

# Positive Rights and Sexual Health

An Analysis of Laws and Policy  
on Sexual & Reproductive Health  
of PLHIV in India

Koshish



## India HIV/AIDS Alliance

Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations affected by the epidemic. The organisation's programmes focus on those most vulnerable to HIV, with a particular emphasis on marginalised populations including men who have sex with men (MSM), transgenders, hijras, sex workers, injection drug users (IDUs), youth, women and people living with HIV (PLHIV).

## About Koshish

Koshish a European Commission-funded programme, strengthens civil society organisations and networks – specifically those representing and working with PLHIV and other marginalised groups like MSM, transgenders, sex workers, and people who use drugs – to effectively advocate for policies and strategies on sexual and reproductive health (SRH) and rights for PLHIV in India. Through coalitions, partner organisations develop and implement state and district-level efforts, affirming the principles of empowerment and meaningful partnerships as core elements of effective advocacy.

Increased capacity and advocacy supported through Koshish will support the realisation of rights of PLHIV and help address dynamics that limit PLHIV access to SRH interventions. Alliance India leads this programme in partnership with Chetna, MAMTA, PWDS and VMM, along with state-level networks for PLHIV in Andhra Pradesh, Gujarat, Maharashtra and Tamil Nadu.

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# Part I | Background

## 1.1 | Introduction

There is growing recognition of the importance of Sexual and Reproductive Health Rights (SRHR) in HIV programmes in order to respond more effectively to the HIV epidemic and to the needs of people living with HIV and key populations (KP).

There are numerous challenges in understanding and promoting SRHR of people living with HIV (PLHIV). These include moral judgments, social stigma and discrimination against PLHIV, limited access to and availability of essential sexual and reproductive health services and the lack of a comprehensive approach to the needs of people living with HIV.

This document will help readers to understand policies and to know to what extent they can help people with HIV realise their sexual and reproductive health and rights. It will help strengthen the efforts of civil society organisations (CSO) and networks who work with PLHIV and other marginalised groups, such as MSM, transgenders, sex workers and injecting drug users (IDU), to advocate for better policies to improve the SRHR of these groups in India.

Specifically, this document provides a) Background information on working definitions of various components of SRHR, the Indian legal system and the Constitutional framework for SRHR in India; b) Information on legislative and policy framework for SRHR in India; c) Information on how to access to key sexual and reproductive health services for PLHIV. This document also examines various cross-cutting issues like discrimination, criminalisation and personal laws, and the like.

This document is a result of a review of about twenty policy and legal documents both national and of the states. The review was undertaken as part of Koshish, a European Commission-funded programme. It studied the provisions in these policies and laws to see how effective they are in meeting the SRHR needs of PLHIV and how best they can be used to improve the sexual and reproductive health of PLHIV in the states where Koshish is being implemented. Koshish is an advocacy-focused programme of Alliance India that works for the realisation of sexual and reproductive health and rights of people living with HIV in Andhra Pradesh, Tamil Nadu, Gujarat and Maharashtra. The programme works through state-level partners and state-level PLHIV networks.

## 1.2 | SRHR, Human Rights and the Indian Constitution

### Reproductive Health and SRHR

Reproductive health (RH) is defined as ‘A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so’.

There are various operational definitions of SRH and SRHR. The World Health Organisation (WHO) defines sexual rights as ‘Human rights that are recognised in national laws, international human rights documents and other international agreements and include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services, to seek and impart information in relation to sexuality, sexuality education, respect for bodily integrity, choice of partner, decide to be sexually active or not, consensual sexual relations, consensual marriage, decide whether or not and when to have children, pursue a satisfying, safe and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others’.

WHO defines sexual health as a state of physical, emotional, mental and social well-being related to sexuality: not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

### Sexual and Reproductive Health Rights of People Living with HIV

From the perspective of PLHIV, SRHR would mean rights that are ‘free from discrimination, criminalisation, stigmatisation and judgment’ and includes the freedom of choice regarding consensual and pleasurable sexual expression, the freedom of choice regarding reproduction, marriage and family planning and the fundamental right to access sexual health information and comprehensive sexual health services.

For PLHIV to realise their SRHR, it is important to ensure that they have universal access to health services that includes prevention, diagnosis, counselling, treatment and care services relating to antenatal, perinatal, postpartum and newborn care, family planning (FP) services, including infertility and contraception, elimination of unsafe abortions, prevention and treatment of sexually transmitted infections (STI), HIV/AIDS, reproductive tract infection (RTI), cervical cancer, etc., and promotion of healthy sexuality.

