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USING DISABILITY LAW TO PROTECT PERSONS LIVING WITH HIV/AIDS: THE INDIAN AND AMERICAN APPROACH

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HIV/AIDS in India continues to be a growing problem for the subcontinent as well as for the rest of the world. Because India has emerged as a global economic player and is the second most populous country in the world, devastation from HIV/AIDS in the region could have far-reaching global ramifications. The protection of civil liberties and elimination of discrimination is critical to any sustainable public health strategy. This article looks specifically at India's Persons with Disabilities Act (PWDA) as a potential tool in addressing HIV/AIDS discrimination. Disability law, as a mechanism for protecting persons living with HIV/AIDS, remains relatively unexplored and underutilized. Currently India stands at an important crossroads in regards to both its disability laws and its fight against HIV/AIDS. As noted in the paper, India's recent ratification of the UN Convention of Rights of Persons with Disabilities (UNCRPD) obligates India to make a complete overhaul of its disability laws and adopt a rights-based approach. In this article, I recommend reforming India's PWDA to expand its protections to not meet only its international obligation but also as a public health strategy. In order to reform its disability law, this paper looks to the American example. This paper will look specifically at the protections afforded in India's Persons With Disabilities Act (PWDA) and compare it to the Americans with Disabilities Act (ADA). While the rights guaranteed under the PWDA are limited and narrowly construed, the ADA is broadly construed and was amended in January 2009 to statutorily protect the rights of people affected with HIV/AIDS. Ultimately, by analyzing both systems, this paper hopes to give guidance to India in reforming PWDA to not only meet its international obligation but also to serve as an effective mechanism against the epidemic.

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INTRODUCTION

For close to three decades, HIV/AIDS has plagued our human race. Since the early 1980s, over 20 million people have died from AIDS-related illnesses.[1] UNAIDS and the World Health Organization estimate that approximately 33.2 million people currently live with HIV worldwide.[2] By claiming millions of lives, the disease undermines "education and health systems, economic growth, micro enterprises, policing and military capabilities, political legitimacy, family structures, and overall social cohesion."[3] Because of

1. Avert, World Wide HIV/AIDS Statistics Including Deaths, http://www.avert.org/worldstats.htm (last visited May 16, 2010).

2. Joint U.N. Programme on HIV/AIDS [UNAIDS] & World Health Organization [WHO], *AIDS Epidemic Update*, 1, U.N. Doc. UNAIDS/07.27E/JC1322E (Dec. 2007), *available at* http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf.

3. MARK SCHNEIDER & MICHAEL MOODIE, CTR. FOR STRATEGIC & INT'L STUDIES, THE DESTABILIZING IMPACTS OF HIV/AIDS 1 (2002), *available at* http://www.kaisernetwork.org/

this epidemic, "[c]hildren are orphaned, communities are decimated, fields go untended, and the risk of famine grows."[4]

Much of Africa has already felt the destabilizing impacts of the AIDS pandemic. In Africa, the pandemic has curtailed economic growth, undermined national security, and encouraged political illegitimacy.[5] "Second wave" countries such as India, Russia, and China are now being threatened with similar socio-economic and political destruction from AIDS.[6] Because both India and China have emerged as global economies and are the two most populous countries in the world, devastation in these regions could have far-reaching global ramifications. Public health experts have warned that without sustainable HIV/AIDS interventions in these countries, the pandemic could threaten international security and devastate the global economy.[7]

This paper focuses specifically on the HIV/AIDS epidemic in India. The country's large population coupled with its weak public health infrastructure, complex social structure, and high mobility (both nationally and internationally) make India particularly vulnerable to an uncontrollable and devastating epidemic. Next to South Africa, India has the second largest number of infections in the world.[8] Therefore, developing a sustainable public health strategy in India is critical.

Despite India's attempts to address the epidemic, deep-rooted HIV/AIDS stigma hampers sustainable public health efforts. The lack of education and open discourse perpetuate misconceptions and encourage prejudice against affected populations. Additionally, complicated social norms and conservative attitudes increase stigmatization, making the fight against HIV/AIDS even more difficult. The marginalization of HIV/AIDS patients encourages infection to be driven underground, as individuals are less likely to seek treatment and testing.[9] Additionally, because of systematic discrimination, people with HIV/AIDS are denied medical treatment, education, and employment opportunities, further exacerbating their plights.[10]

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health_cast/uploaded_files/Destabilizing_impacts_of_AIDS.pdf.

4. *Id.* at 3-4.

5. *Id.* at 4-8.

6. *Id.* at 9-11.

7. *See id.* at 3-4.

8. Mitra Pramit, *India at the Crossroads: Battling the HIV/AIDS Pandemic*, WASH. Q., Autumn 2004, at 95, 95.

9. Mead Over et al., WORLD BANK HUMAN DEVELOPMENT NETWORK HIV/AIDS TREATMENT AND PREVENTION IN INDIA 25 (2004), *available at* http://siteresources.worldbank.org/INTINDIA/Resources/IndiaARTReport1.pdf.

10. Joint U.N. Programme on HIV/AIDS [UNAIDS], *India: HIV and AIDS-Related Discrimination, Stigmatization and Denial*, 9, U.N. Doc. UNAIDS/01.46E (Aug. 2001) (*pre-*

Social rights play an important role in protecting public health by preventing discrimination.[11] In order to effectively address HIV/AIDS, governments must recognize and enforce the civil rights of affected populations.[12] Anti-discrimination disability laws are "one critical, but often overlooked, tool" for addressing HIV discrimination through protecting social rights.[13] Although many different countries have anti-discrimination laws that protect disabled populations, only a handful of countries specifically include HIV/AIDS within the disability protection.[14] Countries such as the United States and the United Kingdom have explicit statutory civil right protections for HIV affected individuals in their disability laws.[15] However, in many parts of the world the protection of rights for persons with HIV/AIDS under anti-discrimination disability law remains largely unexplored and underutilized. [16]

This article looks specifically at India's Persons with Disabilities Act (PWDA)[17] as a potential tool in addressing HIV/AIDS discrimination. India has demonstrated a commitment to combating discrimination against persons with disabilities by passing the Persons with Disabilities Act (PWDA) and by signing the UN Convention of Rights of Persons with Disability (UNCRPD).[18] Although India appears to be committed to disability protection, the PWDA's narrow construction of disability couple with viewing disability scientifically hinders the protections the country could otherwise provide. Because the UNCRPD mandates signatories to adopt an expansive rights-based approach to disability protection, India will have to restructure the PWDA to conform to the requirements of the international agreement they've signed.

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pared by Shalini Bharat), *available at* http://data.unaids.org/Publications/IRC-pub02/JC587-India_en.pdf.

11. *See* Paul Farmer & Nicole Gastineau, *Rethinking Health and Human Rights, in* PERSPECTIVES ON HEALTH AND HUMAN RIGHTS 73, 73-75 (Sofia Gruskin et al. eds., 2005).

12. INTER-PARLIAMENTARY UNION, JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS] & U.N. DEV. PROGRAMME [UNDP], TAKING ACTION AGAINST HIV AND AIDS: A HANDBOOK FOR PARLIAMENTARIANS 85-95 (2007) [hereinafter TAKING ACTION], *available at* http://www.ipu.org/PDF/publications/aids07-e.pdf.

13. S. Yee, Abstract, *Developing Disability Non-Discrimination Law and Policy as a Legislative, Social, and Advocacy Tool for People with* AIDS, 15 INT'L CONF. AIDS (2004).

14. *Id.*

15. Disability Discrimination Act, 1995, c. 50, sched. 1 (U.K.); ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) (codified at 42 U.S.C. §12101 et. seq. (Supp. II 2008)).

