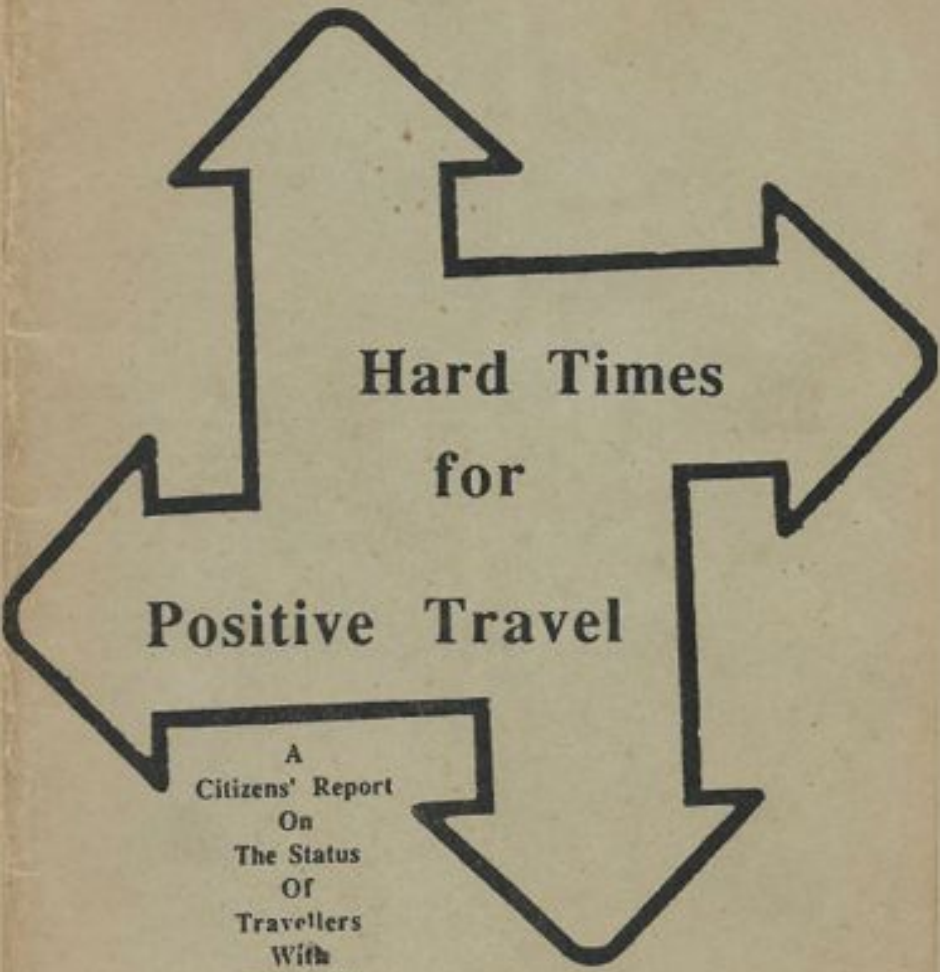

Hard Times for Positive Travel

A Citizens' Report On The Status Of Travellers With HIV/AIDS

AIDS Bhedbhav Virodhi Andolan
(AIDS Anti-Discrimination Movement)

September 1993
New Delhi - India

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A TRIBUTE

Dominic D'Souza died on 21 May 1992 at the age of 33. His untimely death saddened all those who knew and loved him, but it did not come as a surprise. Ever since he was listed HIV positive in 1989, Dominic, his family and friends had been living under the shadow of death.

The years after he was tested positive are an example of extraordinary courage in the face of unbelievable adversity. The first Indian to take a public and political stance on his HIV positive status, Dominic was arrested by the Goa Police on 14.2.89 in the early hours of the morning. The arrest was unjustly executed under the Goa Public Health Act 1935, as the blood he donated for one of his friends tested to be HIV positive.

The Goa authorities kept Dominic in isolation in the most inhuman and derogatory conditions. For 64 days, a lethal government machinery proceeded to strip the dignity and break the spirit of a man who was already suffering and had but a short time to live. ABVA's report "Women and AIDS, Denial and Blame" contains a moving account of the terrible pain and anguish Dominic suffered in isolation. In this account Dominic describes the police brutality, the callous indifferences of the medical establishment, the media's greed for sensationalizing, and a judiciary that failed to deliver. He wrote also of the love and support of his family, friends and the entire village of Para.

A year later, the World Wild Life Fund, an organisation with which Dominic had worked for six

years, terminated his services. Yet all this did not break Dominic's spirit. Undeterred he continued his sometimes lonely fight and struggle for justice. He initiated and headed a project "Positive People" that reaches out to HIV positive people and provides them and their families with care and counselling.

Despite the effects of the virus, Dominic travelled extensively to Amsterdam and U.K. to build up a networking system with NGOs involved in similar work. When ABVA organised a protest demonstration at AIIMS/ ICMR headquarters, New Delhi, in 1990, against the refusal of treatment to an HIV positive African envoy and the forcible HIV testing of women in prostitution, Dominic and his friend Isabelle came to Delhi in an exemplary show of solidarity.

Dominic D'Souza is no more, but his work and example live on. We, at ABVA, salute this brave and courageous crusader !

WHY THIS REPORT ?

For specific action to control spread of HIV infection and AIDS, four 'target' or 'high risk' groups have been projected by the Establishment. These are women in prostitution, professional blood donors, gays and intravenous drug users. For over four years, ABVA has been trying to shatter the misconceptions associated with HIV and AIDS in the Indian society. ABVA has brought out four reports on these target groups. ABVA is equally concerned about the harassment and hounding out of HIV positive foreigners by the Indian Government as also by Governments in most parts of the world. Though the print media has highlighted only few such instances and that too in a sensational and unethical manner, the 'tracking' down and final deportation of HIV positive foreigners from India should not be seen as occasional aberrations but in conformity with and compliance of a clear-cut policy of the Indian government.

ABVA is aware that hundreds of foreigners have been tested to be HIV positive; many have been deported from India. The fate and plight of others are unknown. Clearly foreigners have been projected as another 'target' or 'high-risk' group in India. What is the position world- wide? What is the stand adopted by the WHO, UN in this regard? What do international instrumentalities have to say on this issue? What has been the status of travel in religion, culture, and heritage of Indian and other civilizations spread over several thousand years. How did travel restrictions come about in India and elsewhere? Why is it that the traditional hospitality accorded by ordinary citizens to a (foreign) traveller - even to an ailing one at that - is being sought to be done away with by the various arms of the modern state ? What are the factors responsible for this state of affairs? ABVA tried to get answers to these queries and decided to bring out this report.

ABVA being concerned about individuals' rights, was shocked to read newspaper reports of an HIV positive French tourist visiting Calcutta (West Bengal) in early 1992, being denied emergency medical care by doctors at local hospitals. Finally,

she was forced to leave India. Not a word of regret from the state government, though!

As with earlier reports, this also has been an education for all ABVA members. It helped remove some of the group's own biases and ignorances. Several group discussions were held and a large amount of available literature was scanned and carefully studied. Request letters with questionnaires were dispatched to Chief of Missions of Embassies/High Commissions of about 100 countries, enquiring about their policies on HIV positive foreigners. Likewise, communication was addressed to WHO, UN, Government of India (Ministries of Health, External Affairs and Home Affairs), National AIDS Control Organization (NACO) of India. Response was received from some quarters and has been duly recorded.

Over a period of eight weeks, two ABVA members tried to meet the concerned officials at NACO, Indian Council of Medical Research (ICMR), University Grants Commission (UGC), Jawaharlal Nehru University (JNU)., Foreigners Regional Registration Office (FRRO) and National Institute of Communicable Diseases (NICD) to get their views. Some obliged while others had to be cajoled and confronted in public meetings/seminars/conferences for responses. So much so for the 'right to information' and accountability !

ABVA acknowledges the help extended by Professor Ralf Jurgens, Senior Research Associate, McGill University, Canada, in this documentation. We are thankful to Dr. Gulab Khan, Librarian, Information Centre, New Delhi for his valuable guidance.

ABVA acknowledges the generosity of the Christian Institute for the Study of Religion & Society/Joint Women's Programme in the sharing of their resources - computer, printer and other equipment - with special thanks to Asghar Mehmood for his valuable assistance in this regard.

ABVA feels that the discrimination faced by HIV positive foreigners in the area of travel from one country to another should have no place in a sane and civilized society. This report is an attempt towards this end.

About ABVA

Over four years ago a group of Delhi based citizens involved in community work related to education, health, law, women, gays and lesbians issues, professional blood donors, and in the peace movement came together over the plight of women working in GB Road, Delhi's red light area. The entry into particular communities was with a view to learning more about the problems of these defined groups and to see whether their viewpoints may be conveyed to the outside world. Also, if external support was needed, could it be extended on a long term basis?