The sexual and reproductive health rights of people living with HIV are often linked to their social, economic and political rights. This document, therefore, talks about the structural determinants to these rights and examines in detail the access to certain key health services.

**SRHR may be enforced through the fundamental rights under the Indian Constitution, primarily, the right to equality and the right to life.**

## India's Legal System, the Constitution and SRHR

SRHR should also be seen in the context of the Constitution of India, the supreme law of the land. It lays down the framework that defines fundamental political principles, establishes the structure, procedures, powers and duties of government institutions and sets out the fundamental rights, directive principles and duties of citizens.

## SRHR and International Human Rights Law: The IPPF Charter

The twelve basic human rights recognised in the Charter of the International Planned Parenthood Federation (IPPF) (refer to page 6) are also those recognised in major international human rights treaties signed by most countries, including India. The rights that the IPPF Charter advocates broadly cover the range of SRHR considered in this document and form the basis of Koshish's advocacy efforts.

Human rights in India relate to the right to life, liberty, equality and dignity of the individual which the Constitution guarantees. These rights are enforceable by courts in India. These rights are also embodied in international covenants and treaties and are binding under international law. Signatories are required to enforce these treaties. However, under the Indian legal system, these treaties do not automatically become part of domestic law.

It is important to remember that the Indian Constitution recognises political and civil rights as 'fundamental rights' enforceable by the State. Economic and social rights are recognised as 'directive principles of State policy'; this means they are meant to inform government action but not enforceable in a court of law.

**12 SRHR of the IPPF charter do not appear as stand-alone rights in the Indian Constitution; most are derived from the right to life and personal liberty and from the right to equality.**



### At a Glance: Human Rights and Constitutional Provision

<b>Basic Human Rights</b>	<b>Constitutional Provision</b>	<b>Subjects the Right Covers</b>
<b>Right to Life</b>	<ul style="list-style-type: none"> <li>No person shall be deprived of his life or personal liberty except according to procedures established by law.</li> </ul>	Maternal mortality, safe motherhood, female foeticide, gender-based violence and rape laws.
<b>Right to Liberty and Security</b>	<ul style="list-style-type: none"> <li>Right to personal liberty or the 'right to do as one pleases within the law' as long as they are deemed essential for the full development of human personality.</li> <li>Right to a safe and healthy sex life and right to privacy are also part of personal liberties, although they have met with a lot of controversies.</li> </ul>	Protection against sexual abuse and exploitation of children, women and men, forced sterilisation and abortion, gender-based violence.
<b>Right to Equality and Freedom From All Forms of Discrimination</b>	<ul style="list-style-type: none"> <li>Equality before law and prohibits the State from discriminating against any citizen on grounds only of religion, race, caste, sex or place of birth.</li> <li>The State can positively discriminate and make special provisions for women and children for the advancement of those who are disadvantaged socially and educationally.</li> <li>The Courts have determined the scope of the right to equality in relation to sex, sexual orientation and HIV.</li> </ul>	Gender-based violence, discrimination in access to information, education and services related to sexual and reproductive health.
<b>Right to Privacy</b>	<ul style="list-style-type: none"> <li>Right to be left alone.</li> <li>A citizen has a right to safeguard the privacy of his own, his family, marriage, procreation, motherhood, childbearing and education among other matters</li> </ul>	Includes issues such as sexual health services, medical records, protection of information concerning HIV status and information related to sexual choices and sexuality.
<b>Right to Information and Education</b>	<ul style="list-style-type: none"> <li>Freedom of speech and expression as well as the right to education.</li> </ul>	Useful in providing information that is gender-sensitive, pluralistic and free from stereotypes, discrimination against pregnant girls in education and so on.



<b>Right to Marry and Have a Family</b>	<ul style="list-style-type: none"> <li>• PLHIV have the moral and legal duty to inform the prospective spouse of their condition.</li> <li>• The right to marry still exists among PLHIV despite the initial reservation.</li> </ul>	Helps address issues like forced marriage, forced pregnancy and sterilisation.
<b>Right to Decide Whether or When to Have Children</b>	<ul style="list-style-type: none"> <li>• Right to procreate as well as to abstain from procreating with woman having the right to privacy, dignity and bodily integrity respected at all times.</li> <li>• This includes reproductive choices such as woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods.</li> </ul>	<ul style="list-style-type: none"> <li>• Addresses issues relating to unmet need for information, education and services related to SRH, safe motherhood and safe abortion.</li> <li>• Access to services that are available, affordable, acceptable and convenient.</li> <li>• Campaign for services that offer the widest possible range of safe, effective and acceptable methods of fertility.</li> </ul>
<b>Right to the Highest Attainable Standard of Health</b>	<ul style="list-style-type: none"> <li>• Protect the health of its citizens by upholding right to live with human dignity.</li> <li>• Duty of the state (through government hospital/care centres) to provide timely medical treatment to a person in need of such treatment results.</li> </ul>	<ul style="list-style-type: none"> <li>• Access to a full range of quality SRH services.</li> <li>• Protection against medical negligence.</li> <li>• Prevention, diagnosis and treatment of STI and HIV/AIDS.</li> </ul>