16. Yee, *supra* note 13.

17. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, No. 1 Acts of Parliament, 1996, *available at* http://www.ccdisabilities.nic.in/page.php.

18. United Nations Convention on the Rights of Persons with Disabilities, Mar. 30, 2007, 46 I.L.M. 443 [hereinafter UNCRPD], *available at* http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en;

In this article, I recommend reforming India's PWDA to expand its protections to not only meet its international obligation but also as a mechanism to combat HIV/AIDS discrimination. As a suggested template for reforms to India's disability law, this paper looks to the American example. In many ways, the Indian experience with HIV/AIDS discrimination is reminiscent of the struggle that the United States faced during the 1980s when HIV/AIDS first came on to the American scene. During the emergence of the AIDS epidemic in America, American society approached the disease with similar attitudes of fear and prejudice. Similar to India, stigmatization in America arose, in part, because the first cases of HIV/AIDS were associated with homosexuals and drug users, groups that were already highly stigmatized. Furthermore, initial political denial and inaction fostered a lack of understanding, which created greater fear and discrimination.

The discrimination against persons with HIV/AIDS encouraged Congress to pass the Americans with Disabilities Act (ADA) in 1990.[19] The ADA's purpose is to protect qualified individuals from discrimination based on their disability in employment and in the enjoyment of public goods and accommodations.[20] Although the legislative discussions prior to passage of the Act signaled a commitment to protect the civil rights of persons living with HIV/AIDS,[21] the original language of the statute did not explicitly guarantee such protection. As a consequence, parties have hotly contested the status of HIV/AIDS as a disability under the statute, and many courts have interpreted the ADA as providing much less protection than originally anticipated by Congress.[22] To alleviate

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19. *Americans with Disabilities Act of 1988: Joint Hearing on S. 2345 Before the Subcomm. on the Handicapped of the S. Comm. on Labor and Human Resources and the Subcomm. on Select Education of the H. Comm. on Education and Labor*, 100th Cong. 11-16, 39-41 (1988) [hereinafter *Hearing*] (statement of Rep. Tony Coehlo (noting that many people suffer from hidden disabilities such as HIV and that the federal government should protect persons with disabilities against discrimination) and statement of Adm. James Watkins, Chairperson, President's Comm'n on the Human Immunodeficiency Virus Epidemic (noting that "HIV-related discrimination is impairing this Nation's ability to limit the spread of the epidemic" and that the ADA needs to protect against HIV discrimination)).

20. *See* Americans with Disabilities Act of 1990 § 2, 42 U.S.C. § 12101 (2006).

21. *See Hearing*, *supra* note 19, at 13 (statement of Rep. Tony Coehlo, noting that the passage of the ADA could protect persons with HIV from discrimination).

22. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3553 (2008) (codified at 42 U.S.C. §12101 et. seq. (Supp. II 2008) (referring to Sutton v. United Air Lines, 527 U.S. 471 (1999) and Toyota Motor Mfg, Ky., Inc. v. Williams, 534 U.S. 184 (2002) as cases that "narrowed the broad scope of protection intended to be afforded by the ADA"). *See, e.g.*, Blanks v. Sw. Bell Commc'ns, Inc., 310 F.3d 398, 401-02 (5th Cir. 2002) (holding that plaintiff with HIV is not disabled under the ADA because he did not establish that he is substantially limited in a major life activity); Runnebaum v. NationsBank of Md., N.A., 123 F.3d 156, 171-172 (4th Cir. 1997) (holding HIV/AIDS is not a disability under the ADA).

some of this confusion, Congress amended the Americans with Disabilities Act in 2008 to unambiguously include HIV/AIDS as a disability.[23] The amendment only became effective after January 1, 2009;[24] therefore, it is not clear how courts will interpret and apply this new framework.

This paper will look specifically at the protections afforded in India's Persons With Disabilities Act (PWDA) and compare it to the Americans with Disabilities Act (ADA). In comparison with the PWDA, the ADA statutorily protects the rights of people affected with HIV/AIDS. Notwithstanding this explicit protection, ADA protections may still be avoided via the various loopholes in the statute. By examining the PWDA and comparing it to the treatment of HIV/AIDS under the ADA, this paper hopes to reveal not only the infirmities in the Indian law but also to analyze the methods by which laws can still be circumvented even with statutory protections. Ultimately, by analyzing both systems, this paper hopes to give guidance to India in reforming the PWDA to make it an effective mechanism for combating HIV discrimination.

I. AIDS IN INDIA: A MULTI-LAYERED PROBLEM

A. Epidemiology

In 1986, the first case of HIV in India was diagnosed in the state of Tamil Nadu.[25] Since then, the number of HIV/AIDS cases has drastically increased. The National HIV/AIDS Control Organization of India (NACO) estimates that there are as many as five million people living with HIV in India,[26] making India second only to South Africa for the highest number of absolute infections in the world. [27] Furthermore, the Indian HIV prevalence rate rose from 0.1 percent in 1986 to 0.8 percent in 2001.[28] Because of the large

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23. ADA Amendments Act; *see also* 154 CONG. REC. H8279, 8297 (daily ed. Sept 17, 2008) (statement of Rep. Baldwin) ("Although the ADA clearly intended to protect people living with HIV from being discriminated against based on having HIV, many have had their lawsuits derailed by disputes over whether they meet a narrowly interpreted definition of the term 'disability'.").

24. ADA Amendments Act § 8.

25. E.A. Simoes et al., *Evidence for HTLV-III Infection in Prostitutes in Tamil Nadu*, INDIAN J. OF MED. RES. 335, 335 (1987); THE WORLD BANK, HIV/AIDS IN INDIA (2007), http://siteresources.worldbank.org/INTSAREGTOPHIVAIDS/Resources/HIV-AIDS-brief-Aug07-IN.pdf.

26. MARK LOUDON ET AL., UNICEF INDIA, BARRIERS TO SERVICES FOR CHILDREN WITH HIV POSITIVE PARENTS 1 (2007), http://www.unicef.org/india/The_Barrier_Study.pdf.

27. KAISER FAMILY FOUND., HIV/AIDS POLICY FACT SHEET 1 (2005), *available at* http://www.kff.org/hivaids/upload/7312_02.pdf.

28. OXFAM, HIV/AIDS WORK WITH TRUCK DRIVERS IN ORISSA 1 (2006), http://www.oxfam.org/sites/www.oxfam.org/files/orissa.pdf.

population in India, each 0.1 increase in the prevalence rates means that the number of people living with HIV/AIDS increases by over half a million.[29] In 2005, approximately thirteen percent of the world's HIV cases resided in India.[30]

B. Reasons for Discrimination

Although India has the second highest number of HIV cases worldwide, the majority of Indian society remains in denial.[31] As in many other countries, HIV/AIDS in India disproportionately affects poor and marginalized populations.[32] As a consequence, society has labeled HIV/AIDS "a disease of 'others.' "[33] The disease is highly stigmatized because it is commonly misperceived that only those that engage in risky and morally questionable behavior are affected.[34] However, in reality, being a married monogamous woman is one of the biggest risk factors for contracting the virus.[35] In fact, data from a sexually transmitted disease (STD) clinic in Mumbai, India, showed that seventy percent of the women infected were housewives who contracted the virus from their husbands.[36] Moreover, the idea of HIV/AIDS as a disease of "others" exacerbates lack of awareness in the general population.[37] Many people in society resist learning about HIV/AIDS because of its immoral connotation and continue to believe myths about methods of infection.[38]

This social resistance present in India is similar to the resistance that the American society faced during the 1980s. For example, because the first cases of AIDS were mostly diagnosed in the gay population, the American public labeled AIDS as a "gay disease," which exacerbated homophobia and denial of an epidemic.[39] Additionally, the lack of information regarding transmission led people to believe the myth that HIV could be spread through ca-

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29. *Id.*

30. KAISER FAMILY FOUND., *supra* note 27, fig. 1.

31. UNAIDS, *supra* note 10, at 9.

32. MARIA EKSTRAND ET AL., AIDS POLICY RESEARCH CTR., COUNTRY AIDS POLICY ANALYSIS PROJECT: HIV/AIDS IN INDIA 71 (2003), *available at* http://ari.ucsf.edu/programs/policy/countries/India.pdf.