When the group was started the focus was only on issues concerning women in prostitution. Around the same time forcible testing for HIV infection among women in prostitution was started under AIIMS-ICMR scheme with the help of the police. AIDS and HIV infection therefore became part of the group's concern. Public health policy for control of AIDS/HIV infection was based on targeting 'high risk' groups. ABVA therefore started studying and documenting the issues related to these 'target groups'. In this process the group was joined by other concerned citizens. The group has since taken a stand on all kinds of discrimination against 'target groups'.

ABVA Members

Anuja Gupta (Professor of French), Arun Bhandari (Ankur), Ashwini Ailawadi (Counsellor), Dimple (Social Activist), Jagdish Bhardwaje (Professional Blood Donor) Gauri (Social Activist), Manoj Pande, Lalitha S.A. (Joint Women's Programme), Mathew Varghese (Orthopaedic Surgeon) Dr. Puneet Bedi , (Gynaecologist), Dr. P. S. Sahni, Shalini SCN (Indian Social Institute), Shanta (Ankur), A. Srinivas (Social Activist), Shobha Aggarwal (Activist Lawyer) and Kusum Gupta (Social Activist).

The members of AIDS Bhedbhav Virodhi Andolan (ABVA) have tried hard to broad base its work by mobilizing other voluntary

groups and community people including people with leprosy, women in prostitution, women from slums around Delhi, the gay community, drug dependents and professional blood donors. ABVA has regularly met with concerned officials of Delhi Administration and the Union Government, and submitted memorandums to relevant authorities. With the help of Shobha Aggarwal, an activist lawyer, ABVA has been able to offer free legal assistance to women in prostitution.

ABVA was instrumental in stalling the Draconian AIDS (Prevention) Bill, 1989 through petitions in Parliament, public meetings, protest actions and networking both in India and abroad. As a result, the Bill was placed before a Joint Parliamentary Committee. The Bill was withdrawn in October-November 1991 following a decision made by the Union Cabinet.

ABVA has organized several protests against the government's policies on testing confidentiality and discrimination linked with AIDS, and the 'high risk' groups.

On 28 February 1990, a demonstration was organized at the Indian Council of Medical Research (ICMR) headquarters, New Delhi, to protest against the refusal of doctors at All India Institute of Medical Sciences (AIIMS) to operate upon an African envoy with AIDS.

On 30 November 1990, ABVA staged a protest demonstration at the head office of the Medical Council of India (MCI), urging it to remove from its Medical Register the names of doctors who refused to treat persons with HIV/AIDS. About five months later, the Indian Medical Association responded by publicly stating that a refusal to treat persons with HIV/AIDS would be against medical ethics.

On 18 March 1991, ABVA protested outside the head office of the New Delhi Municipal Committee (NDMC) following the refusal by the NDMC Hospital at Moti Bagh, New Delhi to

treat children with thalassaemia who had contracted HIV infection through blood transfusion.

On 7th August 1991, a 500 strong sit-in was organized at AIIMS following refusal by doctors at the premier medical institute of the country to conduct a delivery on an HIV positive pregnant woman.

On 6 December 1991, ABVA protested outside the World Bank against the use of loan/grant of US $ 80 million to the Government of India. ABVA feels that rehabilitation of HIV positive persons should be an important part of management. Any programme which does not take this into consideration should not be funded. No programme should violate the basic rights of the individual.

On 6 April 1992, the eve of World Health Day, ABVA and 37 other concerned individuals and organizations protested outside the World Health Organization (WHO), South East Asia Regional Office, New Delhi) against the plans for trials of the AIDS and leprosy vaccines in developing countries and in India respectively, as well as against the Norplant 'R' contraceptive for women.

On 11 August 1992, ABVA organized the first ever protest demonstration at the Police Headquarters, New Delhi, against the unwarranted and illegal arrest of 18 allegedly gay persons by Delhi Police from the Central Park, Connaught Place.

ABVA organized a protest demonstration and walk-out at the IInd International Asia-Pacific AIDS Congress held in New Delhi in November 1992. This was to highlight the anti-people policies of the Indian Government vis-a-vis people with HIV/AIDS.

ABVA activities are not limited to AIDS alone. From December '92 to May '93 ABVA has been working with the victims of the violence committed primarily against Muslims at Seelampur, Delhi. ABVA has documented how the Delhi Police injured,

maimed and killed innocent people on 11.12.92, following the demolition of Babri Masjid at Ayodhya on 6.12.92 by fundamentalists of the majority community.

ABVA has organised three protest demonstrations - at the office of Lt. Governor of Delhi; residence of the Indian President; and the office of Police Commissioner of Delhi - in April, May, June 1993 respectively asking for financial compensation to the victims and punishment to the guilty.

BASIC FACTS ABOUT AIDS

Today AIDS is the most significant health crisis of the 20th century. It was first documented amongst groups which have since then been classified as 'high risk' groups; these are: gay men, women in prostitution, professional blood donors and intravenous drug users. The fact that these groups were already marginalized and stigmatized has resulted in the framing of society's responses in harsh moralistic terms. The human rights abuses on these groups are being increasingly documented and publicised across the world. Even foreigners are being projected as a 'high risk' group and deported accordingly.

What Is AIDS ?

AIDS which stands for Acquired Immune Deficiency Syndrome, is a disease which can destroy the immune system in the body. This system is the body's main defence against infection. People with AIDS can get serious and sometimes fatal diseases which do not usually affect people with a healthy immune system. The initial symptoms may be the occurrence over several months, of weight loss, fever, night sweats, skin rashes, diarrhoea, tiredness or swollen nodes (in the neck, underarm or groin). Multiple infections such as shingles, thrush, herpes and tuberculosis may supervene. Some people may get pneumonia, caused by Pneumocysti Carinii or a formerly rare skin cancer, Kaposi's Sarcoma. At a very advanced stage, HIV may also attack the nervous system and cause brain damage.

It is commonly believed that AIDS is caused by a virus called "HIV" which stands for "Human Immune deficiency Virus." The virus is transmitted when an infected person's blood, semen or vaginal fluid enters another person's body. The most common way of spreading the virus is during unprotected penetrative sex (that is penetrative sex without a condom) or when people are given infected blood or share used needles to inject drugs. HIV can also be transmitted from an infected mother to her foetus during pregnancy.

There have been no recorded cases of HIV transmission by casual contact such as hugging, kissing, mutual masturbation, sharing household objects, staying near a person with HIV infection who sneezes or coughs.

What Is the HIV Test ?

When HIV enters the body, the body produces substances to fight the infection called antibodies in the blood in response to the virus. The HIV test simply looks at a small sample of blood to see whether these antibodies ar present in the sample. The HIV test should not be called the AIDS test as it does not detect whether a person has AIDS - it can only tell whether the person who has provided that sample of blood has produced the antibodies in response to the virus that is believed to cause AIDS.

What Does HIV Negative Mean ?

A person is HIV negative if s/he has not developed antibodies to the virus. However, an HIV negative test result does not guarantee that a person is virus free. The body can take between 6 weeks to a year after infection with the virus to produce those antibodies. If a person takes an HIV test after being infected, but before the body has had enough time to produce antibodies, that person will test HIV negative. Tests on recently infected persons can therefore give false negative results. A negative result therefore does not mean that a person cannot transmit the virus to someone else. It is therefore vital that people who think that they are HIV negative as well as people who think (or know) that they are HIV positive, practice safer sex in order to avoid the risk of infecting others.

What Does HIV Postive Mean ?

If at some point in their life, persons are exposed to HIV infection, then, in due course of time they test positive for the antibodies against the virus. Such persons who have the antibody to the virus are known as HIV positive. Being HIV

positive does not mean that the person has AIDS or will certainly develop AIDS in the near future. Some persons may remain healthy for a very long time. Others may develop AIDS anywhere from three years to more than ten years after they were infected with the virus. Other people may develop AIDS Related Complex (ARC) which is a condition with some AIDS symptoms but without any of the major infections that are associated with an AIDS illness. At present there is no way of knowing who will develop AIDS as a result of HIV infection.

Being HIV positive does not mean that a person is immune to the virus. Unfortunately, antibodies to HIV, unlike most of the antibodies that are produced seem to provide no protection against HIV or AIDS. In all cases of persons having tested positive, a second test - the Western Blot - should be performed to confirm the presence of the antibodies.

In a very small percentage of cases people will test positive even though they have not been infected with the virus. This is known as a false positive test. This could be a result of an error in the test itself or if the person had been taking certain drugs. In such circumstances, a second test will usually show that the person is HIV negative. In a very small number of cases the body does not produce any antibodies at all. This is known as silent infection. Consequently, a person may test negative for HIV antibodies though he has HIV infection.