# Part II | India's Legislative and Policy Framework

The Indian government has an obligation to respect, protect and fulfil SRHR rights, primarily through laws and policies. The Indian Constitution provides the framework within which both central and state laws are framed and implemented. These rights have been identified in terms of socio-economic justice and exist within the parameters of social and economic rights. The State creates the conditions favourable for proper and informed exercise of human rights through the implementation of various policies.

The Planning Commission sets forth policies and plans and these act as the blue print for economic and social development in the country. The policies make provisions for several sectoral plans, that cover women, youth, public health, reproductive and child health, education, among others. SRHR and its components can be found in these plans.

The National AIDS Prevention and Control Policy (NAPCP) and the National Population Policy, 2000 are two important formulations the government put forth. It launched the National AIDS Control Programme (NACP) in 1992 and the National Rural Health Mission (NRHM) in 2005. As both population and health fall under the Concurrent List of the Indian Constitution, several states have also formulated their own policies.

## 2.1 | Discrimination

Discrimination can be based on colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status. Discrimination in terms of SRHR has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. It may be directly related to accessing health services. Laws therefore not only prohibit discrimination based on various grounds but also prevent its perpetuation.

### Discrimination Based on Gender

The Indian Court recognises the rights of women as a human right. It has removed impediments in the law to reduce discrimination of women in relation to employment and inheritance of property or sexual harassment.

### **Discrimination Based on Sexual Orientation**

Although the Delhi high court declared that Section 377 of the Indian Penal Code (IPC) violates the rights to life, personal liberty, privacy and equality, the decision has been challenged by several religious and conservative groups in the country's Supreme Court. The high court's decision, though, stands until the Supreme Court comes to a decision.

### **Discrimination Based on HIV Status**

Indian law holds the view that employment cannot be denied based on a person's HIV status if the person is fit to perform his or her duties and does not pose a substantial risk of transmission of HIV to others in the workplace. Discrimination related to HIV occurs in multiple settings – employment, healthcare, education, insurance, etc. Legal immunity against discrimination is available only in the government sector and not in the private sector.

### **National and State Policies**

Various national policies uphold the right to equality. The National AIDS Prevention and Control Policy 2000 (NAPCP), and the National Policy for the Empowerment of Women 2001, recognise gender equality and prohibit discrimination against women and PLHIV.

Unfortunately, despite constitutional guarantee, Indian laws do not recognise transgender individuals' right to equality. Only Government of Tamil Nadu has taken measures to protect their rights and enabled transgenders to be part of mainstream society. No other state has made similar provisions for such individuals. There is a long standing draft HIV bill that seeks to prohibit discrimination based on actual or perceived HIV status; this is still not finalised.

## **2.2 | Consent and Confidentiality**

Voluntary and confidential HIV testing is important for prevention, care and treatment services. It is essential that written informed consent for testing is taken for HIV and is coupled with appropriate counselling both before and after the test.

Consent, which is based on the principle of autonomy, is derived from the right to life and personal liberty. It is required before testing, treatment and any invasive procedure on the patient. Risks, benefits and alternatives are also required to be explained to the individual.

Mandatory testing or treatment, which violates the right to life and personal liberty, can only be allowed under a law or court order and not through policy. It may only be allowed under special circumstances and not as a rule. Thus, under some criminal laws, principles of consent are not followed and mandatory testing is allowed. Consent is generally taken from adults with a sound mind, who must be properly informed and it must be given voluntarily. In most cases, consent for children below the age of 18 years and for mentally disabled persons is taken from their parents/next of kin or guardians. The Medical Council of India (MCI) framed the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002 that defines professional and ethical duties of medical doctors.

It describes consent in the context of medical procedures in select surgeries, assisted reproductive technology and research. The regulations do not address consent for testing and treatment for which the Supreme Court has now laid down requirements.

