available to people as a matter of right. Section 46(2)(e) provides that the State may lay down guidelines for providing such treatment, thus leaving the entitlement completely in the hands of executive authorities thereby further, defeating the purpose of universal precautions. [xxxiv]

The insurance industry is allowed to use actuarial calculations to limit access to products to people with HIV.[xxxv] Though the Act provides for the grievance redressal mechanism, the wordings used "in such manner and within such time as may be prescribed" further dilutes the objective with which the Act is introduced, as it defeats the whole purpose of the Act by not prescribing procedure and time frame for disposal of complaints.[xxxvi]

The Act passed by the Parliament actually fails to bring a longevity and sustainability considering the basic demands of the HIV/AIDS patients/victims. Provisions of chapter V, VI and VII wherein powers of establishments, central and state government to take measures shows how in terms of availability and accessibility the Act fails to improve or strengthen the existing mechanism. The Act promises free ART treatment, however at the backdrop of severe budget cut by UN on funding for HIV/AIDS programmes, it clearly seems a distant dream as it has severely affected the availability of the drugs, kits, etc. [xxxvii]Although free antiretroviral treatment, or ART, has been provided in India since 2004, the uptake remains low. Further, these clinics are neither easily accessible nor economically, physically or informationally available, has added to the complications. [xxxviii]

The General Assembly of United Nations, recalling and reaffirming its commitments on HIV/AIDS, has adopted the Declaration of Commitment on HIV/AIDS (2001) to address the problems of HIV/AIDS in all its aspects and to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner. India being signatory to the aforesaid declaration finally passed the Act in 2017 to the effect, however, the Act will not force the State to invest in HIV treatment as such, which the concern and need of the hour, as the provisions clearly indicate that, it focuses more on to prevention.

As discussed, Right to health being recognized as basic human right by different international documents to which India is a signatory. The different decisions of the SC of India have also time and again stress the importance of Right to health and duty casted on the part of the State, the current law does not seem to be comprehensive enough to deal

with India's commitment as to its commitment on HIV/AIDS, making it a distant dream as to the justice for the HIV/AIDS patients/victims against the discrimination, denial and stigma.

9. CONCLUSION

The challenges AIDS pandemic brings with it are social, legal, economic, and ethical issues. We are grappling to find new treatments, cures, preventive therapies and educational interventions that are both effective and appropriate for persons of diverse races, ethnicities, cultures, languages, religions, ages, gender, sexual orientations, *etc.* The obligations of governments to promote health and prevent disease should enable development of appropriate policies and programmes lacked by suitable legislation although India has it only by 2017.

It is commendable to notice and worth mentioning that the journey of right to health and human rights especially relating to HIV/AIDS has come a long way. But there is still a long struggle ahead in continuing the efforts for implementing the different policies, whether international or national to control this epidemic, wherein the detailed, separate law on this is definitely a great help for protecting and promoting the rights of HIV/AIDS patients and combating the epidemic.

10. RECOMMENDATIONS AND SUGGESTIONS

- Much is talked and discussed about the human rights but the reality check brings to our attention that there is still a need spread awareness and sensitise the people about respecting the human rights of the individuals. Special attention should be given to sensitising programme with respect to vulnerable groups as the violation of their rights is on rise.
- At international level many things are done with respect to making policies, providing guidelines relating to the protection and prevention of HIV/AIDS. But it being recommendatory in nature, it does not cast any responsibility on the States though they are party to different treaties. Considering the scenario it is now required that steps should be taken to make the international laws mandatory at least with respect to matters relating to violation of human rights.
- The contribution of Judiciary is noteworthy, but considering the pendency and overburdening of the courts, special court should be created for handling the matters relating to HIV/AIDS cases wherein the trials should be conducted in camera.
- The public policies of the international committees and those made by the States are not enforceable or lack force of law. Hence, even though many policies are good, they lack implementation. Hence, there should be provision to convert the policies immediately into a law. In India, proper implementation is still a distant dream.
- There are many issues relating to HIV/AIDS. The 2017 Act must address the following pressing concerns:

  a. The 2017 Act must included confidentiality to conform to the recommendations in the International Guidelines on HIV/AIDS and Human Rights, which read as follows: "General confidentiality and privacy laws should be enacted. HIV-related information on individuals should be included within definitions of personal/medical data subject to protection and should prohibit the unauthorized use and/or publication of HIV-related information on individuals. Privacy legislation should enable an individual to see his or her own records and to request amendments to ensure that such information is accurate, relevant, complete and up-to-date. An independent agency should be established to redress breaches of confidentiality. Provision should be made for professional bodies to discipline cases of breaches of confidentiality as professional misconduct under codes of conduct ..."

  b. The policy under the 2017 Act should be developed to make it unlawful to refuse treatment to persons living with HIV/AIDS (PLHAs).