Transmission Issues

It must be emphasized that there are no bio-medical physiological factors which make some groups rather than others more prone to HIV infection. The concept of 'high risk groups' in the context of AIDS irresponsibly suggests that AIDS affects only defined groups to which the majority of people do not belong. The only meaningful factor is what you do and not who you are, that is, if you have unsafe or safe sex or share or be injected with unsterilized/reused needles, or be given infected blood or blood-products.

As a study on heterosexual heroin users points out, (S. Kane HIV, Heroin and Heterosexual Relations, Social Science and Medicine, 32 (9): 1037-1050, 1991) "both in high and low seroprevalence groups consistent and careful condom use is a far more effective method of reducing risk of HIV infection than reducing the number of partners ... must emphasize the safeness of sex not the diversity of partners or casualness..."

The study thus criticizes the weakness of public health models that rely on distinguishing 'high risk' groups from a general population perceived as somehow not at risk of HIV infection.

Today the spread of HIV is as much a part of the risks of unsafe sexual and other practices of the mainstream heterosexual population as of any other groups.

What Is Safer Drug Use ?

1. Use sterile disposable needles
2. Never allow anyone also to use the needle and syringe you are using.
3. If you use the same needle repeatedly, boil the needle for 20 minutes and use bleach to clean it.

In India needles can be purchased from any pharmacist's shop without any prescription.

What Is Safe Sex ? What Is Safer Sex ?

As HIV is present in semen, blood, cervical and vaginal secretions and as it has been shown to be transmitted during sex which involves penetration of the anus or vagina, safe sex is any sexual activity which does not involve penetration. Safer sex , on the other hand, is sex which provides protection against the possibility of infection through the use of condoms, for example (Peter Aglton et al. AIDS : Scientific and Social Issues, 1989). Reuse of condoms once used is not safe.

AIDS and the Foreigner

It is generally ignored that the foreigner visiting an alien country is herself/himself at a risk of getting infected with HIV. It should be mandatory for all governments to provide information regarding AIDS, safer drug use, safe/safer sex to all foreigners at entry points, viz airports, railway stations, seaports, tourist offices/spots etc. Good quality condoms and sterilized needles should be freely provided at these places. Medical personnel refusing to treat foreigners who are HIV positive or are having full blown AIDS should be taken to task. The practice of HIV testing of foreigners and their deportation has no scientific basis and should be done away with immediately.

TRAVEL AND HOSPITALITY IN RELIGION, CULTURE AND MODERN TIMES

"An account will be demanded on the day of judgement of all expenditure except of that on the entertainment of guests. God will be ashamed to demand any account thereof." (Qut al-Qutub, 1310,II.182)

..." And this gray spirit yearning
To follow knowledge like a sinking star
Beyond the utmost bound of human thought".
(Ulysses, Alfred Tennyson)

The links of travel and hospitality with prayer and learning have become leaner over the years. The values regarding travel and hospitality particularly emphasized in the globe's collective cultures are being replaced by an increasingly strong economic base. Today travel and hospitality rank as one of the biggest money spinning industries in the world.

The commercialization manifests itself in different images: five star holiday packages, 'authentic' village experiences, adventure tours and treks, homes away from homes - all of them available for a price. These images are so common and have become such an integral part of the travelling lifestyle that they are now accepted as the norm.

However, various laws and by-laws of a complex travel trade that exist today only serve to make it inaccessible. Most of the travel laws and policies have political, economic and medical dimensions. Each of these dimensions are inextricably linked with the other. Today, one of the prime targets of these laws is the HIV positive traveller, as has been discussed in detail in other chapters of this report.

In striking contrast is the value given to hospitality in religion and cultures all over the world which have always welcomed warmly the stranger, the traveller. The language of hospitality

has been universal, finding expression in literature, religious and social lives of different peoples.

Hospitality In Different Cultures

In early society in Greece and Rome, hospitality was one of the most important relations of life. This relation was interestingly extra political. It carried people beyond their own State thus bringing them together. It was also reciprocal which led one to do as he would be done by. Then, this relation was no light expression of casual goodwill but a solemn engagement which had the sanction of religion. In early Greece, as among Jews, there was a strong sentiment in favour of the protection of the stranger. This sentiment finds strong and frequent expression in the Odyssey.

The spirit of unlimited hospitality is very apparent in the ancient sources. It was with a kindly curiosity that the Japanese saw strangers come among them and offered them a home.

The Chinese are a hospitable people. The tea pot in China is always ready to be produced for a stranger. One of the first sentences in the Confucion Analect says, "How pleasant it is to have friends come from a distance ! "

Hospitality among the Semites rests upon religious sanctions. "To be inhospitable was not only to be despicable, it was also to be irreligious. Hospitality was a sacred duty. " (Day, Social Life of the Hebrews)

In Northern Europe the entire hostelry system came about by special quarters being provided for travellers in larger houses. The guest enjoyed equal privileges with the family members. All Teutonic languages have a term for 'guest- house': 'gesta-hus' 'gast-hus,' 'gesthus'. In the Slavic languages we find 'gospoda', 'hospoda', 'gosti-pod' etc., which originally meant protection of and lordship over guests.

Of the actual forms of Zorastrian hospitality, there is a glimpse in Yast (xxiv. 62-64). It talks about how when a soul of a righteous man arrives in the heaven of Endless Light, it is first given food, is asked to rest after his journey and is seated on a richly adorned throne. Similarly, the Arta-i-Viraf Namak (iii,16f) declares : "To give the hungry and thirsty food is the first thing and afterwards to make enquiry of him and appoint his task." The obligations and duties of hospitality seem to be taken for granted in the Avesta and Pahlavi writings and no word for hospitality is recorded. In Arabic anthologies, the Persian word for guest means 'master of the whole house'. The best source for the details of Iranian hospitality is Sah-namah of Firdausi. Even though the majority of instances describe royal circles and the receptions accorded to ambassadors, there are enough accounts to show that hospitality of humbler classes differed in degree rather than in kind.

Traditionally, in some African cultures, every village had a traveller's tree at its entrance where travellers would tie a strip of cloth as a prayer for a safe journey. Children from the village would rush out to greet the strangers and to tell them the most exciting local news. The seniors of the village would request the travellers to grant their village the honour of a visit. Each village had a special 'hospitality hut' to which travellers were then taken for a wash, a rest or a bed for the night. Food and drink would be shared by the adults of the village and the strangers. The coming of important or special guests meant a time of celebration. In some villages, dried baobab leaves were burnt to drive away mosquitoes and a ceremonial tobalo drum was pounded to announce the arrival. All villagers and visitors would sit together around several fires, instead of the usual custom of having different fires for men, women and children. The visitors would walk inside the circle to tell stories about their travels and adventures. A feast would follow.

Hospitality was equally important in the Celtic cultures. The Gauls manifested a great desire for knowledge of habits and customs of foreign peoples. They welcomed travellers, loved to listen to their stories of distant nations and never refused

hospitality to a stranger. In Ireland, hospitality was not only a virtue, but was enforced by law from the earliest times and numerous references to this subject can be found in religious and secular literature. The Welsh too were hospitable. The house of Cymro was always open to the traveller. If the traveller was looking for a place to stay, for the first two nights he was treated as a guest of the householder with whom he stayed, but on the third night he was regarded as an 'agenhine' or a member of the household. Violation of the laws of hospitality was greatly condemned among the Welsh and severe punishments were meted out to the guilty.

The Hawaiian term 'Aloha' encompasses love, hospitality, greetings and good luck. 'Aloha' implies an openness of spirit, and thereby a vulnerability, which infact, made it so easy for the white man to conquer the indigenous people of the Hawaiian islands. It was a similar spirit that existed among the American Indians, the aboriginal or Kuri people of Australia, the Maoris of New Zealand and other peoples of the Pacific.

Indian cultures have been no exception. Among the Bhil tribals, a guest is special. When a guest comes to a Bhil house, whoever is present welcomes him with the words 'Come ! seen after so many days, and then takes him into the house . A cot 'khatno' is brought for him to sit on. If the elderly member of the family is out in the field, a child runs up to call him home. Food is cooked for him, he is given water to wash and the guest and the elderly host eat together. A passer-by, an acquaintance or a stranger may stop at a Bhil house to drink water. He is given water kept on the mali' in the same utensil from which the house drinks.

In his folk songs, Tiruvalluva, a great poet from Southern India in the third century A.D., counts hospitality as one of the chief virtues. He says:

'Domestic life, the heaped-up store,
Should look to one great end,

To bless the stranger and the poor
By hospitality.

Though one ambrosia should pour,
To which the Gods would bend;
To wish a guest outside the door
Is immorality.

To children's children evermore,
God doth salvation send,
Of him who daily giveth more
in hospitality.

Prosperity dwells on his floor
Who cheerfully doth tend
His guest, and ever proveth pure
His liberality.