It is important to remember that apart from the consent seen as grant of permission by the patient for diagnostic, surgical or therapeutic procedure, consent can be implied. For example, when a patient enters a dental clinic and sits on the dental chair, his consent is implied for examination, diagnosis and consultation. However, the consent given for a particular operative procedure cannot be extended to any additional or further operative procedures if there is no immediate threat or danger to the patient's health or life.

## Confidentiality

Confidentiality of an individual's personal information derives from the right to privacy. A doctor or person, who come to know of a patient's HIV status or sexuality based on fiduciary trust, is not permitted to disclose such personal information. Disclosure is allowed only in special circumstances. The court holds the view that the right is not absolute and can be restricted lawfully. Courts have spelt out the circumstances in which doctors may disclose a person's HIV status. Disclosure of a person's HIV status to a partner who may be at risk of HIV transmission is allowed or mandated by a court order. In several countries, the dilemma of partner notification has been resolved through the application of thorough procedures for such notification.

Current Medical Council of India regulations do not provide clarity to medical professionals on confidentiality. The regulations recognise the need for confidentiality regarding a patient's personal information, but at the same time they direct medical professionals to share medical records with legal authorities without specifying the circumstances under which such information can be shared. MCI regulations also encourage doctors to discuss the medical condition of a patient with family and friends. Disclosure to a partner remains one of the most contentious areas related to HIV.

## 2.3 | Criminalisation

The transmission, or spread, of STI also comes under the purview of criminal law. It is used as a deterrent and as a tool to prosecute sexual conduct that may endanger the lives of others or spread the medical condition.

### Laws

Indian law talks of penalising what is deemed 'negligent, malignant and unlawful' transmission of a potential life threatening condition like HIV. Even putting the fear of transmission in a person, without actual transmission, is enough to make it an offence. Laws criminalising marginalised populations, such as sex workers, injecting drug users, and men who have sex with men, push them underground and away from health services.

## Sex Work

Criminal laws relating to sex work criminalise several activities surrounding sex work, resulting in impeding HIV prevention services and preventing key populations from accessing them. In India, sex workers have been described as a category of people threatening the social order by endangering public health, sexual morality and civic values. The Immoral Trafficking (Prevention) Act, 1956, was brought with the understanding that sex workers need to be 'rescued' from their plight and then 'rehabilitated' in order to exist in the mainstream of society. ITPA takes the rescue-and-rehabilitation approach and criminalises sex work; this leads to arrest of the sex worker, discrimination and exploitation in the area of health care, reinforcement of negative social attitudes, further financial insecurity and often resulting in violation of basic human rights of sex workers.

## Injecting Drug Users

Similar laws relating to drug use penalise injecting drug users for consumption and possession of small quantities of drugs, thereby preventing public health workers from providing them safe needles or drug substitution therapy as part of harm reduction measures. The National AIDS Prevention and Control Policy of 2001, which clearly recognised the impact of criminalisation of marginalised groups, recognises that upholding human rights, of people who are vulnerable and/or living with HIV/AIDS, will make public health measures more effective.

## 2.4 | Violence

Women generally are the victims of gender-based violence both at home and at the workplace. Violence can take place in the form of physical, sexual, mental and economic exploitation.

### Laws

The right that gives protection against gender-based violence is derived from the right to life and right to equality. There are various standalone laws in India that protect women against violence – Dowry Protection, Prevention of Sati and Domestic Violence Act.

Protection of Women from Domestic Violence Act of 2005 (DV Act) provides legal protection to women from violent relationships both within marriage and in a live-in partnership. The law addresses physical, sexual, verbal, emotional and economic abuse as well as harassment. This law also provides married women with a legal remedy to sexual violence in marriage; the existing criminal law does not recognise sexual violence in a marriage or marital rape.

### Sexual Violence

There are provisions in Indian law that penalise sexual violence and rape; it defines rape as sexual intercourse with a woman against her will or without her consent. The penal code does not mention marital rape and other sexual offences within a marriage unless the wife is under the age of 15. The law on rape is limited to penile-vaginal penetration and is gender specific. Section 377 of the IPC penalises sexual violence that is not penile-vaginal penetration, for example, non-consensual oral, anal or object rape. This section, though, covers child sexual abuse of boys.