33. UNAIDS, *supra* note 10, at 7.

34. *Id.* at 8-9.

35. Physician for Human Rights, Sex Trafficking and the HIV/AIDS Pandemic, http://physiciansforhumanrights.org/library/2003-06-25.html (last visited May 17, 2010).

36. N Chatterjee, *They Have Not Heard of AIDS: HIV/AIDS Awareness Among Married Women in Bombay*, 113 PUB. HEALTH 137, 137 (1999).

37. *See id.*

38. UNAIDS, *supra* note 10, at 7.

39. *See* NAN D. HUNTER, ACLU, EPIDEMIC OF FEAR: A SURVEY OF AIDS DISCRIMINATION IN THE 1980S AND POLICY RECOMMENDATIONS FOR THE 1990S, at 2, 14, 17 (1990).

sual contact, increasing the fear of AIDS.[40]

Both the American and Indian examples show us that the misperception of HIV/AIDS as a disease that only affects a small subset of society results in systematic discrimination and stigmatization against affected populations, affecting adults and children alike. Not only does discrimination victimize HIV positive individuals, it also affects HIV negative people who are closely associated with persons who have HIV/AIDS, such as children of HIV positive parents.[41]

C. Types of Discrimination

In developing a law that effectively addresses HIV/AIDS discrimination, we must first understand the different types of HIV/AIDS discrimination that currently exist in society. For example, when Congress was considering passage of the ADA, some individuals who testified in hearings noted that health care workers, educators, and employers were denying services to persons living with HIV/AIDS.[42] In considering this discrimination, some feel that Congress enacted the ADA to specifically target this type of maltreatment.[43] Similarly, India must also consider the HIV/AIDS discrimination that exists within its society in order to effectively restructure its anti-discrimination laws.

1. Discrimination and Education

Children in India who are affected by HIV/AIDS face many significant barriers to obtaining education.[44] Although the Indian Constitution recognizes education as a fundamental right and obligates the states to provide education to all children aged six to fourteen,[45] children who are either HIV positive or closely associated with someone who is infected are often separated from other

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40. *Id.* at 2, 23-24.

41. LOUDON ET AL., *supra* note 26, at 18-29.

42. *Hearing*, *supra* note 19, at 13 (statement of Rep. Coehlo and Adm. James Watkins); 154 CONG. REC. H8279, 8297 (daily ed. Sept 17, 2008) (statement of Rep. Baldwin); *see* Bragdon v. Abbott, 524 U.S. 634, 631 (1998) (holding that HIV as a disability under the ADA is consistent with legislative intent).

43. *See* Lisa Keels, *"Substantially Limited:" The Reproductive Rights of Women Living with HIV/AIDS*, 39 U. BALT. L. REV 389, 412 (2010).

44. HUMAN RIGHTS WATCH, FUTURE FORSAKEN: ABUSES AGAINST CHILDREN AFFECTED BY HIV/AIDS IN INDIA 36-37 (2004), *available at:* http://www.hrw.org/sites/default/files/reports/FutureForsaken.pdf.

45. INDIA CONST. art. 21A: inserted by the Constitution (Eighty-sixth Amendment) Act, 2002.

students or denied admission to the school.[46] Furthermore, HIV positive children risk expulsion due to health related absences when the school does not tolerate special accommodations.[47] Additionally, when children lose family members to AIDS, they are often unable to afford school fees and related expenses, forcing them to withdraw from school.[48] Thus begins the cycle of misfortune.

Even if an HIV/AIDS affected child is able to obtain an education, these students are often discriminated against by their teachers and peers.[49] The discrimination is a result of the societal view that HIV positive children are the product of immoral behavior and a lack of understanding about modes of transmission.[50] Many teachers actively discriminate against HIV positive children by avoiding, neglecting, or abusing them, physically or verbally.[51] For example, a number of teachers use [the children's] "parents' status and supposed transgressions to humiliate these children in class."[52] If the HIV status of a child or a parent of a child is known, other children and administrators in the school have excluded the affected child from extracurricular activities and even forbade the student from using water fountains and toilets.[53]

2. Discrimination and Employment

The Indian Constitution protects employees from discrimination by their employers. Article 14 of the constitution prohibits states from depriving citizens of "equality before the law or . . . equal protection."[54] Furthermore, Article 16 requires "equality of opportunity for all citizens in matters relating to employment or appointment."[55] Despite these protections, persons with HIV/AIDS face discrimination in the workplace.[56] They are often ostracized for their condition.[57] Recently, however, an Indian High Court took important strides to address HIV/AIDS related discrimination in the work force. In the landmark judgment of the Bombay High

46. HUMAN RIGHTS WATCH, *supra* note 44, at 63.
47. *Id.* at 63, 66.
48. *Id.* at 78-83.
49. *Id.* at 75-76; LOUDON ET AL., *supra* note 26, at 23-26.
50. *See* HUMAN RIGHTS WATCH, *supra* note 44, at 118-122; LOUDON ET AL., *supra* note 26, at 30.
51. LOUDON ET AL., *supra* note 26, at 23.
52. *Id.*
53. *Id.*
54. INDIA CONST. art. 14.
55. *Id.* art. 16(1).
56. Navin Paul, Letter to the Editor, *Discrimination Against People Living with HIV/AIDS in India: Educated Persons as Perpetrators*, 54 J. INFECTION 103, 103 (2007).
57. *Id.*

Court, the court held that an HIV positive person could not be denied employment if the person is otherwise fit for work.[58] The court noted that if a person were fired from his employment solely because of his or her HIV positive condition, it would be condemning a person to "virtual economic death."[59] Moreover, in 2004, the Bombay High Court directed New India Assurance Company to employ an HIV positive individual after she was denied employment because she tested positive on an employer-required HIV test.[60] The court ruled that denial of employment on the grounds of HIV status was discriminatory and a violation of human rights.[61]

Although these court cases have made a positive change for addressing employment discrimination against HIV positive individuals, HIV/AIDS sufferers still face discrimination in the workplace and are forced to quit because of mistreatment by employers and co-workers. Therefore, in order to quell the epidemic, India must require greater employment protections for HIV/AIDS affected individuals.