Their fields give increase by the score.
Though they no seed expend
Who eat but what their guests abhor,
Through hospitality.

The Gods will greet those on the shore
To which the good ascend,
Who having guests , new guests implore
With true humility.

Who can kindly deed explore,
Or trace it to its end ?
'Tis measured only by the lore
Of hospitality.

"To heap up wealth we laboured sore,
Yet now on gifts depend"...
Say they who from all good forbode
Through lack of charity?

Amidst their wealth they most are poor
Yet ne 'er the poor befriend
Their wealth they only who can restore
By hospitality.

The Anicham fades long before
Its sweets you apprehend;
So fares the guest whose host 's a boor,
Without civility.

Kalidasa, India's national poet, talks about the entertainment of guests in his works. The guest was treated with singular hospitality. He was given the honour of a God and was actually worshipped. Water was given to wash his feet, he was seated and entertained with auspicious offerings consisting of rice and honey.

Ancient India has seen numerous travellers and in fact, some of her history has been written by them. Interesting accounts, for example, have been given by Chinese scholars and pilgrims of the University of Nalanda as far back as the 7th century A.D. At the time, Nalanda boasted of about 5000 students, and it has had up to 10,000 students at a time, many of whom had travelled all the way from China, Korea and Tibet. At other times, students also came from Greece and Burma. Needy students received free tuition, board, lodging, clothes and medical attention. Travel to and from the country was not unusual. From centres like Nalanda, Indian scholars and teachers went to distant lands in Asia carrying with them religious and cultural ideas of India.

No travel restrictions were imposed either on inhabitants from adjacent states or on foreigners as aliens. A Greek was serving as a viceroy of an important frontier province in the 3rd Century BC, a Parthian was serving as governor in 1st century BC. The non-recognition of aliens as a separate class was due partly to the universal spirit of Hinduism, partly to its confidence of completely absorbing the foreigners in its body politic by means of its 'superior' culture. Hindu constitutional writers

therefore, did not think it necessary to differentiate between citizens and aliens.

Passports were however necessary for entry, but when procured, further movements were unrestricted. Foreign merchants visiting the country regularly did not require a passport for every visit. 'Dutas' or ambassadors between countries were not uncommon. Megasthenes was the Greek ambassador in the 4th century BC, and in turn Indian ambassadors went to the court of Seleukos. In the 3rd century BC religious missions were sent to the Kingdoms of Antiochus, Ptolemy, Antigonos, Magas and Alexander.

The foreign department must have thus been a very busy branch of administration, especially under the Mauryas who had to keep in touch with a large number of kingdoms in and outside India. Officers in charge of foreigners, registered them and looked after their comfort and needs when sick.

Religion and Hospitality

The notion suggested by hospitality in Islam is the bestowal of food; 'to entertain' and to give food are used in the Koran as synonomous (xviii.76). The definition of hospitality in the Koran is 'feeding on a hungry day an orphan who is also a kinsman or a poor man who is in need ' (xc.l4). Sayings attributed to the Prophet are: 'Hospitality is a right' 'Any area or village wherein a Muslim is allowed to pass hungry is out of the pale of Islam.' In early Arabic poetry, the subject is commonplace. A good collection of verses dealing with it is to be found in the Hamasa. The bards boast that in the dead of night their fires attract wayfarers; their dogs welcome their arrivals without inquiring who they are; or even when the stranger is known to be an enemy they immediately slaughter a camel and cook it for the stranger's benefit. They clothe him and talk him to sleep. However gentle they may be, they are ferocious in defense of a guest; however ferocious, they will endure anything from one who is partaking of their hospitality.

In the Koran (xi.80), Lot appeals to the people of Sodom not to disgrace him in the matter of his guests.

Hospitality in Buddhism is divided into hospitality of laymen one to the other, hospitality of the laity to members of the Religious Orders and the hospitality of the latter to each other.

Passages in the canonical books refer to this subject, it is stated in the 'Digha' (i; 117) that the duty of a good citizen is to treat guests with honour and respect. In Jataka, (iv. 32, in the canonical verses), one of the heroes of tale boasts of the reception he always accorded to guests. When Buddhism arose there were quite a number of wandering teachers. It was considered a virtue and privilege to provide these unorthodox teachers with the simple necessities of life, especially lodging, food and clothing. In the edicts of a Buddhist emperor in 3rd century BC frequent mention is made of the duty of hospitality to teachers of all different sects. Within the Order, a set of rules were prescribed for looking after guests.

The foundation of the first hospitals and hospices by the Christian Church shows the practical way in which principles of hospitality was applied by Christian charity to invalids and weary travellers. The guest was sacred and inviolable even though discovered to be an enemy. Christianity transformed hospitality into a public virtue by demanding it as a formal duty from Church members and especially bishops. Early Christians interpreted Christ's words "I was a stranger and ye took me in" (Mt 25:/35), in their broadest sense and showed hospitality towards non-Christians as well as Christians. In the East, it was the travellers attacked by illness that called forth the greatest pity and anxiety, which led to the origin of hospitals. In the Wes Christian hospitality gave rise to hospitals intended for inva ds and other sufferers and hospices or almhouses situated alon chief roads to extend a welcome to travellers overcome by fatig e.

In Hinduism, hospitality is fully recognized and is an important part of the duty of the householder. There is however,

discrimination in the entertainment of guests on the basis of caste. The Vedic culture preaches the message of effacing the ego -Ahankara- which keeps one bound down to one's family, group, nation. The ideal of this culture is to establish the bonds of love, unity and universal brotherhood and treat the whole of mankind as one family ,one nation. Thus great importance was given to travel and hospitality. An entire hymn in the Atharvaveda is devoted to the praise of hospitality (ix.6). Guest-offering is an integral part of the daily ritual of the household. The Rig Vedic age laid great stress on hospitality. The frequent epithet of 'Agni' (fire), namely 'Atithi' (a beloved guest; one who has no fixed time for coming), takes for granted the affection and respect generally shown to a guest. In later literature detailed descriptions of the merits of hospitality occurs and hospitality to a guest is elevated to the rank of a religious duty, as one of the five great daily sacrifices (panch-mahayagnas).

In the Ramayan age also, hospitality was a virtue. The rites of hospitality were known as 'atithi-satkar' or 'atithya'. These criteria varied according to the status and position of the host, but was given the importance of religious ceremonies and were accompanied by oblations offered into the fire.

Travel and Hospitality Today

It is instructive to see how the concept of traditional hospitality prevalent amongst ordinary people for millennium has been hijacked, commercialised and arrogated by the modern state to subserve its economic interest. Sooner, rather than later, the modern Indian State may declare the traditional hospitality practised by the ordinary people to be a crime. The 'hospitality industry' alone, controlled by the State, multi-national companies and the corporate sector, would be recognised as 'legal'. Traditional local brewing by tribal societies has likewise met a similar fate. The Indian State has tabooed such practices and it now runs the liquor empire converting it into an industry.

In fact, the Government of India is contemplating having a Ministry of Culture! Do we need an official National Cultural Policy ? Will not the 'Sarkari Sanskriti' have more 'Sarkar' than 'Sanskriti' in it ? As a consequence, references have been made to terms and strategies such as airport capacity, transnational hotels, hotel accommodation, air-lines, tour-operators, development of long stretches of beaches and race-courses, developing winter sports in Gulmarg namely skiing on new slopes, foreign management of tourist enterprises as well as foreign investment, arranging loans from foreign commercial banks, getting professionally trained man-power for tourism management. There is not even a pretence to hide the effort to woo the richer tourists. Financial Express issue dated 25. 10. 92 states "To cater to selective and upmarket visitors the administration would do well to revise the abandoned golf course project at Diu !"

Unhindered travel by people, in existence for thousands of years, has been controlled and converted into a profit-making venture. Likewise, the caring of the sick, that is, provision of health services, has been converted into an industry. It has been institutionalised. Hospitality in its traditional form implied caring of the sick. It was the traveller attacked by illness that called forth the greatest anxiety which led to the origin of hospitals. In the context of AIDS, multinational companies are manufacturing the AIDS testing-kits state-owned Institutions and Corporate hospitals are conducting these costly tests. HIV positivity/AIDS is becoming another method to control the free movement of citizens. There is no scientific basis for it. It is violative of all the international instrumentalities to which India is signatory.

How did the 'traveller' of ancient times, who moved about freely from one part of the world to another and was received with love and compassion all along, become a 'tourist' with binding controls and restrictions, who could be thrown out of this or that country or prevented from entering a particular region? What are the factors responsible for this state of affairs? — science and technology, development, modern state,

geographical discoveries, militarisation, materialism, consumerism, competitiveness?