## Rape Laws in India

Rape is clear violation of the Right to Life as enshrined in Article 21 of the Constitution. The history of Rape Law in India begins with the enactment of the IPC in 1860. It has since then seen several amendments. There are four major Law Commission reports which address the law on rape. The Criminal Law (Amendment) Act, 1983, brought about major changes in the laws on rape with rape of a woman treated as an 'ultimate violation of the self'. While all these changes were welcome, unresolved issues remained. The definition and scope of the term 'penetration', corroboration, consent and marital rape largely remained grey areas. Statutory provisions or amendments are required to clarify the law on these points.

## National and State Policies

The 2001 National Policy for the Empowerment of Women aims to create and strengthen institutions and schemes for victim assistance in cases where women suffer physical and mental violence.

## 2.5 | Workplace Rights for Women Living with HIV

Indian courts have recognised discrimination against PLHIV in employment. Laws related to employment also affect women's sexual and reproductive choice.

### Laws

Laws that eliminate gender discrimination in the workplace – whether in terms of hiring, wages and benefits or in terms of making the workplace safe for women – play a role in ensuring women's independent sources of income and their access to the labour market. This, in turn, influences whether or not women can leave violent marriages or homes and can take care of their own and their children's medical and other requirements. Widows living with HIV have to bear a double burden of vulnerability. Widow-headed HIV affected households are economically far more vulnerable than widow-headed households not living with HIV. Discrimination based not only on HIV, but also on grounds of sex, must be eliminated.

## 2.6 | Information and Education

The freedom of speech and expression guaranteed under the Constitution also includes the right to information. This is useful from the perspective of information, education and communication in all HIV programmes and campaigns in India. However, one should remember that certain provisions within the Constitution can use 'morality', 'decency' clauses as grounds for curtailing the freedom of speech and expression.

The right to education, which is a fundamental right, includes imparting education and information about SRHR, about STIs, HIV and prevention methods.



**Information**

The right to information can be curtailed in special circumstances related to national security, defence and public safety. Health workers and others providing information on HIV have on occasion been harassed and criminally charged in the past under obscenity laws. Yet, the right to freedom of thought and expression and the right to receive information enable all citizens, including adolescents, to seek access to information on sexual and reproductive health and contraception in order to make an informed choice of a contraceptive method. The Indian Supreme Court has also recognised citizens' right to information or the right to know about government actions and decisions.

**Education**

Right to education, which the Constitution guarantees, is useful for running literacy campaigns in for women and the girl child. This basic right also covers access, particularly of adolescents, to education and information on sexual and reproductive health.

**Responsibility of the State**

The State has responsibility in checking the accuracy of information, play the role of censor, act in an unbiased manner and be morally neutral. The citizen has the right to know of the health care available via the public and private health care system. The State has to permit the media to impart information on HIV and sexual and reproductive health.

# Part III | Access to Key Health Services

## 3.1 | Regulation of Health Services and Access to Treatment

The Indian State has the responsibility to protect the health of its people and the fundamental right to life, personal liberty and the right to live with human dignity.

The right to health is derived from the right to life. The Supreme Court recognises that in a welfare state adequate medical facilities for people should form an essential part of the government's obligations. When a government hospital fails to provide timely medical treatment to a person who needs it, it is a violation of his or her right to life.

The right to health may be the basis to argue for better public healthcare as well as a higher standard of care. This can cover advocating for training of healthcare professionals, running of hospitals and primary healthcare centres and access to safe drugs. The scope of right to health can be extended to include sexual and reproductive health rights.

## 3.2 | HIV Testing and Counselling

For PLHIV, access to treatment, care and support services is dependent on early testing.

### National Policies

HIV testing and counselling in India remains the primary responsibility of the NACP. The government recognises that there is no public health rationale for mandatory testing for HIV. If any, it is counter-productive as it may discourage people from seeking testing services. NRHM recognises the need for converging its health programmes with HIV related services delivered under NACP at the district and sub-district levels. For convergence of HIV testing and counselling services, which NRHM and NACP provide, state governments plan to include among others, universal HIV screening as an integrated component of check-ups at ante-natal clinics. Village Health and Nutrition Days (VHNDs) are to be used for rapid blood tests and positive cases referred to Integrated Counselling and Testing Centres (ICTC). It is important to remember the following provisions for HIV testing under NACP:

- No individual should be made to undergo a mandatory testing for HIV.
- No mandatory HIV testing should be imposed as a precondition for employment or for providing healthcare during employment. However, the armed forces may encourage voluntary screening for HIV before employment with pre-test and post-test counselling and the results may be kept confidential.
- Adequate voluntary testing facilities with pre-test and post-test counselling should be made available throughout the country in a phased manner. There should be at least one HIV testing centre in every district with proper counselling facilities.
- Necessary help should be provided to those who wish to get their HIV status verified through testing and also keep the results of the test confidential.
- Disclosure of the HIV status to spouse/ sexual partner should always be done by the attending physician with proper counseling. The person should also be encouraged to share this information with the family to ensure proper home-based care and emotional support from family members.
- In case of marriage, if one partner insists on a test to check the HIV status of the other partner, the other party should carry out such tests to the satisfaction of the person concerned.
- The private sector too must follow HIV testing guidelines and offer counselling services.