3. Discrimination and Access to Health Care

In addition to discrimination in education and employment, many HIV positive individuals are unable to receive regular access to health care because of discrimination within the health care sector.[62] UNAIDS India conducted a study about HIV/AIDS discrimination and found that nine out of ten medical service providers confirmed encountering cases of children of HIV-positive parents being denied of care by physicians and other health care workers in Maharashtra, a high prevalence state.[63] The type of mistreatment varies. For examples, physicians or nursing staff may overtly refuse to render care to HIV/AIDS affected individuals by turning them away because of their status.[64] Additionally, physicians and nurses may passively mistreat HIV positive individuals by making them wait for treatment, charging them more than other patients, placing them in separate waiting rooms, or giving them substandard care.[65] In labor and delivery procedures, some report that doctors have refused to perform Caesarean sections or help in the procedure when the physician knows that the mother is HIV posi-

58. MX vs. ZY, 1997 A.I.R. (Bom.) 406.
59. *Id.*
60. G v. New India Assurance Co. Ltd., Bombay H.C. (2004).
61. *Id.*
62. UNAIDS, *supra* note 10, at 18-33.
63. LOUDON ET AL., *supra* note 26, at 27.
64. UNAIDS, *supra* note 10, at 25-26.
65. *Id.* at 27-33.

tive.[66] Similarly, nursing staff sometimes refuse to give HIV patients necessary injections, dress wounds, or dispose of used bandages out of fear of infection.[67] Additionally, many HIV positive individuals receiving treatment in hospitals are ridiculed because of their status, attended to less frequently by the nurses and physicians, and are forced to stay in filthy rooms.[68]

Confidentiality in the health care sector is also a major issue for HIV/AIDS affected individuals. Often, medical staff will publicly announce the HIV/AIDS status of an individual, making them more subject to discrimination.[69] Policies in India require physicians to provide the names and addresses of persons testing positive for HIV/AIDS and exempt them from the requirement of confidentiality.[70] Because there is no requirement for confidentiality with regards to HIV/AIDS patients, the International Labor Organisation noted that some Indian hospitals publish names in local newspapers of people who test positive for HIV/AIDS.[71]

D. Effects of Discrimination on the Epidemic

The stigmatization and discrimination against persons with HIV/AIDS hinders effective public health interventions on many different levels.[72] For example, persons who experience discrimination are more likely to suffer from depression, which can hasten disease progression and mortality.[73] Furthermore, when individuals believe that they will be discriminated against because of their HIV status, they are less likely to get tested and seek treatment.[74] People who conceal their status not only increase the risk of infection but also increase the financial burden on the household.[75] Without treatment, HIV affected households are more prone to HIV related illness and mortality, which consequently reduces their economic productivity.[76]

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66. Katherine Heine, *AIDS Moves Beyond High Risk Groups in India*, REUTERS ALERTNET, Dec. 11, 2003, http://www.alertnet.org/thefacts/reliefresources/107115648816.htm.

67. UNAIDS, *supra* note 10, at 27-33.

68. *Id.* at 16-19.

69. *Id.* at 23-25, 29-30.

70. U.N. Dev. Programme [UNDP], Regional HIV and Development Programme for Asia-Pacific, *HIV-Related Stigma and Discrimination in Asia: A Review of Human Development Consequences* 8 (2007) (*prepared by* Jeanette R. Ickovics et al.), *available at* http://www.undprcc.lk/Publications/Publications/HIV/HIV_Related_Stigma.pdf.

71. Heine, *supra* note 66.

72. TAKING ACTION, *supra* note 12, at 85.

73. UNDP, *supra* note 70, at 2, 4, 10-11.

74. HUMAN RIGHTS WATCH, *supra* note 44, at 9.

75. *Id.* at 11.

76. DAVID E. BLOOM ET AL., AUSAID, HEALTH, WEALTH, AIDS AND POVERTY 9-10

Moreover, denying educational and employment opportunities also exacerbates the epidemic through increasing poverty. People in poverty are less likely to know about HIV/AIDS and consequently are less likely to engage in safe sex practices.[77] Furthermore, people in poverty may be forced to take high-risk jobs. Men, for example, may enter into the trucking industry because of the lack of other employment opportunities and risk spreading infection along India's highways.[78] Similarly, women may be forced to enter into the commercial sex trade because of the lack of other employment opportunity.[79] In fact, economic distress is cited as the primary reason that women enter into the sex trade because commercial sex becomes "their only means to obtain desperately needed money."[80]

E. India's Current Attempt to Address HIV/AIDS Discrimination

Although discrimination in education, employment, and health care is rampant, the government has made minimal attempts to address discrimination against persons with HIV/AIDS. However, in 2003, the National AIDS Control Organization (NACO) directed the Lawyers Collective HIV Unit (LCHAU) to draft an HIV/AIDS bill to address discrimination.[81] In 2006, NACO presented this bill to the Indian Parliament.[82] Although NACO envisioned this bill to be an important component to India's response to the HIV/AIDS epidemic, the Indian Parliament has demonstrated much resistance in passing the bill.[83] Parliament has delayed review of this bill and recommended changes that would greatly curtail protection.[84]

As originally drafted by the Lawyers Collective HIV/AIDS Unit, the bill precludes discrimination against persons affected by

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(2001), *available at* http://www.ausaid.gov.au/publications/pdf/health_wealth_poverty.pdf.

77. Multivariate analyses demonstrated that rural, uneducated, and poor women "are the least likely to be AIDS-aware and if aware, have the poorest understanding of the syndrome." Deborah Balk & Subrata Lahiri, *Awareness and Knowledge of AIDS Among Indian Women: Evidence From 13 States*, 7 HEALTH TRANSITION REV. 421, 421 (1997); *see also* BLOOM ET AL., *supra* note 76, at 8-9.

78. Mohammad Khairul Alam, Aids in India: Sex Workers and Truck Drivers Playing Vital Roles, http://globalhealth.org/reports/report.php3?id=257 (last visited May 18, 2010).

79. Ushma D. Upadhyay, *India's New Economic Policy of 1991 and Its Impact on Women's Poverty and AIDS*, FEMINIST ECON., Nov. 2000, at 105, 112.

80. *Id.*

81. Lawyers Collective, Draft Law on HIV, http://www.lawyerscollective.org/hiv-aids/draft-law (last visited May 18, 2010).

82. *Id.*

83. *See* Lawyers Collective, Update on the HIV/AIDS Bill, http://www.lawyerscollective.org/hiv-aids/draft-law/update (last visited May 18, 2010).

84. *Id.*

HIV/AIDS in education, employment, health care, travel, residence, and insurance both in the public and private sphere.[85] The bill not only covers persons living with HIV/AIDS but also those closely associated with the epidemic, such as friends and families of HIV infected persons, sex workers, injecting drug users, truckers or migrants.[86] Furthermore, in order to address discrimination in the health care sector by alleviating the risk of occupational exposure, the bill requires health care institutions to provide universal precautions and training for health care workers.[87]

With regards to HIV testing and treatment, the HIV/AIDS bill requires the testing and/or treatment site to obtain informed consent.[88] Moreover, when the HIV status of an individual is known, the bill mandates confidentiality but notes that there are exceptions such as spousal notification.[89] Nevertheless, in order to prevent domestic violence in response to notification, the bill stipulates the circumstances and procedures for disclosure.[90] The HIV/AIDS bill also guarantees the right to access comprehensive HIV-related medical treatment.[91] The services include voluntary testing, counseling, anti-retroviral treatments, and nutritional supplements.[92] In addition, the bill contains many prevention-centered provisions. For example, it calls for public health strategies for risk reduction irrespective of whether the underlying activity targeted is illegal.[93] The bill also proclaims the importance of "information, education and communication" as a component to successful HIV containment strategies.[94] "It obliges the [g]overnment to frame their messages on the basis of evidence and not myth and prejudices."[95] Additionally, for enforcement purposes, the bill provides for a "Health Ombud" in every district to ensure easy access to medical treatment should a person with HIV/AIDS be discriminated against or denied treatment.[96] Additionally, the bill also includes special procedures in the judicial

85. Draft HIV/AIDS Bill 2006 § 4 (2006), *available at* http://www.lawyerscollective.org/sites/default/files/hiv-2006-for-naco.doc.

