Lawyers Collective HIV / AIDS Unit
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"Rather than requiring that people seeking marriage licenses be tested for HIV, states should focus on education, e.g., providing marriage applicants with AIDS education materials. Education should emphasise the importance of prevention and voluntary testing."

From 'Mandatory Pre-marital HIV Testing: A Record of Failure'
An American Civil Liberties Union Report, March 1998

MANDATORY PRE-MARITAL TESTING

TThe National AIDS Prevention & Control Policy of the Indian government clearly mandates voluntary testing as the appropriate public health strategy in dealing with HIV/AIDS and the Union Health Minister has been quoted recently reaffirming this stand. On the other hand there have been opposing views expressed at the governmental level in other parts of the country particularly favouring mandatory pre-marital testing for HIV. These have been voiced recently in the Goa legislature and by the Andhra Pradesh legislature and reported in the press. Lawyers Collective HIV/AIDS Unit believes that such a proposal will have a deleterious impact on India's efforts to contain HIV/AIDS and that such a strategy is based neither on sound public health nor human rights visions. In light of this, the Unit wrote to the executive and legislative representatives in Goa and the Chief Minister of Andhra Pradesh explaining its reasons for opposing such a proposal and requested a rethink on this issue. Reproduced in this edition of Positive Dialogue is Lawyers Collective HIV/AIDS Unit's letter to the Chief Minister of Andhra Pradesh that awaits a response:

Date: September 18, 2002

The Hon'ble The Chief Minister,
Shri Chandrababu Naidu,
Andhra Pradesh

Dear Sir,

This is with reference to make HIV testing compulsory for couples before marriage, as was reported in Aaj Tak on September 18, 2002.

1. We appreciate that a policy to mandatorily test couples before marriage could be motivated out of the concern to protect the prospective spouses of persons living with HIV from acquiring the disease, thereby, as a public health initiative trying to reduce and prevent the spread of the disease. However, we would like to bring to your notice a few issues and concerns for individuals and the public that arise in mandatorily screening couples before marriage for HIV which would be counterproductive at an individual level as well as a public health level.

2. Testing persons for HIV mandatorily in the pre-marital situation does not fulfil the objectives sought to be achieved at an individual level. Also at a public health level, mandatory testing for HIV has negative public health consequences. This is mainly because of the following reasons:-

(a) The most common way of testing for HIV is through an antibody test. However, the peculiarity of an HIV antibody test is the "window period". The "window period" is one in which even though a person is infected with HIV, s/he would be tested negative as her/his antibodies are not developed. Therefore, even though a person is infected with HIV, s/he will test HIV negative. Therefore, a single antibody test for HIV does not serve the purpose of preventing the prospective spouse from getting infected. Therefore, mandatory testing would not result in achieving the objective sought to be achieved.

(b) It may also be noted that there is also a high rate of false positive results in the country and persons may not actually be infected. Thus, in view of the stigma surrounding HIV, a person who is actually not HIV positive could be marred for life on account of a false positive result and may not be able to marry at all. This would have a traumatic effect on her/ his life and on her/ his family.

(c) Mandatory testing for HIV prior to marriage would only give the state a false sense of security and a false belief that the infection is being effectively prevented from spreading.

(d) A pre-marital HIV mandatory test does not prevent persons from getting infected after marriage, and thereby putting the spouse at the risk of getting infected.

(e) A pre-marital HIV test would not really prevent the spread of infection to the unmarried sexual partners or the needle-sharing partners of the person affected by HIV.

(f) For reasons stated above, mandatory testing for HIV before marriage does not really serve the purpose of preventing the spread of the disease, as such a policy does not consider sexual relations prior to marriage and extra marital relations.

3. This apart, a pre-marital mandatory HIV testing policy would tend to have negative public health consequences, in the following manner:-

(a) Mandatory testing would only drive the disease underground. Not many persons are aware of HIV, the nature of the disease, the testing methods, the methods of transmission of HIV, etc. Due to the ignorance, there is fear even to get an HIV test done. There is a lot of stigma attached to the disease, which ostracises persons living with HIV from their community and prevents them from getting any support. Mandatory testing would only dissuade people from getting their tests done. This is against the National AIDS Control Organisation (NACO) policy on testing, which encourages voluntary testing after pre-test counselling. Mandatory testing would actually only drive the disease underground and would be very costly for the state in the long run.