As one of the few government programmes addressing such issues, it is essential that the Adolescent Reproductive and Sexual Health (ARSH) programme aim not only to provide friendly services but also professional high quality services that maintain confidentiality and help adolescents make informed choices.

National programmes like NACP, NRHM, ARSH and Rajiv Gandhi Scheme for Empowerment of Adolescent girls, Sabla a centrally sponsored programme of Government of India, covers important issues pertaining to HIV testing and counselling. The most common rights violations in the context of HIV have been the denial of healthcare, breach of confidentiality and lack of consent/counselling before and after testing. NACP will seek redressal of these issues through a rights based approach as enshrined in the HIV Bill, which clarifies the legal position on informed consent and confidentiality for HIV testing.

According to the guidelines, HIV/AIDS counselling/education should be seen as a confidential dialogue between a client and a counsellor aimed at providing information on HIV/AIDS and bringing about behaviour change in the client. It is also aimed at enabling the client to take a decision regarding HIV testing and to understand the implications of the test results.

The existing guidelines state that that HIV testing must be voluntary, confidential and with pre- and post-test counselling. It makes it clear that mandatory testing is only recommended during organ transplantation and blood donation. In relation to HIV testing in healthcare facilities, the guidelines specify that the fear of transmission to healthcare workers is minimal and that the demand that patients be tested is not rational or appropriate. A mandatory HIV test is no substitute for standard work precautions necessary for all patients and healthcare settings, the guidelines point out. The guidelines also state clearly that testing without explicit consent of patients is counter-productive in the long run as 'such testing can drive the target people underground and make it more difficult for launching interventions'. The guidelines reiterate the key elements of national

HIV testing policy.

The guidelines call for encouraging HIV-positive persons to share the positive result with their spouse, sexual or needle-sharing partner(s), and bring the spouse or partner for counselling as well. The guideline also explains how disclosure may be made in the interest of public health or where it is necessary to protect individuals, including health care workers, who are endangered by persons living with HIV. The Ministry of Women and Child Development believes adolescent health as crucial to public health. Yet it is unclear how referrals to ICTCs will be made and confidentiality maintained in HIV testing.

## Areas of Concern

Provider-Initiated Counselling and Testing has attracted criticism due to concerns regarding stigma and privacy. Choice of testing depend upon an assessment of levels of stigma and discrimination and/capacity of healthcare providers to implement provider-initiated HIV testing and counselling in a particular country.

One of the main areas of concern in the HIV testing guidelines is lack of clarity on partner notification. Also, there is no provision within the guidelines to address complaints of discrimination or harassment.

## Consent and Confidentiality in Non-HIV Health Policies

The concept of consent including informed consent has not been specifically laid down in NRHM or any of the programmes under NRHM. This is a big gap in the health delivery system, as consent is the basic right to autonomy, self determination, and empowerment.

## 3.3 | Family Planning, Contraception and Condoms

Government hospitals, urban family welfare centres, primary health centres and in rural areas health sub-centres primarily provide family planning services in India. Private health facilities and NGO clinics also provide family planning services. Government hospitals and primary health centres often conduct camps for female sterilisation and insertion of intra-uterine contraceptive devices (IUCD). The primary area of concern from a legal and ethical perspective is whether the government facility offers informed choice of method to its clients with complete information, side-effects and risks of contraceptive failure included, prior to the procedure and whether confidentiality is maintained.

These facilities advise a majority of pregnant PLHIVs to abort the foetus and seek sterilisation; the advice stems from concerns over the health of the child and the risk of HIV transmission. Thus for women living with HIV it is hardly ever a matter of choice whether or not to have a child and when to have a child. The thrust on abortion and sterilisation for women living with HIV is a matter of great concern especially in light of treatment available for the prevention of mother to child transmission and more recent evidence suggesting that early treatment and low viral loads may play a significant role in preventing transmission of HIV in sero-discordant couples.