86. Draft HIV/AIDS Bill 2006 § 2; *see also* ANAND GROVER, KAISER FAMILY FOUND., LAWS ARE NECESSARY TO PROTECT RIGHTS OF POSITIVE PEOPLE: INDIA'S HIV/AIDS BILL YET TO BECOME A LAW, HIV/AIDS Reporting Manual 21, 22 (2008), *available at* http://www.kff.org/hivaids/upload/7408-02Sec4.pdf.

87. Draft HIV/AIDS Bill 2006 § 20.

88. *Id.* § 8.

89. *Id.* § 13.

90. *Id.*

91. *Id.* § 17.

92. *Id.*

93. *Id.* § 25(2); *see also* GROVER, *supra* note 86, at 22.

94. Draft HIV/AIDS Bill 2006 § 75(2); *see also* GROVER, *supra* note 86, at 22.

95. GROVER, *supra* note 86, at 22; *see* Draft HIV/AIDS Bill 2006 § 24.

96. Draft HIV/AIDS Bill 2006 § 26; *see also* GROVER, *supra* note 86, at 23.

system such as confidentiality of identity and speedy resolution of cases.[97]

Despite the momentous steps that this bill proposes to take to address discrimination against persons living with HIV/AIDS, the government insists on narrowing its protections. For example, the Ministry of Health has recommended deleting provisions regarding strategies for risk reduction, expeditious grievance procedures, access to treatment, and access to information, education, and communication.[98] Additionally, provisions pertaining to discrimination, informed consent, and confidentiality have also been greatly curtailed.[99] Instead of protecting the rights of HIV affected persons, the Ministry of Health has attempted to impose draconian measures like mandatory testing and the tracing and isolation of persons with HIV/AIDS.[100] NACO has objected to these measures as violations of personal rights and contrary to effective public health strategies.[101]

Consequently, whether the HIV/AIDS bill can effectively address discrimination against persons living with the disease is questionable. Because the Ministry of Health has recommended changes to the bill, it is very unlikely that the bill will pass in its original form. If the bill passes with the recommended changes, it will do very little good for fighting the epidemic. In fact, if the draconian provisions requiring mandatory testing and disclosure are incorporated into this bill, the legislation may in fact increase stigmatization and discourage effective HIV/AIDS interventions. India, therefore, currently remains without an adequate solution for addressing the discrimination that persons living with HIV/AIDS face. Without an effective means to address discrimination, India will not be able to successfully combat the epidemic. With the HIV/AIDS bill severely curtailed, India must consider other ways to address discrimination against persons living with the disease. In this regard, disability law may be an effective tool, as India has already shown a commitment to protecting the rights of persons with disabilities.

97. Draft HIV/AIDS Bill 2006 §§ 26; 50(3); *see also* GROVER, *supra* note 86, at 23.

98. *Restore Original HIV/AIDS Bill of 2006: NACO*, DECCAN HERALD, Dec. 9, 2008, http://archive.deccanherald.com/Content/Dec92008/state20081209105607.asp (last visited May 18, 2010).

99. *Id.*

100. *Id.*

101. *Id.*

II. THE INDIAN APPROACH TO DISABILITY LAW: THE PERSONS WITH DISABILITIES ACT

A. India's Commitment to Disability Protection

When India adopted its constitution, very few disability protections existed. In fact, one of the only references to disability protection in the Constitution is article 41, which is a non-enforceable provision directing the states within their economic and development capabilities to "make effective provision[s] for securing the right to work, to education and to public assistance in cases of . . . old age, sickness and disablement."[102] However, in 1992, India signed the Proclamation on the Full Participation and Equality of People With Disabilities in the Asian and Pacific Region, signaling its active commitment to protection of people with disabilities.[103] To comply with its international obligation, in 1995 the Indian Parliament passed the Persons with Disabilities Act (PWDA), which recognizes disability as a civil rights issue and guarantees access to certain public goods.[104]

In 2007, India ratified the UN Convention on the Rights of Persons with Disabilities (UNCPRD).[105] This convention obligates parties to the agreement "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[106] The Convention mandates that the principles and rights explicated in the Convention be reflected in each country's relevant laws.[107] Therefore, in order to comply with its international obligations, India must ensure that its disability laws reflect the protections and purposes espoused in the UNCRPD.

B. The Protections of the PWDA

Section 2(i) of the PWDA defines disability as blindness, low vision, hearing impairment, locomotor disability, mental retardation, and mental illness. Under the statute, in order to be a person with a disability, the individual must be "suffering from not less than forty [percent] of any disability as certified by a medical au-

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102. INDIA CONST. art. 41.

103. *See* Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, No. 1 Acts of Parliament, 1996.

104. *See id.*

105. UNCRPD; *supra* note 18; U.N. Enable, Ratifications, http://www.un.org/disabilities/countries.asp?navid=12&pid=166 (last visited May 18, 2010).

106. *Id.* art. 1.

107. *Id.* art. 32, § 1.

thority."[108] The definition of disability adopted by the PWDA is problematic to the HIV epidemic. The enumerated list forecloses the possibility of including HIV/AIDS as a disability. Moreover, the statute endorses a mathematical approach by using percentages to define disability.[109] An Indian court has interpreted the forty percent provision to mean that disability is to be determined through a quantitative comparison to an individual of "ordinary faculties".[110] Because HIV infection often remains asymptomatic for many years until the infection progresses to AIDS, the individual may not qualify as a person with disability.

Because persons living with HIV/AIDS suffer discrimination in education and employment, the PWDA can serve as an effective framework for protecting the social rights of this population. Under this statute, if a person is disabled, the PWDA prohibits discrimination in education and employment and requires access to public accommodations. With regards to education, the PWDA requires "that every child with a disability has access to free education in an appropriate environment [until] he attains the age of eighteen years."[111] In order to address educational cost, the PWDA requires government to provide "every child with [a] disability [with] free of cost special books and equipment[ ] needed for his education" as well as making scholarships and grants available so that disabled students can attend schools and universities.[112] Moreover, PWDA also requires all "[g]overnment educational institutions and other educational institutions receiving aid from the [g]overnment" to reserve at least three percent of the seats for persons with disabilities.[113] Because many children affected by the HIV/AIDS are denied educational opportunities and can face significant financial hurdles, these protections will be important to addressing HIV/AIDS discrimination.

Similar to the educational provision, the employment protections guaranteed under the PWDA require corporations or any entity receiving public money to reserve three percent of positions for persons with disabilities.[114] The statute, however, makes an exception; if the employment position cannot be filled by a suitable person with a disability, then it can be offered to a person without a disability, contingent upon the government's approval.[115] Addi-

108. Persons with Disabilities Act, ch.1, § 2(t).
109. *Id.*; *see also* Gopal v. Andhra Bank, 2003 II-LLJ 916 (Andhra Pradesh).
110. *Gopal*, 2003 II-LLJ 916.
111. Persons with Disabilities Act, ch. 5, § 26(a).
112. *Id.* ch. 5, §§ 27(f), 30(a)-(d).
113. *Id.* ch. 6, § 39.
114. *Id.* ch. 6, § 33.
115. *Id.* ch. 6, § 36.

tionally, if a person develops a disability during his or her time of employment, the PWDA prohibits entities from demoting or firing a person because of that disability.[116] If the individual can no longer perform the functions of his or her position, the employer is required to try to shift the person to another position with similar pay and benefits.[117] The Act also explicitly prohibits the denial of promotion "merely on the ground of his disability."[118] These employment provisions are important to addressing HIV/AIDS discrimination because they preclude employers from denying employment based on disability status. Consequently, if disability protection is expanded to include HIV/AIDS, employers will be prohibited from discriminating against HIV positive employees.