(b) Further, this would only have the consequence of people going outside the State to marry, where such tests are not required.

(c) Pre-marital mandatory testing for HIV would be a myopic policy, as it does not take into consideration infection after marriage, infection to sexual partners and needle sharing partners. Therefore, from a public health perspective it does not really prevent the spread of the disease.

(d) Mandatory testing often ignores issues of consent and confidentiality of a person's HIV status. This again would have a negative public health impact as people would lose their faith in the health system of the state.

(e) Mandatory testing could also open a racket of issuance of false certificates prior to marriage, thereby having a negative impact on the entire public health system.

(f) Mandatory pre-marital testing for HIV could prove to be a very costly public health strategy for the state, as repeated tests require to be undertaken for confirming the positive status of a person. This could drain out the funds substantially.

(g) In most personal laws marriages are not required to be registered. Thus, for example, a Hindu marriage can be solemnised only by performing ceremonies. No registration is required. Therefore, a policy for mandatory testing would be impossible to implement.

4. Successful public health strategies are those that have optimally utilised the scarce resources, both infrastructural and financial resources, in empowering and encouraging women to prevent themselves from getting infected. It is not our intention to suggest that a woman (or any prospective spouse) does not have the right to ask for an HIV test. The question is that should it be done by making it mandatory or by empowering women so that they can themselves decide.

(a) Women are vulnerable to HIV infection within and outside the marital setting. It is easy to pronounce a policy of pre-marital testing for the ostensible reason that it will prevent women from getting infected. Pre-marital testing is an easy way out. However, such a policy will only give a false sense of security. It will not empower women to negotiate sexual relations, which is what is really required i.e. the empowerment of women to prevent infection. But mandatory pre-marital testing does not really prevent women from getting infected, it does not give information to women about HIV, about safe sexual practices, it does not empower them, it does not emancipate women. A policy that would actually empower women so as to prevent themselves from getting infected is difficult to implement and sustain.

(b) The policy required today is to impart information, educate people and to counsel women about HIV, at the adolescent stage, thereby helping them to prevent themselves from getting the infection. This is the real challenge. It is difficult but possible. A determined legislative action can really emancipate women, thereby helping them to prevent themselves from getting the infection.

(c) Therefore, if the same funds are allocated in spreading information about prevention, safe sex, and emancipating women, educating women and the girl child, and in removing the ignorance and bias attached to HIV, it would in the long run prove to be a more cost-effective public health strategy. It would then encourage people to voluntarily test themselves prior to marriage and help people from protecting themselves from getting infected. This could prove to be an effective policy in reducing and preventing the spread of the infection in the long run.

5. The American Civil Liberties Union Report of March 1998 reported that mandatory pre-marital HIV testing was a record of failure. It stated that more than 30 states in the USA considered pre-marital HIV testing. However, all the states except for Illinois and Louisiana rejected the idea. Illinois and Louisiana enacted and enforced mandatory pre-marital testing, but subsequently repealed them. In Utah too, a state in the United States of America, there was a legislation making a marriage to an HIV positive person void. However, the legislation in Utah was reversed as it was against public policy and they amended the same making such marriages valid. Please find enclosed the relevant documents for your kind perusal.

6. Thailand has been able to control the spread of HIV infection through intensive dissemination of information, education and communication. Condom usage was encouraged in all awareness campaigns, thereby increasing the rate of condom usage and drastically bringing down the rates of HIV and STD infections.

7. We therefore request you not to pass any legislation to make pre-marital HIV testing mandatory which could have a negative impact on public health and on the individual, but to re-think of the strategies that would empower women so that they can effectively prevent the spread of HIV infection in the population.