## Policies

Despite the range of contraceptive options the government provides, studies suggest that a considerable number of HIV related abortions appear to take place in India. The policies presumably function within the legal framework, but they do not address issues of consent and confidentiality. Providing safe abortion at health care centres is an important aspect of NRHM; it envisages the provision of quality healthcare facilities in remote rural areas including access to a wide range of contraceptive choices to meet the unmet demands for services that will contribute to reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance.

The health mission also provides family planning, STI, RTI, services in partnership with NGOs. Anganwadi Workers and the accredited social health activist (ASHA), who is the first point of contact in rural area linking the community with government health services, motivate young couples to use pills, condoms, and adopt other methods to limit the family size and space the birth of children.

ARSH, under Reproductive Child Health – II (RCH) makes provisions for young persons and adolescents and provide them with information/services on SRH. The aim is to provide friendly services to adolescents, married and unmarried girls and boys during clinic sessions with an additional focus on marginalised sub-groups. The National Curriculum for school education highlights the need for age appropriate adolescent reproductive and sexual health (including HIV/AIDS) education.

## State Policies

Some States also have their own Population policies and follow and implement the NRHM and RCH programme for providing family planning and contraception services. However, most population policies are guided by the goal of population stabilisation.

Policies must emphasise on training of frontline health workers, counsellors, ASHA workers, who implement the policies, in a) Understanding and following the laws laid down under the Medical Termination of Pregnancy Act and the Pre-Conception, Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act and b) Basics of HIV.

## 3.4 | Prevention of Parent-to-Child Transmission

Both NRHM and NACP view pregnancy as an important focal point for programmes. In the case of the NRHM, the short-term goal is to deliver unmet needs for contraception and if women are pregnant to deliver maternal and child health services, and in the medium and long term, to lower the fertility rate and stabilise the population. In NACP, the prevention of vertical transmission is the reason for the focus on pregnant women. This has resulted in Provider-Initiated Testing and Counselling (PITC) for pregnant women, specific counselling on abortion and disclosure to partners. All women living with HIV, in addition to regular post-test counselling, are advised on the importance of institutional delivery and anti-retroviral (ARV) prophylaxis to prevent prevention of parent-to-child transmission (PPTCT) of HIV. The pregnant woman is also given the option of medical termination of pregnancy.

PPTCT is an important feature of the NACO-NRHM convergence. It aims at improving access to HIV counselling, screening, testing, and providing PPTCT services nearest to the residence of the people.

## 3.5 | STI/RTI Testing and Counselling

STI screening and management is considered an important area of convergence between government programmes providing HIV services and those providing SRHR services.

### National Policies

Both NACP and NRHM address the prevention and control of RTI and STI. The National Population Policy (2000) mandated the then Reproductive and Child Health programme (which was later co-opted in NRHM), to include STD/RTI and HIV/AIDS prevention, screening and management in maternal and child health services. For NACP, addressing STI is considered a key prevention strategy.

The government accords top priority to prevention and control of STI as a strategy for the prevention of HIV transmission. NACP provides for treatment and care of STI based on symptoms and signs (the 'syndromic' approach) rather than on laboratory investigations. The policy also recognises the role stigma plays in poor uptake of treatment services for RTI and STI. The policy directed NACO and the Department of Family Welfare to coordinate and integrate their STI-related services. Under NACP, STI clinics at the district and block levels function as referral centres for STI treatment referred from all corners and are being strengthened with technical support, equipment, reagents and drugs. All STDs clinics are required to provide counselling services (through NGOs) and also disburse condoms.

According to NACP, the expansion of STI services is through effective integration with NRHM. State AIDS Control Societies supervise the STI/RTI programme at the state level (in close co-ordination with NRHM officials) and also provide technical support in training, monitoring, etc., of STI/RTI services at all health facilities. NACO, with funding support at the central level from NRHM, will continue to procure and supply drugs and testing kits for STI for government health facilities. In addition, officials are under instruction to adopt uniform operational guidelines, training and service delivery protocols as developed jointly by NACO and NRHM.

In 2007, NACO and the Maternal Health Division of NRHM jointly issued the National Guidelines for the prevention, management and control of RTI and STI. The guidelines provide detailed guidance on the diagnosis and treatment of STIs. Some key issues that the guidelines address are: confidentiality and privacy, partner notification, STI services for young persons.





# Part IV | Points for Advocacy

## 4.1 | Observations

SRHR of PLHIV finds mention across several laws and policies. Areas of law as diverse as employment law, personal law, criminal law and constitutional law present the complex web from where these rights can be derived. The spectrum of laws and policies that inform the SRHR of PLHIV is so broad that drawing general conclusions, trends or observations other than those at the macro level is counterproductive. In terms of the larger picture of sexual and reproductive health and rights of PLHIV in India, three key observations emerge from this review.