C. Enforcement of the PWDA and the HIV Epidemic

Even with statutorily guaranteed protections, society will continue to perpetuate discriminatory practices unless the government provides for adequate enforcement. To ensure compliance, the PWDA requires the state and national government to appoint commissioners to monitor and enforce the statute.[119] When a violation is alleged, the PWDA does not explicitly provide for private causes of action. Rather, aggrieved parties can file a complaint with either the Chief Commissioner or the state commissioner.[120] If the aggrieved is not satisfied with the Commissioner's decision, an appeal may be filed with the judicial courts.[121] Despite the process available under the PWDA, judicial courts in India are plagued with inefficiencies.[122] Consequently, India must consider methods to streamline the judicial process and ensure timely access to the courts.

Notwithstanding the judicial inefficiencies, a number of courts have ruled on issues regarding violations of the PWDA. While the majority of cases concerned disabilities that were explicitly defined under the statute such as visual, auditory, and locomotor disabilities, a few cases involved illnesses such as heart disease and cancer.[123] The fact that the courts have considered other illnesses un-

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116. *Id.* ch. 8, § 47(1).
117. *Id.*
118. *Id.* ch. 8, § 47(2).
119. *Id.* ch. 12, §§ 57-65.
120. *Id.* ch. 12, §§ 59, 62.
121. *See, e.g.*, Gupta v. Ahirwar, A.I.R. 2007 S.C. 3136.
122. *Report: Indian Court is 466 Years Behind Schedule*, USA TODAY (Feb. 2. 2009); *available at* http://www.usatoday.com/news/world/2009-02-12-india-court_N.htm.
123. *See, e.g.*, Singh v. Airports Auth. of India, 2005 V AD 513 (Del.); Kumari v. Karunashanker, A.I.R 1988 MP 232 (2005) (Madhya Pradesh).

der the PWDA demonstrates that courts are willing to take an expansive approach to disability. In the *Airports Authority* case, the court extended the protection of the PWDA to a person who suffered from heart disease.[124] In *Karunashanker*, the court held that disability law applied to cancer because it characterized malignancy as a physical handicap.[125] The court stated, "malignancy . . . is a physical disability as it has the tendency to reduce or impair functional capacity. Such a person must be held a 'physically handicapped person' within the meaning of the [Madhya Pradesh Accommodation Control Act]."[126] Although none of the high court cases specifically dealt with HIV/AIDS, the judicial interpretation of the statute to include other illnesses not explicitly enumerated demonstrates the courts' overall liberalization. Similar to the reasoning in *Karunashanker*, HIV/AIDS also greatly impairs and reduces functional capacity. Thus, expanding the PWDA to include HIV/AIDS is well within the courts' interpretation of disability

D. Disability Protection under the UN Convention

The restrictive statutory language of the PWDA is problematic for India. The ratification of the UNCRPD requires countries to take a rights based approach to disability and view disability broadly. While India defines disability via an enumerated list, Article 1 of the UNCRPD defines disability as individuals "who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[127] The Convention requires countries to recognize disabled persons' right to marriage and family,[128] ensure access to primary, secondary, "tertiary education, vocational training, adult education and lifelong learning,"[129] provide equal rights to employment,[130] and protect a right to the "highest attainable standard of health without discrimination on the basis of disability."[131]

The rights-based approach to disability that the UN endorses is contrary to the approach furthered in the PWDA. The PWDA views disability through a scientific lens and justifies its protections based on the idea that disability is an individual defect in

124. *Singh*, 2005 V AD 513.
125. *Karunashanker*, A.I.R 1998 MP 232.
126. *Id.*
127. UNCRPD, *supra* note 18, art. 1.
128. *Id.* art. 23.
129. *Id.* art. 24.
130. *Id.* art. 27.
131. *Id.* art. 25.

need of social compensation. In contrast, the Convention recognizes that the social limitations of disabled persons are not the result of their impairment but the result of the discrimination that people with disability face. Rather than viewing persons with disability as incapable or handicapped, the UN recognizes that disabled persons can be fully functioning members of society if their rights are properly protected.

Because the UNCRPD mandates that India reform its disability law to be more expansive, India should consider reforming the PWDA to not only remove the social compensation view of disability that resonates throughout the statute but also to include protections for persons living with HIV/AIDS. The recognition of civil rights and protection against discrimination is paramount to creating sustainable public health interventions. If reformed correctly, India's disability law may become an effective weapon in the fight against the HIV/AIDS epidemic.

III. THE AMERICAN APPROACH TO DISABILITY: AMERICANS WITH DISABILITIES ACT

A. The History and Transformation of the ADA

Similar to the UN Convention, the ADA endorses a rights-based approach and views disability protection in terms of preventing unwarranted discrimination rather than compensating for a physical limitation. Therefore, the ADA can serve as a useful framework for India to restructure its laws. Although the ADA can serve as a helpful example, we must not forget the important distinction between the American and Indian commitment to protection of persons with disabilities. By understanding the important distinctions, we are more able to grasp the difficulties that India might face in trying to pass a disability law similar to the ADA.

One important distinction that exists between India and America is their respective views of disability. The Indian Parliament, for example, has only viewed disability protection from the lens of social compensation.[132] The reason for passing disability protection in India hinged on this idea that persons with disability are less competent or functional, and therefore, require social protection.[133] Congress, on the other hand, noted that its impetus for passing the ADA was the recognition that disability did not diminish a per-

132. *See* SEEMA TIWARI, CTR. FOR LEGISLATIVE RESEARCH AND ADVOCACY, CLRA POLICY BRIEF FOR PARLIAMENTARIANS: INDIAN DISABILITY LAW - AN OBSOLETE PICTURE 1 (2008), *available at* http://www.clraindia.org/include/DPbriefno5.pdf.

133. *Id.*

son's right to fully participate in all aspects of society, but disabled individuals were frequently precluded from participating in different aspects of society because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers.[134] Congress passed the Americans with Disabilities Act "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" and provide broad coverage.[135]

Additionally, in contrast to the Indian Parliament, some members of Congress recognized the importance of guaranteeing the rights of persons living with HIV/AIDS when discussing passage of the ADA.[136] Despite the commitment expressed by some members of Congress, the courts have disagreed on whether HIV is a disability under the statute. The controversy of HIV as a disability under the ADA began in 1998 when the Supreme Court held that HIV was a physical impairment but refused to determine whether HIV/AIDS was a per se disability.[137] After this Supreme Court case, a number of lower courts refused to consider HIV as a per se disability and looked at a number of factors to determine whether persons living with the disease were guaranteed protections under the ADA.[138]

In 2008, Congress amended the ADA to clarify the definition of disability and thus overturn Supreme Court decisions that narrowed the scope of protections under the ADA.[139] More specifically, the amendment rejected the Supreme Court's mitigating measures analysis that required disability to be considered in light of wheth-

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134. *See* 42 U.S.C. § 12101(a),(b).

135. 42 U.S.C. § 12101(b)(1).

136. *See* 154 CONG. REC. H8279, 8297 (daily ed. Sept. 17, 2008) (statement of Rep. Baldwin).

137. Bragdon v. Abbott, 524 U.S. 624, 647, 655 (1998) (holding that HIV was a disability in this case because "it is an impairment which substantially limits the major life activity of reproduction").