Outlining the historical process, S.N. Chib (Perspectives on Tourism in India, July 1983) states "There was an outburst of travel in the Inter-War years as a result of the fact that the First World War had kept the people confined for four years. This was the beginning of travel for pleasure and of the transformation of travel into tourism. The era of organised tourism had started. Besides travel agencies, municipal councils started establishing holiday associations and travel bureaus. After the Second World War, Europe lay in ruins. The Marshall Plan, which was introduced by the USA for the revival of the economies of European countries, made tourism one of its planks. For the first time tourism was viewed as an engine for economic development. This made the Governments start assuming responsibility for the promotion of tourism. The post-war years saw the emergence of a number of international organizations concerned with travel and tourism. In 1951, India was one of the first developing countries to become a member of the International Union of Official Travel Organisations. In 1949, the Government of India set up a small tourist branch in the Ministry of Transport; in 1957 a separate Department of Tourism was established, there was mushrooming of Government approved hotels and travel agencies."

Late 18th century witnessed the beginning of the formation of new nation-states, as in the Western Hemisphere. Travel was made faster with the advent of the steam engine rail and steam-ship) before 1914, the Internal Combustion engine (automobile) in the inter-war years and the Jet Propulsion engine in the post-war years. Simultaneously, passports or visas or cumbersome formalities were introduced in Europe in 1915 as war time measure.

"Before the First World War, there were no passports in international travel; you could travel wherever you wished. The War for freedom and peace brought the passport controls and they stuck to you like lice. And so it still is, years after the

termination of the Second War to end all wars. And so it will remain after the third and the nth. war to end all wars." (Wilhelm Reich in 'Listen Little Man,' 1948).

Tourism As An Industry

Next to oil, International Tourism has become the second largest industry in the world. In fact, the U.N. definition of TOURIST, which is generally followed by all countries in compiling their tourist statistics is not based on motivation but on the economic concept. Reports indicate that the Indian Ministry of Civil Aviation & Tourism is hoping that if all goes well the foreign exchange earnings from tourism would increase annually from Rs. 2,440 crores to Rs. 10,000 crores by the end of the century (The Hindu, 22.10.92). Tourism is the third largest foreign exchange earner for India, equivalent to 8% of her exports. There is talk of promotional and marketing strategies to woo the tourists, concentration on high spending category of tourists as opposed to small-time tourists and a promotional policy to sell the 'mystique 'of India. Ironically there is a suggestion to upgrade the facilities available at Bodh Gaya and Nalanda as these are grossly inadequate to meet the requirements of Japanese or other Buddhist tourists as distinct from pilgrims!

On the Role of international funding agencies in financing tourism development, the former Minister of Civil Aviation and Tourism, Mr. Madhavarao Scindia, brazenly confessed: "The strengthening of infra-structure and a liberated economic policy was expected to contribute to promotion of tourism in a big way in the coming years." (National Herald, 20.10.92). The rulers have driven India into a huge foreign debt. More funds are being borrowed from the World Bank the I.M.F. and multi-lateral agencies to tide over the crisis. The World Bank and I.M.F. are imposing their unilateral conditionalities, thus forcing the country to turn into a banana-republic. The New Economic Policy ensures that foreign capital and multi-national corporations are welcomed in India to perpetuate a consumer culture since the country represents a vast market for consumer items manufactured by MNCs. Welfare measures for the

common people are being squeezed. Prices of essential commodities are ever increasing. Instead of providing cereals at cheap and controlled prices through Fair Price Shops to the masses, what is being dished out is the consumer-item propaganda through satellite T.V. Private sector is displacing the public sector, even as lakhs of workers get retrenched. The results in terms of hospitality would be to 'catch' rich foreign tourists and sell the 'mystique' of India to them through packaged tours envisaging 5-star hotels, golf-courses and the like.

Recently, at the International AIDS Congress held in a 5-star hotel, Ashoka, in New Delhi from 8-12 November 1992, the hospitality industry was much in evidence. Around 2,000 delegates from over 65 countries participated in this jamboree. The Congress was sponsored by agencies such as WHO, U.S. Aid, UNDP, UNICEF as well as the Government of India. Around 24 million rupees were reported to have been spent in all. Multi-national corporations openly vied with each other in welcoming the delegates. Of course, this hospitality ensured that the common citizens and people with AIDS /HIV were effectively barred from participating in the Congress. Plain-clothes policemen were deputed in the Convention Hall to thwart any dissent. Glossy hand-outs from I.T.D.C. (Indian Tourism Development Corporation) sent along with the invitation cards urged the participants to avail of package tours to different parts of the country. It seemed that the aim was to sell the Mystique of India to earn foreign exchange.

A Professional Approach

"Eating out was not at cost but was a form of treating the guest' to one's best hospitality. With the passing of time, first came the roadside inns and caravan sarais, to help the traveller with his basic needs. Till the end of the 19th century, the concept of a hotelier or a restauranteur was thus restricted and he was known as an inn keeper who provided the much needed food and shelter to the traveller who arrived either by road or by sea. With the advent of railways and the air-ways, a need was felt for a

professional approach to provide the necessary facilities: hoteliering was established. With the evolution over the years, a concept of modernisation and standardisation has developed. In the last few decades, the industry on its own and the Government by way of regulation, introduced the concept of star rating wherein one to 5-star deluxe categories of hotels and graded restaurants have been established. The government of India as well as various state governments have granted the status of'Industry' to the hotel and restaurant trade" (S.R. Shetty in I.E., 17.10.92). Ironically it is referred to as the Hospitality Industry.

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THE MEDICAL ESTABLISHMENT AND THE POLICE

The role of the medical establishment is to provide health care to the population. This should be done on the basis of sound scientific knowledge. Doctors, covered by the Medical Council of India Act, are supposed to maintain a strict code of conduct in their practice of medicine.

The declaration of Code of Medical Ethics clearly states that "I will respect the secrets which are confided in me" (MCI, Code of Medical Ethics). The Code further highlights the responsibility of a physician. "The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man."

The police, on the other hand, are a group of persons selected and trained to maintain law and order and to protect and serve the people 'What You Should Know About the Police', P.D. Mathew, Indian Social Institute, Legal Education Series 35 ,New Delhi .

As per the Indian Medical Council Act, 1956, a physician can be punished and disciplinary action can be taken against a physician if s/he discloses the secrets of the patients. The Act also prohibits publication of photographs or case reports of patients in any journal in a manner by which their identity could be revealed without their permission. But how well do they live up to the standards laid out for them?

In February 1993, a French tourist visiting Calcutta fell ill. She was taken by a colleague tourist to a private nursing home of Calcutta. At the nursing home the tourist informed the doctors that she is HIV positive. This set a chain reaction of panic. Instead of taking basic precautions for infection control, the health professionals only displayed the level of their ignorance which was evident from the sequence of events that followed. The patient, who had dehydration was shifted to another nursing home and subsequently deported from the country.

Till now fortunately, HIV infection does not come under the purview of a notifiable disease. In notifiable diseases like cholera, the doctor is duty bound to inform higher health authorities regarding any case of that notifiable disease. The AIDS Prevention Bill 1989 which was withdrawn from Parliament under public pressure, would have legalized the notification of persons with HIV infection.

In the case of the French tourist, the medical personnel chose to inform the press about the case. The national press carried the news prominently, including a front page coverage. (Telegraph 1 .2. 92)

The Health Ministry officials of West Bengal allegedly came to know about the incident from newspapers (Statesman 8. 2. 92). Investigations were conducted by the health department. Several police officers were sent to the residence of the French woman. They examined her documents and were talking to her as if she were a criminal. (Statesman 8. 2. 92). The police went to the place she was staying to make sure she was leaving the country. Under which law did the police go to the residence of a patient? The police who is supposed to protect and serve the people end up only harassing them. Three ministries, those of External Affairs, Health and Home Affairs are responsible for deporting HIV positive foreigners. Though the police department comes under the Ministry of Home Affairs, a police department has no legal or constitutional sanction for this.

The letter that follows was written by Sigrid Kulkowitz, the person who accompanied the French tourist to the nursing homes. It clearly outlines the whole problem of discrimination against HIV positive persons and people with AIDS. ABVA whole-heartedly agrees with her view point.

Harassed when help was needed
(Telegraph 3.2.92)

Several clarifications are in order regarding the article "Tourist detected with AIDS virus" (Feb.1.) about a woman supposedly suffering from AIDS who was treated at two nursing homes recently. She was suffering from severe dehydration and not a cough and cold as reported. I accompanied the patient to both nursing homes, consulate, doctors, etc. In my country I work at a clinic which treats hundred people a week with the HIV virus and AIDS. I would like to comment about the disease and the treatment we received in Calcutta.

HIV destroys the immune system, making a person vulnerable to disease. People do not die from the virus but from the infections, many of which healthy persons would not contract. At this point the patient is said to be suffering from AIDS. People can live a healthy life for years without showing any symptom.