Thanking you,

Yours truly,

Anand Grover
Project Director

cc: Andhra Pradesh State AIDS Control Society

Enclosed:

1. *A letter written by UNAIDS, by Susan Timberlake, Human Rights Adviser, Policy, Strategy and Research, to Ms. Marina Mahathir, Malaysia.*
2. *Mandatory Pre-Marital HIV Testing - An American Civil Liberties Union Report, March 1998.*
3. *Utah Code.*

Supreme Court of India restores HIV+ person's Right to Marry

On 10 December 2002 the Supreme Court of India passed an order in a case related to the issue of an HIV+ person's right to marry. This case was filed by Lawyers Collective HIV/AIDS Unit on behalf of its client Mr. X, seeking clarifications and challenging the judgment of the Supreme Court in the case of Mr. X v Hospital Z in 1998 wherein the court had suspended the right of PWA to marry, although this was never an issue before it.

In this order the Supreme Court held that all observations relating to marriage in Mr. X v Hospital Z in 1998 were not warranted as they were not issues before the Court. The Supreme Court did, however, state that it's pronouncements regarding the role of hospitals to make disclosure of HIV+ status in Mr. X's judgment remain as they were made regarding an issue before it in the case (Mr. X's case concerned the issue of breach of confidentiality of the petitioner's HIV+ status by a hospital blood bank to the petitioner's relatives). In effect, therefore, the Supreme Court's judgment in Mr. X v Hospital Z to the extent that it suspends the right of PWA to marry is no longer good law. The right of an HIV + person to marry is restored. However, this does not take away from the duty of those who know their HIV+ status to obtain informed consent from their prospective spouse prior to marriage.

We are happy to convey this positive order of the Supreme Court and extremely pleased that the rights-based approach to HIV/AIDS has received further support and PWA rights have been strengthened. This is the only effective way in dealing with HIV/AIDS - taking away rights only strengthens stigma and fear, protecting and providing them strengthens understanding and empowerment.

Violence against sex workers continues

After the incident in Nippani, Karnataka earlier this year (reported in Positive Dialogue #13), where sex workers belonging to Veshya AIDS Mukabla Parishad (VAMP) were harassed and abused by police while carrying out HIV/AIDS prevention work, yet another horrific incident of violence against women in sex work has come to light. This time the targets were sex workers from the Durbar Mahila Samanvay Committee (DMSC), the largest organisation of sex workers in the region with over 60,000 members.

In August 2002, Rekha, a sex worker, was severely beaten up by local hoodlums in the Tollygunj red light area in Kolkata for having a public altercation with her husband. When Swapna, the President of DMSC protested and lodged a complaint with the police, the same gang publicly attacked her for "daring to involve outsiders in an internal matter". Policemen on duty were silent spectators to the incident and refused to file a FIR.

The DMSC organised a rally of more than 3000 sex workers from all over the state to protest against the violence and inaction of the police. They also registered complaints with State agencies, including the Government of West Bengal, the State Human Rights Commission and the State Women's Commission. Since then two of the three assailants have been arrested while one is still absconding. The local goons persist in threatening Swapna, who has been rendered shelterless, and other members of DMSC. Following threats and coercion, the STD clinic run by DMSC has been shut down and has ceased to function. Needless to say, the HIV/AIDS prevention intervention programme has been adversely affected.

This is not just a stray incident of violence against individual sex workers but a deliberate attempt to undermine the collective leadership of sex workers represented by DMSC. The organisation's role in implementing effective HIV/AIDS interventions in Sonagachi, Kolkata have been acknowledged at national and international levels. The self-regulation mechanisms introduced by DMSC to address exploitation including entry of children and other unwilling persons within the sex industry have been an unparalleled initiative. Above all, DMSC's untiring efforts in organising sex workers for their rights and building a movement against exploitation has continued to enthuse and inspire human rights activists, organisations working on HIV/AIDS and other marginalised communities all over the world.

The incident once again points to the failure of state agencies, particularly the police, in safeguarding fundamental rights of women in sex work including the right to life and protection of law. Besides disrupting health and HIV/AIDS interventions such incidents result in destabilising movements for human rights by marginalised and minority communities. The time is overdue for the state to take responsibility in protecting the lives of women in sex work and ensuring that their disempowerment and abuse ceases.