138. *See, e.g.*, EEOC v. Lee's Log Cabin Inc., 546 F.3d 438, 445-46 (7th Cir. 2008) (holding that HIV infection is not a per se disability and therefore plaintiff must show how the infection substantially limited her life); Blanks v. Sw. Bell Commc'ns, Inc., 310 F.3d 398, 401 (5th Cir. 2002) (holding that plaintiff did not show how he was substantially limited by his HIV infection and thus was not disabled under the ADA definition); Carter v. Taylor, 540 F. Supp. 2d 522, 527-28 (D. Del. 2008) (holding that HIV is not a per se disability and plaintiff must allege more than that he suffers from HIV); St. John v. NCI Bldg. Sys., Inc., 537 F. Supp. 2d 848, 861 (S.D. Tex. 2008) (holding that HIV is not a per se disability and plaintiff was not substantially limited because infection was asymptomatic); Carrillo v. AMR Eagle, Inc., 148 F. Supp. 2d 142, 145 (D.P.R. 2001) (refusing to find HIV as a per se disability and holding that plaintiff failed to show how HIV substantially limits a man's ability to reproduce); Gutwaks v. Am. Airlines, Inc., No. 3:98-CV-2120-BF, 1999 WL 1611328, at *5 (N.D. Tex. Sept. 2, 1999) (holding that HIV is not a per se disability).

139. ADA Amendments Act § 2 (Congress noted that the ADA amendment was to overturn Sutton v. United Airlines, 527 U.S. 471 (1999) and Toyota Motor Mfg., Ky., Inc. v. Williams, 534 U.S. 184 (2002)).

er mitigating measures were available.[140] In rejecting these cases, the amendment notes, "the determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures" and states that the use of medication cannot be used to assess disability.[141] Furthermore, the amendment overturned the notion that the ADA required a "demanding standard" for the definition of disability.[142]

In broadening the definition of disability, the amendment clearly classifies HIV/AIDS as a disability under the statute.[143] The amendment notes that the definition of disability "shall be construed in favor of broad coverage"[144] and includes functions of the immune system as a major life activity.[145] The amendment clarifies that the individual's impairment needs to substantially limit only one life activity to be considered a disability.[146] Moreover, the amendment also revised the ADA to explicitly state "[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active."[147] Based on this language, HIV/AIDS does not have to be symptomatic in order for an individual to be protected under the ADA.

The transformation of the ADA can show us two important things. First, the transformation demonstrates that even with a commitment to protecting persons with HIV/AIDS, courts and other social institutions may still try to narrow its protection. Additionally, the history of the ADA also shows us that rights protection for persons living with HIV/AIDS could be codified because Congress had a long-standing commitment to such protection. For India, codifying rights protection for persons living with HIV/AIDS will be more difficult because parliament has not demonstrated an equivalent commitment to protection of these individuals. Furthermore, India must also recognize the necessity of explicit language in guaranteeing the rights of persons with HIV/AIDS to prevent courts from curtailing protection.

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140. *See* Sutton v. United Airlines, 527 U.S. at 481.

141. ADA Amendments Act § 4.

142. The *Toyota Motor* case required the definition of disability to be strictly interpreted and held that a person is qualified under the statute only if their impairment "severely restricts the individual from doing activities that are of central importance to most people's daily lives." 534 U.S. at 198.

143. 154 CONG. REC. H8297 (daily ed. Sept 17, 2008) (Statement of Rep. Baldwin) ("Due to . . . narrow court interpretations, people with HIV who have been fired, not hired, or suffered other adverse employment actions have been denied the protection of the ADA.).

144. ADA Amendments Act § 4.

145. *Id.*

146. *Id.*

147. *Id.*

B. The Protections of the ADA: A Comparison to the PWDA

Some of the protections under the PWDA are similar to the protections guaranteed under the ADA. For example, the ADA provides civil rights protections in employment, education, and freedom from discrimination. The ADA, however, extends much further in its protections than India's PWDA. Unlike the PWDA, the rights guaranteed under the ADA extend to private schools and health care entities. Furthermore, though the PWDA defines disability by an enumerated list, the ADA defines disability more broadly. The ADA defines disability as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual."[148] Because the UNCRPD mandates signatories to adopt a broad definition of disability, India should consider adopting a similar definition.

Title I of the ADA prohibits employment based discrimination.[149] The statute prohibits employers with 15 or more employees from discriminating based on disability in "job application procedures, the hiring, advancement, or discharge or employees, employee compensation, job training, and other terms, conditions and privileges of employment."[150] Unlike the PWDA, the ADA does not reserve a certain percentage of the workforce for disabled individuals. Rather, the ADA generally prohibits discrimination and adverse employment actions based on a person's disability. The ADA's approach endorses a much more rights-based strategy to disability protection than the PWDA. By reserving a certain percentage of the workforce for the disabled, India once again seems to be viewing disability as a condition that requires social compensation.

Both the ADA and the PWDA require employers to make accommodations for disability. The ADA requires employers to make reasonable accommodations to persons with disabilities such as restructuring the job functions, increasing flexibility in work schedule, granting leniency with sick leave, and providing special equipment.[151] In addition to making reasonable accommodation, the statute also prohibits employers from making medical inquiries based on disability.[152] When institutions make medical inquiries, the statute requires that medical information be treated con-

148. Americans with Disabilities Act, 42 U.S.C. § 12102 (1990).
149. *Id.* § 12112(a).
150. *Id.* § 12112(a)
151. *Id.* §§ 12111(9), 12112(b)(5)(A); *see* EEOC v. Yellow Freight Systems, Inc., 253 F.3d 943, 950-952 (7th Cir. 2001).
152. 42 U.S.C. § 12112(d)(4)(a).

fidentially.[153] This type of privacy protection is absent from the PWDA. The PWDA does not mention medical inquiries or confidentiality. Privacy protection and limitations on medical inquiries, however, are paramount to addressing HIV/AIDS epidemic. Without such protection, institutions will continue to discriminate against HIV/AIDS affected individuals by forcing medical evaluations and disclosing status. As a consequence, HIV/AIDS affected individuals may avoid employment opportunities altogether or be ridiculed and ostracized by others if their status is disclosed.

Title II and III of the ADA prohibit education and health care discrimination.[154] Title II and Title III apply to public and private institutions, respectively.[155] Similar to the employment provisions, health care and educational institutions must make reasonable accommodations in order to avoid the exclusion and discrimination of persons with disabilities.[156] Although all provisions of the ADA require reasonable accommodations, the ADA does not specifically define or include examples of reasonable accommodations within Title II and III.[157] By not defining the term, the ADA focuses on the reasonability of the accommodation and remains flexible in determining whether the entity did in fact provide appropriate accommodations. This flexibility allows parties to argue the propriety of the accommodation and allows courts to determine on a case-by-case basis whether the entity's response was adequate to the specific disability.

Title II and III protections in the ADA differ from the PWDA in three important respects. First, the PWDA does not apply to private institutions. This is extremely problematic for the HIV/AIDS epidemic because most of the education and health care in India occurs through the private sector. Second, although India requires accommodations, some of the accommodations mentioned in the PWDA deny disabled individuals equal opportunity. For example, the PWDA's educational accommodations include removing mathematical examinations for blind individuals and limiting hearing-impaired students to the study of only one foreign language.[158] These accommodations endorse the social compensation view of disability. They assume that disability generally makes the individuals incapable of normal cognitive ability and therefore requires compensation. Lastly, unlike the ADA, the PWDA does not

153. *Id.* § 12112(d)(3)(B).
154. *Id.* § 12131; § 12181.
155. *Id.* § 12132; § 12182(a).
156. *Id.* §12182(b)(2)(a)(ii).
157. *Id.* § 12111.
158. Persons with Disabilities Act, § 30(f)-(h).

include any protection for discrimination within the health care sector. In order to address the HIV/AIDS epidemic, India must also include provisions regarding discrimination in the health care sector. Many health care institutions in India deny services to HIV affected individuals, which increases morbidity and discourages testing.[159] Moreover, in order to be in compliance with the UNCRPD, India should extend disability protection to the health care sector.