We left both nursing homes, my friend had been admitted to because of unprofessional conduct and a lack of correct safety measures. For example, tainted needles thrown into the thrash and changing of intravenous lines without gloves. We attempted, at all times, to be vigilant about practicing safe hygiene.

My friend chose to be honest out of consideration for others. I only wish she had received the same treatment. Confidentiality regarding her condition was not maintained. The police came to the place she was staying to make sure that she was leaving the country.

She was treated as a criminal and suffered great distress. She needed help not harassment. My friend is not a criminal, but the way she was treated was a crime. Like leprosy, HIV and AIDS are met with fear and misconception. Education is needed to counter this.

Simple intervention, facts and compassion will stop the spread of this disease. Tourists are not the problem, the disease is worldwide. My comments are not meant to point fingers at those who do not understand this disease but to say that I expect those who do not act appropriately and those who do not to learn.

I met with a medical director of one of the nursing homes, he apologized and said there would be a seminar on HIV the next day. Its too late for my friend, but we appreciate the effort as it may make similar situations easier for others in the future. Fight AIDS, not people with AIDS.

According to the French Consul General, Mr. Xavier Dilleman: "She was treated as if she were a criminal or a cinema personality; she had to hide her face" (Statesman 8.2.92). Deportation of a foreign tourist found HIV positive does not in any way help control the spread of the disease. Medically, the doctors should have known that the disease spread can be checked by adoption of universal protection and universal infection control methods. Even the WHO recommends universal protection and not selective protection in HIV positive cases.

The West Bengal State Health Department subsequently convened a meeting to plan a massive public awareness campaign. It also planned to take steps so that all foreigners will be subjected to AIDS checks (Telegraph 16.4.92). Mr. Prashanta Sur, the West Bengal Health Minister said that "the government is considering steps to test the blood samples of

foreigners, including tourists coming by air or by train as a part of the prevention measure against the spread of AIDS in the state. Testing the blood samples of sailors of ships anchoring at the Calcutta port after a voyage might also be examined (Statesman 16.4. 92). He suggested the creation of an isolation bay for tests and check ups at airports and ports (Telegraph 17.4.92).

Each Elisa test costs about Rs. 60/- testing of a 100,000 tourists would cost 60,00,000 rupees. Considering the number of tourists and travellers arriving by air and trains, crores of rupees would be required in this exercise. In the year 1991 alone 16,77,508 foreign tourists visited India as admitted by the Minister of Tourism in Rajya Sabha (Hindustan Times 25.11.92). Do we have the money and manpower to test all tourists? Even assuming that we had the money, will it really help control the disease spread? Testing of foreigners is "based on the specious premise that foreigners belong to the 'high risk' group. It is time the policy makers realise that AIDS has come to India and a concerted effort has to be made to tackle it at home rather than panic over baseless fears coming from across the seas" (Editorial, Statesman, 19.4.92). The editorial further adds "The Government's misplaced zeal to 'track down' HIV infected patients sends the wrong signals."

"Dr. Subrata Das, Director, Medical Research Institute, Calcutta, criticized the West Bengal government's proposal for AIDS test on foreigners not on scientific grounds but because of the fear of resentment among foreign diplomats" (Kusum Gupta, letter to the Editor, Statesman, 23.4.92). The writer of the letter, Mrs. Kusum Gupta , an ABVA member, reacted publicly that "It was frustrating to see the director of Medical Research Institute, Calcutta, having such a biased opinion on AIDS." What was required was a policy statement outlining the medical fallacies of screening and the futility of deporting foreigners. What about Indians returning from abroad? Concerned about a number of persons testing positive in Kerala, "Senior doctors in the Medical College Hospital have revealed that Keralites returning from the Gulf via Bombay are primary

carriers of the deadly virus" (Pioneer 28.3.92) So far 22 Indians with AIDS have been sent back to India. But there was no trace of them in files maintained in the international sections and the special AIDS monitoring cell of the Health Ministry. (Indian Express 15.5.92). "The Kerala Health Minister, Mr. R. Ramachandran Nair, announced in the State Assembly that the Government would take immediate steps to provide isolation wards in government hospitals for AIDS patients" (Pioneer 28.3.92).

As long as universal precautions for infection control are taken, there is no need to isolate people with AIDS/ HIV. This is proven scientifically and is being practiced worldwide. Statements like these from senior health professionals and ministers only add to the fear psychosis against the disease.

* The National Institute of Communicable Diseases (NICD) conducts the ELISA and Western Blot tests for HIV detection. In August 1991 two foreign students were referred for HIV testing by the foreign students advisor at the Jawaharlal Nehru University (JNU). This is the normal procedure in case of foreign nationals. The students were found HIV positive both by the ELISA and Western Blot technique. The NICD conveyed the result of the tests to both the students and the advisor to the Health Ministry. According to the clearly laid down procedure the Ministry once informed that the person has AIDS or is HIV positive has to be deported (Hindustan Times, 10.4. 92).

Dr. S.B. Aggarwal, a Medical Officer of JNU, told an ABVA member on 17.11.92 that "the Kenyan student's case is not our case, we are being unnecessarily blamed." In 1988, the JNU laid down a policy for testing foreign students. JNU gets about 30 students tested per year. In 92, 22 students were tested but nobody was tested positive.

* The state department of health of West Bengal in fact deported four foreign students carrying the AIDS virus (Telegraph, 17.4.92).

* On 6.3.93, The Statesman carried the following item "Spaniard Tests HIV Positive in Orissa". "A Spanish national has reportedly been sent back to his country after having tested HIV positive at Puri where he was staying since February 9 as a tourist, according to reliable sources.

It is learnt that the Spanish national, a student, was staying at a hotel in the temple town. According to reports, he fell ill and showed certain symptoms which made the local doctors fear that he contracted the dreaded disease. In the presence of district officials, his blood sample was taken and sent for ELISA to Cuttack hospital on February 26th.

The tests revealed that it was a case of HIV positive and the first detected case in the State. Informal sources find that the Spanish national was sent to Calcutta under heavy security on February 28 from where he was supposed to return to his country. This is the first HIV positive test case in Orissa ".

* On March 21st 1992, a child born to an Ugandan mother and a Kenyan father tested ELISA positive. The father and his friend had donated blood for the child. The names and addresses of the child's parents were prominently displayed in the media (Midday 10.4.92). The hospital authorities who let out the names and addresses of the patient and relatives of the patients violated the codes of Medical Council of India. Till date no action has been taken against any one of them.

The Resident Doctors Association (RDA) of Safdarjang Hospital demanded immediate retesting of the mother and child to confirm their HIV positivity. The baby, they say, could have infected those who gave him a needed blood transfusion. The equipment used on them is still in use. (Times of India 9.4.92). The true fact is that any equipment once sterilized can be safely reused irrespective of the type of infection in which it was used.

The RDA held a general body meeting to decide what to do. Proposals suggested were — doctors should not touch the equipment and should refuse to work till given dispensable

gloves and syringes. The doctors want screening of all patients coming for any kind of surgery. They do not want to handle AIDS cases. It was also suggested that some kind of pre-emptive tests be done before admission of patients, especially those who were foreign nationals and had a high chance of being HIV positive. (Hindustan Times 10.4.92)

By making such proposals the doctors only confirmed their level of ignorance and biases on the principles of control of HIV and AIDS.

The medical superintendent of Safdarjang Hospital, Dr. P.L. Rai, subsequently conveyed that the foreign nationals were tracked down and their blood retested. The method of tracking them down was, however, no mentioned. Was police help sought in tracking them down? How did it help if they were tracked down and retested?

First the doctors demand that travellers should be tested for HIV. Then they demand testing of 'high risk 'patients getting admitted for surgery. Then again they demand HIV testing of all patients admitted for surgery. The plea given is to reduce the risk for doctors and other health care workers treating such patients. In the case of an African envoy, after he was tested positive for HIV, surgery was refused at AIIMS . He subsequently died in the hospital. The AIIMS doctors even refused to conduct a post-mortem on the envoy. They quietly transferred the patient to Lady Hardinge Hospital College for the post mortem. Therefore from past experiences HIV testing is used only for refusing to handle HIV positive patients. All this is indicative of the phobia against HIV positive persons. Doctors perhaps do not realise that real danger lies in not knowing true scientific facts.

POLICIES - THE INDIAN GOVERNMENT & DISCRIMINATION

In the current state of medical knowledge, AIDS has become an incurable scourge and is thus known as a cruel violator of human rights. The fact is that not only the public, medical establishments and media are misinformed, but that the Indian Government through its policies and instrumentalities perpetuates this misinformation.

Discrimination, therefore, is bound to arise and impair the efforts of those concerned persons who want to cope with the pandemic of AIDS in a constitutional and ethical manner.