  c. Legislative barriers to make available the antiretroviral drugs, such as TRIPS and WTO agreements, should be removed.

  d. Legislation protecting consumers, especially PLHAs, from fraudulent claims regarding cure for HIV/AIDS should be put in place by the 2017 Act.

  e. Emphasis should be placed on pre-and post-test counselling for patients. To achieve this, PLHAs should be trained as counsellors.

  f. Government should follow the examples of other countries that will adequately make the workplace safe for all. Such Act should discourage mandatory testing for HIV before employment but should encourage HIV/AIDS education in the workplace, emphasizing universal precaution and prevention, and care and support for employees already infected.

  g. The Act of 2017 needs to clarify the employer's obligations in daily work practices to take reasonable care of the health and safety of employees.

h. Government, labour unions, and employers of labour should work together in developing legislative codes for the industries, which will address specific risks of occupational infection. Perhaps HIV/AIDS educational programs should form the basis of collective agreements between employers and workers unions.

i. Government and NGOs should embark on HIV/AIDS education among religious leaders/groups.

j. Professional bodies, policymakers, legislators, interest groups, and the entire public should be sensitized to the human rights of PLHAs and about the provisions of 2017 Act.

k. The courts have a great role to play in ensuring that PLHAs are not discriminated against. As a back up to the court system, an independent human rights body should be set up to hear cases on discrimination against PLHAs. This should ensure speedy trial of cases brought by PLHAs.

l. Free legal assistance should be made available to PLHAs by the government or NGOs working on the human rights of PLHAs.

m. Government programmes should aim at sensitizing women to negotiate safe sex and determine the number of children they want.

n. Men should be sensitized to respect the human rights of women and desist from negative practices against women.

o. Criminal law in the area of prostitution impedes the provision of HIV/AIDS prevention and care by driving people engaged in the industry underground. Such laws should be reviewed with the aim to decriminalize sex work where no victimization is involved and regulate occupational health and safety conditions to protect sex workers and their clients.

p. By treating sex work as a personal service industry that is neither condemned nor condoned, public health objectives are much more likely to be achieved than under the criminal law.

REFERENCES:

1. Lauren, Paul Gordon, *The Evolution of International Human Rights: Visions Seen*, (2003) Philadelphia: University of Pennsylvania Press, 36.
2. Cribb, Alan, *Health and the Good Society – Setting Healthcare Ethics in Social Context*, (2005), Oxford: Oxford University Press, 26.
3. Marks, Stephen P., 'Health From A Human Rights Perspective', (2003) http://www.hsph.harvard. edu/fxbcenter/ FXBC_WP14-Marks.pdf, [Accessed on 25 July, 2017.]
4. Gruskin, Sofia and Daniel Tarantola, 'Health and Human Rights', (2000) http://www.hsph.harvard. edu/fxbcenter/ FXBC_WP10--Gruskin_and_Tarantola.pdf, [Accessed on 5 March 2017.]
5. Taylor, Allyn L., Bettcher, Douglas W., Fluss, Sev S., Katherine DeLand and Derek Yach, 'International Health Instruments: An Overview', in Detel, Rogers, McEwan, James, Robert Beaglehole and Heizo Tanaka (ed.), *Oxford Textbook of Public Health*, (4th ed., 2004) Oxford: Oxford University Press, 379.

End Notes

[i] https://www.coursehero.com/file/pcudu4/C-Right-to-Health-in-India-Health-is-one-of-the-goods-of-life-to-which-man-has/ [accessed on 12.12.2014]

[ii] https://www.google.co.in/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0ahUKEwic3IatocfVAhXIPI8KHRbfC98QFgg2MAQ&url=http%3A%2F%2Fwww.unaids.org%2Fen%2Fresources%2Ffact-sheet&usg=AFQjCNFAka1FT6wMBycvMDQKR5W_9dOA6Q

[iii] Lauren, Paul Gordon, *The Evolution of International Human Rights: Visions Seen*, (2003) Philadelphia: University of Pennsylvania Press, 36.

[iv] *Paschim Banga Khet Mazdoor Sanity and others* v. *State of West Bengal*, (1996) Supreme Court of India, Case No.169, 4 SCC 37, http://www.escr-net.org/usr_doc/Paschim_banga_ Khet_ Samity_judgment.doc, [Accessed on 5 July 2017.]

[v] Art. 47-Duty of the State to raise the level of nutrition and the standard of living and to improve public health The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health

[vi] Sister Payyappily Celine, "What is Holistic Health", *Health for the Millions*, (April-May 2005-06).

[vii] S.L Goel, *Public Health Administration* (New Delhi: Sterling Publishers Pvt. Ltd., 1984), p.20.