The ADA, therefore, can serve as a good example for India in restructuring its disability laws. The protections in the ADA do not focus on the disability itself. Rather the ADA focuses on the social response to disability and endorses a rights based approach. The ADA also includes HIV/AIDS as a disability. By adopting a rights-based approach similar to the ADA and expanding the PWDA to include HIV/AIDS, India will not only comply with the UNCRPD but also will create an effective framework to combat its own HIV/AIDS epidemic.

C. Judicial Treatment of HIV Under the ADA and the Various Loopholes

Although Congress always intended to protect persons affected with HIV/AIDS with the ADA,[160] courts remained reluctant to interpret the ADA to grant such protection. The 2008 amendment resolves the conflict as to whether the ADA includes HIV/AIDS as a disability. Notwithstanding, the statute may still be circumvented.[161] For example, defendants may discriminate based on disability when the disability poses a direct threat to the health and safety of others and reasonable modifications cannot eliminate the threat.[162] Because many jurisdictions only require a theoretical, unrealized risk, the direct threat standard for HIV/AIDS may not be difficult to prove when bodily fluid contact is possible. In fact, courts have found that HIV positive prisoners,[163] health care workers,[164] and martial art students[165] were not qualified under the sta-

159. *See* LOUDON ET AL., *supra* note 26, at 26-27.

160. *See* ADA Amendments Act § 2.

161. *See* 42 U.S.C. §§ 12113, 12182(b)(3).

162. *Id.* § 12182(b)(3).

163. Onishea v. Hopper, 171 F.3d 1289, 1299, 1303 (11th Cir. 1999) (noting that the violence, drug use, and sex in prisoners made HIV positive inmates a direct threat and that hiring more police guards was not a reasonable modification because it "would place an undue financial and administrative burden on the already strapped prison system"); Smith v. McFarland, No. 3:06-CV-592-WKW, 2008 WL 606986 at *3 (M.D. Ala. Feb. 29, 2008) (holding that HIV positive prisoners are not qualified individuals under the ADA because they pose a significant risk to the rest of the prison population).

164. Waddell v. Valley Forge Dental Assocs., Inc., 276 F.3d 1275, 1281 (11th Cir. 2001)

tute because their HIV infection posed a direct threat to others. Moreover, defendants may also avoid application of the ADA if they are able to show that accommodating the disability is not reasonable or appropriate.[166] With regards to employment actions under the ADA, HIV positive individuals may also face difficulties in proving discriminatory practices by the employers because the plaintiff will have to show that the employment action was adverse and motivated solely by disability-based discrimination.[167]

Although claiming these exceptions in certain circumstances may be reasonable, direct threat and undue burden standards may also become loopholes. Therefore, if India follows the U.S. example and adopts similar exceptions, India must be cognizant of the possibility that courts may use these provisions to improperly circumvent the statute. As a result, India must clearly include HIV/AIDS as a disability and narrowly define any exceptions.

RECOMMENDATIONS AND CONCLUSION

The HIV/AIDS affected population in India, like much of the rest of the world, confronts discrimination in education, employment and access to health care. The refusal to treat, educate, and accommodate has led to worse health outcomes for persons suffering from HIV/AIDS and greater infection rates. As HIV affected populations become more and more alienated because of discrimination, people are less likely to get tested, seek treatment, and receive social support.

India's ratification of the UNCRPD gives the country a unique opportunity to reform its laws. In order to reform its law, India should not only expand the definition of disability to reflect the United Nation's broad definition but also include HIV/AIDS as a disability. Because the UNCRPD defines disability as a long term

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(holding that a dental hygienist posed a direct threat to patients); Mauro v. Borgess Med. Ctr., 137 F.3d 398, 407 (6th Cir. 1998) (holding that a surgical technician posed a direct threat to patients).

165. Montalvo v. Radcliffe, 167 F.3d 873, 877 (4th Cir. 1999) (holding that a HIV positive student denied admission to a martial arts school posed a direct threat).

166. 42 U.S.C. § 12111(b); EEOC v. Yellow Freight Sys. Inc., 253 F.3d, 943, 950-52 (holding that an unlimited number of sick days without being penalized is not a reasonable accommodation).

167. Brown v. Pension Bds., 488 F. Supp. 2d 395, 405 (S.D.N.Y. 2007) (holding that plaintiff failed to show that discharge was discriminatory because the board members did not know of the HIV status and the employee violated the call-into work policy); Swatzell v. Sw. Bell Tel. Co., No. 7:00-CV-193-R, 2001 WL 1343429, at *5 (N.D. Tex. Oct. 31, 2003) (holding that forcing an individual to take long term disability after disclosing HIV status was an adverse employment action).

physical, mental, or intellectual impairment, clearly HIV/AIDS can qualify as a long-term physical impairment under the Convention.

Furthermore, India should also include access to health care and confidentiality standards in the PWDA. Not only are these requirements mandated by the UNCRPD, but they are critical to effective HIV/AIDS interventions. With an access to treatment provision, health care professionals will no longer be able to discriminate against persons affected by HIV/AIDS and deny necessary treatment. Additionally, because much of healthcare and education occurs through the private sector, the act should be extended to private institutions such as schools and health care facilities.

More importantly, the inclusion of HIV/AIDS as a disability will not be sufficient to address discrimination unless India adopts the rights-based approach to disability that is mandated by the UNCRPD. In fact, India's current view of disability as a defect in need of social compensation may, in actuality, lead to greater discrimination. Viewing disability as a condition of inferiority further stigmatizes and alienates disabled populations. Therefore, the PWDA should specifically recognize the right of disabled persons to be full-functioning members of society and acknowledge the importance of equality. Furthermore, the government should remove provisions in the PWDA that deny persons with disabilities equal opportunity.

The Americans with Disabilities Act may serve as a good example for India as it restructures its laws, because the ADA is a rights-based law that extends protections to HIV/AIDS affected individuals. Similar to the discrimination in India, HIV/AIDS discrimination was rampant in the United States during the early years of the epidemic. In part, to address this discrimination, Congress passed the ADA. Therefore, the evolution of the ADA may be useful to understanding India's own transformation. In considering the American example, India should be cognizant of how U.S. courts have treated HIV/AIDS under the ADA to avoid any loopholes and narrowly define any exceptions.

While the ADA is a useful example to India, India faces great challenges in reforming the PWDA into an effective public health strategy. First, the political will in India remains weak. Unlike Congress, the Indian Parliament has not demonstrated a united commitment to addressing HIV/AIDS discrimination. Therefore, passing a law similar to the ADA may be difficult. Moreover, in order for the reform to be effective, there must be corresponding HIV/AIDS awareness and speedy judicial resolution of cases. In the United States, for example, much of the systematic HIV/AIDS discrimination subsided because of increasing social awareness

about the disease and modes of transmission. In addition to reforming the PWDA, India must also correspondingly increase HIV/AIDS discourse and education in order to reduce discrimination.

Unless the epidemic is effectively curtailed, India will face economic and political devastation from HIV/AIDS. In order to avoid national and global destabilization, India must quickly address its epidemic. The PWDA is an invaluable tool for India in its fight against the epidemic. The PWDA guarantees civil rights to vulnerable populations. Further, by signing the UNCRPD, India obligated itself to reform the PWDA to be more expansive. India, therefore, has an incredible opportunity to reform the law to not only comply with its international obligation but also as a public health strategy. The PWDA will not be a complete answer to the epidemic, but it will serve as an important and necessary component of a successful Indian response. The protection of civil rights is the foundation of any sustainable public health intervention.