Reports from the Ministries

The Annual Report (1990-91) from the Ministry of External Affairs, Government of India, estimates that nearly 12 million persons of Indian origin reside in different parts of the world. (These include all who continue to retain Indian citizenship). The same report (p.87) states that during 1990, 1,024 Indian nationals deported by foreign governments were brought to the notice of the Indian Government. During this same year, the report asserts, 4726 Indian nationals were arrested in foreign countries. In India 531 cases of death of foreign nationals were handled and 905 cases of death were compensated. No vital statistics about how and why persons were deported, causes of death and treatment of Indians by foreign governments have been included in the report. The report makes no special mention of HIV infection and AIDS in respect to the arrests, compensations for deaths and deportation.

The vacuum in the report was further highlighted in a news item carried on the front page of the Indian Express (15.5.92) which questions the inaccuracy of the records on the deportation of foreign and Indian nationals. The item states that foreign nationals were found to be HIV positive since 1987 (204 of whom were students) and that to date (of the news item) no one

knows how many have been deported according to the clearly prescribed guidelines issued by the Health Ministry.

The news item elaborates on the stray remark made by a Health Ministry official dealing specifically with AIDS that there were a large number of HIV positive Indians being deported to India from the Gulf countries. "The figure mentioned was 130. Subsequently the official said there were 22 Indians with AIDS who had been sent back to India. However, there was no trace of them in the files maintained in the international section and the special AIDS monitoring cell of the Health Ministry." The allegations made in the Indian Express 15.5.92 that no acknowledgement is given to the Indian nationals deported because of HIV infection or AIDS is well confirmed.

The Ministry of Health and Family Welfare's Annual Report of 1990-91 refers to the obligations under the International Health Regulations that are being observed and the position in respect of internationally quarantinable diseases viz. cholera, plague, yellow fever. What is questionable is why no mention of HIV infection or AIDS is made in the report even though the first cases in India date back to 1987 and foreigners have been scapegoated to a great extent. The report, however, does speak of surveillance on principal communicable diseases "other than those covered under the International Health Regulations." Could this category include HIV infection and AIDS? It is left to one's speculation as there is no direct reference made in the report.

The Ministry of External Affairs which is designed to develop social, economic and cultural contacts in order to render assistance to Indians abroad disseminates information and is involved in deliberations on Non Resident Indian (NRI) affairs. The Ministry also develops a data base on overseas Indians. Yet its Annual Report makes no mention of the difficulties encountered by NRIs or of cases of HIV infection/AIDS amongst them "With three ministries - External Affairs, Home and Health - sharing responsibilities, each is passing the buck to the other." (Indian Express, 15.5.92)

All reports of the Indian Government during the year 1991-92 show an influx of tourists in and out of India. The issue of new passports and visas to Indian and foreign nationals during the year 1990-91 is a consequence of the liberalization of policies by the Ministry of Home Affairs. The Annual Report records this policy - liberalization for foreign technicians and experts working in India and foreign nationals of Indian origin. The purpose is definitely to earn foreign money by attracting foreign tourists to India. Under section 9.9 of this report more than 8 points have been written to favour the liberal policies of the nation. The 1991-92 report of the Home Ministry shows the effects of the liberal policy (4,83,931 foreigners were granted visas up to September 1991). So on the one hand the government encourages tourists/visitors to the country and on the other scape-goats them.

The Acts of 1939, 1946 and the Amendment of 1962

The Registration of Foreigners Act 1939 (Act No. 16 of 1939) which requires foreigners to report their presence in a prescribed manner to the concerned authority within a specific time limit, spells out the details of these prescriptions and what failure to comply with the said rules and regulations would imply. What is interesting in the Act of 1939 - made during the British rule in India - is the total power of the Central Government - then British - in so far as it applied to all foreigners except British subjects domiciled in the United Kingdom. In November 1946 Act No. 31 was created to confer upon the Central Government certain powers with respect to foreigners.

In this Act 'foreigner' means a person who is not a natural born British subject or has not been granted a certificate of naturalization as a British subject under any law. While giving sweeping powers to the Central Government on the matter of foreigners, the British reserved several benefits for themselves that were denied to other foreign entrants. Thus control over the free movement of people was established.

The details of the prescriptions in the Act of 1946 includes the insertion of a clause under section 3 (2e:v) not in the 1939 Act. This clause requires the'foreigner' to "submit himself to such medical examination by such authority and at such time and place as may be prescribed or specified." The specifics as under sections 3 (2e : vi,vii,viii and ix) are additional regulating clauses not present in the Act of 1939. On the one hand , the Act 31 of 1946 makes some harsh requirements of foreigners, on the other hand, in section 8 of the same Act, it specifies that "when a foreigner is recognized as a national by the law of more than one country or where for any reason it is uncertain what nationality if any is to be ascribed to a foreigner, that foreigner may be treated as the national of the country with which he appears to the prescribed authority to be most closely connected for the time being in interest or sympathy." The power to exempt is further elaborated upon in section 10 when the Act states that "The Central Government may by order declare that any or all of the provision of this Act or the made thereunder shall NOT apply or SHALL apply with such modifications or subject to such conditions as may be specified to or in relation to any individual foreigner or any class or description of foreigner."

The power to exempt is also accompanied by the power to penalize: "If any person contravenes the provisions of this Act or of any order made thereunder, or any direction given in pursuance of this Act or such order, he shall be punished with imprisonment for a term which may extend to five years and shall also be liable to fine." (ACT 1946 : V :14). Does the State effectively define who a 'national' could be, especially as showing interest/sympathy for the prescribed authority? And could the rest be deemed anti-national and kept in exile ? The British had a reason to keep in exile those with extreme dissenting views. The present governments are not content with this line of action. They have entered into extradition treaties, whereby dissenters with extreme views are forced to return to their country of origin while they are jailed.

In November 1962, an Act called the *Foreigners Law (Application and Amendment) Act* inserted the following clause under (g) "shall be arrested and detained or confined in such place and manner and subject to such conditions as to maintenance, discipline and the punishment of offences and breaches of discipline as the Central Government may from time to time by order determine." This amendment further strengthened the hand of the Central Government in matters pertaining to the detainment and confinement of foreigners whether in travel or otherwise.

The Annual Report 1990-91 of the Department of Tourism makes no mention of health regulations regarding tourists. Rather, the report highlights the activities of the Department of Tourism and shows how the Department exercises the functions of laying down norms and conditions for the operation of hotels, travel agencies, tour operators, tourist guides and transport facilities. The individualism of certain ministries and the lack of coordination and cooperation between the Health Ministries and the Department of Tourism, is clearly noticed in the lack of overlapping that should occur in their mutual concerns, viz. the health of those entering the country or leaving it. An item carried in the business section of the Indian Express 18.6.92 further emphasizes the attitude of some Indian authorities. The item titled "No Sex Tours Please, We're Indian" praises the Indian travel industry leaders because they are of the opinion that no encouragement should be given to "sex tourism by way of legislative changes or executive indulgence."Does the pat on the back for the Indian travel industry make subtle suggestions that perhaps Indians are 'better' ? However, the concerns of public ethics are ignored by five star hotels in Bombay, Delhi, Calcutta and Bangalore. A lenient view is taken of female guests sneaking into rooms and of the free availability of companionship magazines to customers. ABVA's concern goes beyond the lack of coordination and the chaos it perpetuates. What is central to ABVA is that what is seen as chaos is really a design to promote commercial interests.

The 13,29,950 foreign tourists who visited India during 1990 (excluding nationals from Pakistan and Bangladesh) are referred to only in terms of numbers rather than in terms of their impact on the nation's or their own, health. Does this omission cater to callousness on the part of the officials, or does it give sweeping powers to such authorities that wish to use them for harassment and discrimination, is a question that needs to be looked at within this framework.

Discrimination and Fundamental Rights

Given the current state of medical knowledge, the discrimination practised and the non-existence of a public interest litigation, AIDS has taken on the shades of a fatal and incurable disease. The crux of the matter is that the physicians have a duty to treat the patient, and have no right to refuse are doing just that. And this unconstitutional and unethical practice continues to exist not only for foreign but also Indian nationals. "Municipal and State-aided hospitals fall within the definition of "State" in Article 12 of the Constitution of India as expansively interpreted by our Supreme Court. Consequently they are bound to respect and observe the fundamental rights of part III of our Constitution", states Soli J. Sorabjee in his article: "**AIDS Victims Cannot Be Denied Rights**" (Times of India, 14.4.92) . "There is no reason why a public interest litigation cannot be initiated for the protection of fundamental rights of AIDS victims, namely equality and freedom from discrimination and the right to life, the most basic of all human rights." (Ibid.)