Treatment Access - positive developments

Thailand, October 1, 2002 - People living with HIV/AIDS in Thailand won a precedent-setting court case in Thailand's Central Intellectual Property and International Trade Court (CIPITC) against the pharmaceutical company, Bristol - Myers Squibb (BMS). The court ruled that the pharmaceutical company had illegally amended its application three years after its original submission, in order to claim a wider monopoly on ddI (NRTI a critical first regimen AIDS drug) than the patent description justified and has ordered BMS to revert to its original claim. BMS in its original patent application filed in July 1992, asked that its patent be extended to cover only a "range of 5 mg to 100 mg per unit of use." In 1997, BMS amended its patent and omitted the dosage restriction.

The decision rejected BMS' exclusive right to market ddI in Thailand and paved the way for its generic production (patented ddI tablets cost twice as much as generic ones). The drug company can now exclusively produce ddI only in doses from 5 milligrams to 100 milligrams, while other drug companies can produce the drug in larger doses.

There are over one million people living with HIV/AIDS in Thailand. Only a few thousand have access to treatment. The Thailand Network of People Living with HIV/AIDS (TNP+) and other treatment access groups have campaigned for expanded and improved access to treatment. In 1998, treatment activists demanded that the Thai government exercise its rights to use

a compulsory license to produce generic ddl tablets in order to address its AIDS treatment crisis. The government refused, citing fear of trade sanctions. Instead the Thai Government Pharmaceutical Organisation (GPO) produced ddl in powder form which causes increased side affects in comparison to tablets and was also not easy to administer.

In May 2000, the plaintiffs, two persons living with HIV/AIDS and the AIDS Access Foundation initiated legal action on behalf of all people living with HIV/AIDS in Thailand, against BMS and the Thai Department of Intellectual Property (DIP).

Some significant points from the judgement include:
a) For the first time the Doha Declaration on Patents and Public Health was cited by a court to ensure access to treatment. The court stated that the Doha Declaration insisted that TRIPS be interpreted and implemented so as to protect the country's public health, especially the promotion and support of access to medicine for all people.

b) People living with HIV/AIDS and an NGO working on AIDS, and not commercial enterprises contested a patent in court on the grounds that health interests supersede patent protection.

In October 2002, Thai activists have also decided to challenge BMS' Thai patent (number 7600) that it applied for and received in 1998 for a formulation of ddl despite the fact that it does not involve any significant inventive step or novelty, a necessary criteria for granting a patent. Activists point out that the patent is invalid, as BMS had simply combined the drug with a buffer, an antacid that helps ddl to be better absorbed from the stomach, (a common practice among pharmacists) and that this is not an inventive step. As a result, BMS managed to maintain its monopoly on this important AIDS drug.

Contributions: Veena Johari, Tripti Tandon, Leena Menghaney

Monthly Drop-in meeting

Lawyers Collective HIV/AIDS Unit holds monthly drop in meetings on the first Thursday of each month. The meetings start at 3.30 pm at the Delhi Office and at 5.00 pm at the Mumbai Office. The objective of the meeting is to share experiences, information and discuss issues of concern. We invite your active participation in these meetings.

Lawyers Collective HIV/AIDS Unit provides legal aid and allied services for people affected by HIV/AIDS. The main objective of the Unit is to protect and promote the fundamental rights of persons living with HIV/AIDS, who have been denied their rights in areas such as:

- Health care
- Employment
- Terminal dues like gratuity, pension
- Marital rights relating to maintenance, custody etc
- Housing

The Unit is involved in initiating public interest litigation on issues like the right to marry, confidentiality, access to health care, safe blood supply, quacks, etc. Lawyers Collective HIV/AIDS Unit also conducts workshops on legal and ethical issues relating to HIV/AIDS for people living with HIV/AIDS, lawyers, judges, health care providers, NGOs etc.

Please send your comments and queries to the addresses given below. Those affected by HIV/AIDS seeking legal aid, advice and support are welcome to contact us at:

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