[viii] http://www.who.int/governance/eb/who_constitution_en.pdf

[ix] U.N Committee on Economics, Social and Cultural Rights, General Comment No.14: The Right to the Highest Attainable

Standard of Health, adopted on 11 May 2000, UN Document E/C.12/2000/4.

[x] Cribb, Alan, *Health and the Good Society – Setting Healthcare Ethics in Social Context*, (2005), Oxford: Oxford University Press, 26.

[xi] Marks, Stephen P., 'Health From A Human Rights Perspective', (2003) http://www.hsph.harvard. edu/fxbcenter/ FXBC_WP14--Marks.pdf, [Accessed on 25 July, 2017.]

[xii]Gruskin, Sofia and Daniel Tarantola, 'Health and Human Rights', (2000) http://www.hsph.harvard. edu/fxbcenter/ FXBC_WP10--Gruskin_and_Tarantola.pdf, [Accessed on 5 March 2017.]

[xiii]Customary law is evidence of a general practice of States accepted as law and followed out of a sense of legal obligation.

[xiv] U.N Committee on Economics, Social and Cultural Rights, General Comment No.3: The Nature of States Parties Obligations, (fifth session, 1990), E/C.12/1990/8.

[xv] The Maastricht Guideline on Violations of Economic, Social and Cultural Rights, (1998) *Human Rights Quarterly,* Vol. 20, 691–705.

[xvi] World Health Organization, *Global Strategy for Heath for All by the Year 2000*, (1981) Geneva: World Health Organization, 31.

[xvii] Taylor, Allyn L., Bettcher, Douglas W., Fluss, Sev S., Katherine DeLand and Derek Yach, 'International Health Instruments: An Overview', in Detel, Rogers, McEwan, James, Robert Beaglehole and Heizo Tanaka (ed.), *Oxford Textbook of Public Health*, (4th ed., 2004) Oxford: Oxford University Press, 379.

[xviii] The World Health Organization Alma Ata Declaration, 1978, states the following:

"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care." http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/ [Accessed on 15 April, 2017.]

[xix] AIR 1973 SC 1461

[xx] See *PUCL* v. *Union of India,* AIR 1997 SC 1203; *PUCL* v *Union of India,* AIR 1997 SC 568; *Vishaka* v. *State of Rajasthan* (1997) 6 SCC 241.

[xxi] *Viceconti v. Ministry of Health and Social Welfare, Poder Judicial de la Nación*, Causa no, 31.777/96, 2 June 1998, quoted from http://www.actionaid.org/main.aspx?PageID=741, [Accessed 15 June2017.]

Edgar Carpio Castro Jofre Mendoza &Ors v Ministry of Public Health and the Director of the HIV-AIDS National Programme, Tribunal Constitucional, 3ra. Sala, Ecuador, Resolucion No.0749-2003-RA, 28 Jan. 2004, quoted in Fairstein, Carolina, 'The Right to Health – An Ecuadorian Perspective', (2005) *Housing and ESC Rights Quarterly* Vol.1No.1,http://www.cohre.org/store/attachments/Housing%20&%20ESC%20Rights%20Law%20Quarterly%20Vol1%20No1.pdf,[Accessed on 15 June 2017.]

Cruz Bermudez et al v. Ministerio de Sanidad y Asistencia Social, Supreme Court of Justice of Venezuela, Case No. 15.789, Decision No. 916 15 July 1999, quoted in COHRE, 'Leading Cases on Economic, Social and Cultural Rights: Summaries', (2006) ESC Rights Litigation Programme, Working Paper No.3, http://www.cohre.org/store/ attachments/ COHRE_ Leading%20ESC%20 Rights%20Cases.pdf.pdf, [Accessed on 15 June 2017.] Full text of decision available at http://www.tsj. gov.ve/ sentencias/SPA/spa15071999-15789.html.

Odir Miranda Cortez Et Al. v. El Salvador, Case 12.249, Report No. 29/01,OEA/Ser.L/V/II.111 Doc. 20 rev. at 284 (2000), http://www.cidh.org/annualrep/2000eng/ChapterIII/Admissible /ElSalvador 12.249.htm, [Accessed on 15 June 2017.]

Glenda Lopez v. Instituto Venezolano de Seguros Sociales, (2002) Case No. 00-1343, DecisionNo.487,
http://www.tsj.gov.ve/decisiones/scon/Diciembre/3013-021202-02-0481.html, [Accessed on 15 June 2017.]

[xxii] *Paschim Banga Khe tMazdoor Sanity and others v. State of West Bengal*, (1996) Supreme Court of India, Case No.169, 4 SCC 37, http://www.escr-net.org/usr_doc/Paschim_banga_ Khet_ Samity_judgment.doc,[Accessed on11 May2017.]

[xxiii] *Ibid*.