**First:** In recent years, significant progress has been made in terms of law reform or in encouraging law reform either through the Parliament or through the judiciary that have impacted the sexual and reproductive health and rights of PLHIV in India. The first is the Domestic Violence Act which has been a critical step towards protecting women from violence in the household. In this sphere of personal life, women could only get protection in cases of dowry demands or by alleging cruelty. For women living with HIV, violence in the home is a significant area of concern.

An HIV-positive test result, usually during pregnancy, often means the woman is the first to be tested, is blamed for the infection and can face violence, abandonment or isolation in the household. The most crucial element of this law is its understanding of violence as being physical, emotional, sexual and economic and thus is applicable to the many different scenarios that women living with HIV find themselves in.

The role of the judiciary in upholding the Constitutional rights of marginalised communities has also been vital. Stalling of the change in Immoral Trafficking (Prevention) Act, 1956 (ITPA) which intended to punish the clients and the Delhi High Court decision in the Section 377 case demonstrated an astute understanding on the part of the judges of the interplay between legal and social marginalisation and morality. By outlining a constitutional morality to guide government policy making, the decision stretches far beyond the law that it struck down and lies squarely within the highly controversial debates that SRHR for PLHIV raise.

**Second:** Despite the progress achieved in improving the law, ambiguities plague the legal framework in most areas and provide little certainty on rights to PLHIV. The legal principles of consent and confidentiality related to HIV testing and treatment are derived from different sources of law which are often overturned in courts as judges grapple with cases involving what they perceive as conflicting rights. The matter of partner notification is just one such area where a proper legal framework is required.

Nor is the law keeping up with the science or the evidence. With treatment today, PLHIV are leading longer and healthier lives. Evidence that treatment is also key to prevention in the most direct way possible by preventing transmission begs to question why there is an outright ban on adoption or the use of assisted reproductive technologies for PLHIV. A long standing civil society campaign has produced the HIV/AIDS Bill that continues to languish in the halls of government and which clarifies many of the legal ambiguities highlighted in this document. The bill is anti-discrimination law that covers the private sector, outlines clear principles of consent and confidentiality. It ensures access to treatment, prohibits forced sterilisations and abortions for women living with HIV, ensures rights of children and young people, requires proper government support for survivors of sexual violence, provides legal protection for the provision of HIV services to marginalised populations and ensures access to justice. It is high time the bill sees the light of day.

**Third:** Perhaps one of the most interesting findings of this review of laws and policies has been the vast gap between the policies of the National AIDS Control Organisation and those of other departments of Health Ministry in terms of legal and ethical issues. In terms of access to services, information and tools, SRHR of PLHIV straddle two very different policy areas with very different approaches. The difference perhaps flows from their histories as well.

India's National AIDS Control Programme grew from a strong international movement that was already discussing various legal and human rights aspects of the HIV epidemic and the appropriate policy responses. Programmes like the Reproductive and Child Health programme and NRHM of the Government of India evolved from coercive family planning programmes that aimed primarily at population control. Thus while legal and ethical issues feature prominently in the AIDS programme, they are seldom accounted for in any of the other health programmes such as the NRHM.

The finding highlights the fact that as opposed to the oft repeated critique that vertical AIDS programmes are harmful for health systems, AIDS programmes, based as they are on a legal, ethical and rights framework, offer some of the most important learnings for other government departments. The single most important factor in the differences in the programmes could be attributed to community empowerment and involvement in the AIDS programme which holds the government to account when it strays from this framework. Other health programmes provide neither the space nor do they approach people they provide services to as partners.

## 4.2 | Conclusion

The SRHR of PLHIV present some of the most controversial issues where morality, religious intolerance and stigma can play a big role in legal and policy debates. The responsibility of government programmes to provide people and couples living with HIV with safe and informed choices about their sexual behaviour and reproductive choices is clear. It finds its legal support in the Constitutional and human rights framework and its most powerful argument in the application of constitutional morality to government policies and programmes.

The key to the achievement of these rights lies, as over a decade of experience with the HIV epidemic has shown, in the hard battle for rights PLHIV and community groups are fighting for law and policy reform. The battle is not one of narrow self interest as is so often portrayed by critics, but is one informed by a deep sense of justice and dignity. HIV has become pandemic because of social and economic inequality and injustice. It is only when these root causes are confronted that we can hope to get ahead of the epidemic.

## Notes

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