[xxiv] *Francis Coralie Mullin* v. *Union Territory of Delhi,* AIR 1981(1) SCC 608.

Bandhua Mukti Morcha, etc v. *Union of India and Ors,* AIR 1984 SC 802

Vincent Panikurlangara v. *Union of India,* AIR 1987 SC 990 - (1987) 2 SCC 165,

Parmanand Katara v. *Union of India,* (1989)4 SCC 286.

C.E.S.C. Ltd. v. *Subhash Chandra,* AIR 1992 SC 573

Consumer Education and Research Centre v. *Union of India,* (1995)3 SCC 42.

Murli Deora v. *Union of India and Ors,*(2001) 8 SCC 765

[xxv] *Ibid*

[xxvi]*Lucy D'Souza* v. *State of Goa,* AIR 90 BOM 355

Common Cause v. *Union of India,* AIR 1996 SC 929

M. Vijaya v. *The Chairman and Managing Director, Singareni Collieries Company Ltd,*2002 ACJ 32

P of Bombay v. *Union of India,*2001 Calcutta High Court

Shri. Subodh Sarma & Anr. v. *State of Assam & Ors* ,Guwahati High Court (2000)

M. Chinnaiyan v. Sri *Gokulam Hospital & Queen Mary's Clinical Laboratory,* National Consumer Dispute Redressal Commission, 2006

India Network of Positive People v. *T.A. Majeed & Ors,* Order of the Supreme Court in SLP (Civil) No (s). 5527 /2004 dated 03.01.2007

MC of Bombay Indian Inhabitant v. *M/s ZY,* AIR 1997 BOM 406

Mr. X, Indian Inhabitant v. *Chairman, State Level Police Recruitment Board and Ors,*2006 (2) ALT 82

X v. *State Bank of India,*(2002) – Bombay High Court

G v. *New India Assurance Co. Ltd,*(2004) – Bombay High Court
X v. *The Chairman, State Level Police Recruitment Board &Ors*,2006 ALT 82
RR v. *Superintendent of Police & others,* Unreported (2005) Karnataka Administrative Tribunal
S v. *Director General of Police, CISF and others,* Unreported (2004) High Court at Bombay in WP No. 202 of 1999
CSS v. *State Of Gujarat (2001),*Unreported Special Civil Application No. 11766 of 2000 (Gujarat High Court) (17 February 2001)
Mr. X v. Hospital Z, A.I.R. 1999 S.C. 498.
Dr.Tokugha Yepthomi v. *Appollo Hospital and Anr,* AIR 1999 SC 495
M. Vijaya v. *The Chairman and Managing Director, Singareni Collieries Company Ltd,* AIR 2001 AP 502
VHAP v. *Union of India,* 2003 still pending in Supreme Court
LX v. *Union of India*, *Delhi High Court (CWP – 7330/2004, 5 May 2004)*
Shri Subodh Sarma & Anr. v. *State of Assam &Ors*., Guwahati High Court (2000)
Ramdas R. Ubale v. *State of Maharashtra,* Bombay High Court (Criminal Application 371 of 2008 in Appeal No. 706 of 2006)
Ex. Const. Badan Singh v. *Union of India and Anr,* 97 (2002) DLT 986
Rao Saheb Mahadeo Gayekwad v. *Life Insurance Corporation of India and Anr,* AIR 2004 KAT 439
[xxvii] Section 3 of The HIV/AIDS (Prevention and Control) Act,2017
[xxviii] Section 5,6,7 of The HIV/AIDS (Prevention and Control) Act,2017
[xxix] Section 8,9 of The HIV/AIDS (Prevention and Control) Act,2017
[xxx] Section 11 of The HIV/AIDS (Prevention and Control) Act,2017
[xxxi] Section21, 23-28, S.34-36,& S. 41 of The HIV/AIDS (Prevention and Control) Act,2017
[xxxii] Chapter VII of The HIV/AIDS (Prevention and Control) Act,2017
[xxxiii] Section 14 of The HIV/AIDS (Prevention and Control) Act,2017
[xxxiv] Section 2 (y) of The HIV/AIDS (Prevention and Control) Act,2017
[xxxv] Section 3 (j) of The HIV/AIDS (Prevention and Control) Act,2017
[xxxvi] Section 21 of The HIV/AIDS (Prevention and Control) Act,2017
[xxxvii]Aditya Kalra and Zeba Siddiqui, Funding Crisis Puts India's AIDS Programme and Lives at Risk', Reuters, 24/07/2015, available at http://in.reuters.com/article/aids-india-funding-idINKCN0PY1JU20150724 [Accessed 10 August. 2017].
[xxxviii] https://www.ncbi.nlm.nih.gov/pubmed/24946513[Accessed 10 August. 2017].