Sorabjee holds lawyers responsible in the promoting of effective responses to the AIDS epidemic and the prevention of unconstitutional acts. Advocates such as Pandit Parmanand Katara of the Supreme Court are good examples of how the learned members of the law have tried to promote discriminatory and unconstitutional responses from the Indian Government. Katara filed a public interest writ petition in the Supreme Court seeking that no foreigner should be permitted to enter India unless he shows a quarantine certificate (HIV free medical certificate), to save the lives of Indians from this disease. The

apex court dismissed this petition. (Hindustan Times 28.8.90). In India the entire discussion around AIDS has not only centered around a sexist morality but also a blame campaign of foreigners.

The pronouncements of Dr. A. S. Paintal, former Director General of ICMR scapegoats women and foreigners in one sweeping statement of : "Women are a lousy lot" who have AIDS poured into them... because they did not stop cohabiting with foreigners two years ago." (Times of India.28.6.90) Dr. Paintal's suggestion for a complete ban on sex between Indians and foreigners and visiting NRIs was turned down by the Law Ministry. (Indian Express 24.8.90). In an interview given to Sunday magazine early this year, the West Bengal Health Minister Prasanta Sur responded to the query of 'How did the disease spread in this State' by saying: "I wholly blame foreigners. They frequently visit the red-light areas and infect the prostitutes, who in turn transmit the disease to others who visit them". In outlining the steps he wants to take against the foreigners "who are spreading AIDS" Sur states, "I want to set up blood screening centres at the Calcutta airport and the dock. The foreigners will have to undergo AIDS tests before entering the city. Those found to be infected will be immediately sent back." (Arindam Sarkar, Sunday; '92)

Medical practitioners cannot be exempted from their duty to meet the challenge posed by AIDS. Biased comments and strategies of panic should be ruled out as also discriminating responses from members of this distinguished profession. Suggestions such as "Sex with foreigners and NRIs should be banned. You don't have the right to have sex with anyone if it can destroy the country" (India Today, 31.7.88) can be not only an unethical interference in the private lives of people but very discriminatory. Remarks such as these and the response of the ICMR to the 10 cases of HIV infection in the Andamans furthers the recommendations of the former Attorney General Sorabjee that there is a need for public interest litigation to be initiated for the protection of the fundamental rights of persons with

AIDS. It is ridiculous however, to expect that constitutional measures could be a remedy.

A news item carried in Times of India 29.5.92 said that all the infected cases in the Andamans "are prisoners of foreign origin - Thais, Burmese and a Pakistani." The item not only shows discrimination against persons of foreign origin by scapegoating them, but furthers the blame campaign of the ICMR that these prisoners "admitted to having visited local prostitutes." National loyalties, however, are strong, for in the interest of blaming foreigners ICMR was willing to let go its former stance of "prostitutes being the embodiments of infection". The item stated, "none of the prostitutes tested positive for HIV, ICMR said. The government is yet to decide whether to keep them in jail or send them back to their home countries" (Ibid). The questions that the Indian Government needs to address are : If these persons contacted the infection in India, is it fair to deport them ? Will the Indian Government be happy if similar treatment is meted out to Indian nationals under the same circumstances?

Indian government discriminates against foreigners. Similarly Indians are also on the receiving end. Statistics show that Indians were thrown out of Kenya in the 1960s and out of Uganda in 1970s. (Both Hindus and Muslims were unwanted). 70,000 Indians were rescued from Kuwait in 1991 and about 90 lakhs refugees from the then East Pakistan 1971. 'Sunday', July 5-11,1992 recorded the above statistics and went on to show how the discrimination of Indians does not lessen the discrimination meted out to Sri-Lankans and Bangladesh refugees in India. Discrimination of tourists and of nationals of all countries existed prior to the scourge of AIDS. However, with the pandemic growing in every nation discrimination has seen no bounds. "The Union Health Ministry recently directed the state governments to take all possible measures to curb the increasing incidence of AIDS cases in different parts of the country. The ministry reportedly told the states to be more careful in the case of foreign students as some of them could be the carriers of the deadly virus."(The Tribune 18.8.92) Will this caution be

extended to Indian students who have studied abroad for many years and return to the country? Historically what seems to emerge is that when a people do not further the economic interest of a nation and are possibly a threat to the powers that be, they are "kicked out". In today's scenario, the HIV positive/person with AIDS is seen in the same context (the U.S. Immigration Ban exemplifies this) and is hence thrown out.

Foreign students aspiring for admission to educational institutions in Punjab have been reportedly told to produce an "AIDS clearance" certificate issued by the Post Graduate Institute, Chandigarh, AIIMS, New Delhi or by a medical institute of the same standing. Foreign students coming to the Universities of Punjab are mostly from Uganda, Nigeria, Zambia, Kenya, and Gulf countries. This policy smacks of racial discrimination. Does the infection then have a colour bias? A question to raise at this juncture is: does discrimination get associated with race and colour? The Nav Bharat Times carried an article that highlighted discrimination of foreigners on somewhat the same scale. On 4.9.92, a staff reporter claimed that three men were dying of AIDS in Himachal. The first cases of AIDS in that state were of foreigners who were deported. In view of this information there seemed to have been a condemnation of tourism and a promotion of ways to check foreigners who come into the country with the infection.

While the validity of both of the above suggestions is debatable, the lack of government concern shown through inadequate facilities in Kulu, Manali and Mandi is equally condemnable. Whether it concerns foreigners or Indians, what facilities does the nation provide for the prevention of HIV infection? What the Government does provide though is the continual discriminatory rules against those with HIV infection and data against targetted groups such as truck drivers and women in prostitution who are viewed as vectors of this infection.

Authorities in India view foreigners as carriers of this infection. A statement made by Dr. H.N. Mangal after a medial college in

Jaipur completed a survey of 13,500 persons tested for HIV that "Indians going abroad bring AIDS into the country, due to free sex" presumes that Indians in India do not have access to free sex. (Nav Bharat Times 7.9.92). Dr. S.P. Tripathy, Director General of ICMR during a panel discussion on AIDS at India International Centre on 17.9.92 was forced to confess in response to an ABVA member's query: "Travel ban on foreigners with HIV infection /AIDS was introduced in our country when there were very few HIV positive cases here. Today it is no longer so. We should be in a position to amend the law. In fact we could export HIV to other countries." This statement, however, is in direct contradiction to the reality.

Discrimination Within Discrimination

Perspectives

An article written by Cindy Patton on 'From Nation to Family Containing "African AIDS"' (Paula, Russo, Samson & Yaegan (Ed) Nationalism and Sexualities, 1992) highlights the invention of a heterosexual "African AIDS". The promotion of a new kind of colonial domination by countries of the North who have reconstructed Africa as a supranational mass is well reflected in this article. The overt concerns of international health workers has construed African and Asian nations as the margin of economic and cultural development. Therefore these nations have been accused of being at the heart of the AIDS epidemic by Euro-American discriminatory measures. "The labeling of African AIDS "as a heterosexual disease quiets the Euro-American fear that men will need to alter their own sexual practices and identity", says Patton. The Indian Government apes these measures.

HIV infection is certainly an important African concern, but studies and statistics indicate that seroprevalence rates are rising everywhere and not just in he African continent. An article in the New York Times "AIDS in Africa : A Killer Rages On" (whose headline continues "AIDS is Spreading Rapidly and Ominously Throughout Africa) is accompanied by a nearly full

page chart, AIDS in Africa: An Atlas of Spreading Tragedy." This sensationalization displaces the responsibility for the epidemic. The newspaper furthers the discriminatory mentality of certain nations by attaching a map of the continent and the location of countries ridden by the infection. Subtle references used indicate that the disease transcends the people and the nation.

Racial Overtones

What is very specially devastating is the method that the media and scientists worldwide adopt to create discrimination in global polices of travel. In 1986 Western media and scientists created a linguistic distinction between "AIDS" and "African AIDS". These designations are informal names for the more technical WHO terms of Pattern One and Pattern Two ("ONE" describes the epidemiologic scenarios where "homosexual behavior and drug injecting are considered primary in the HIV transmission and "Two" indicates places where transmission is held to be exclusively heterosexual). A third category Pattern "Three" recognizes the emergence of heterosexual AIDS outside Euro-America and Africa in places where HIV arrived largely through postcolonial sex tourism and international blood banking. In 1990 India's top most scientists of ICMR made sweeping statements about sex with foreigners being the cause of the spread of AIDS in the country. If the ordinary citizen must learn then from these pronouncements and methods of linguistic distinction, discrimination not knowledge will be the consequence.

A World Health official focusing on the AIDS problems in India stated: "India is where the African countries were a decade ago. If immediate action is not taken to control its spread, AIDS can lead to significant decimation of the population within 10 years." (TIME 3.8.92). The media and scientist in their efforts to create awareness not only tend to reduce a country like Africa (which is far more culturally, linguistically, religiously and socially diverse than North America and Europe) into one AIDS lump through an act of political and cultural violence but take

one more step towards social and cultural violence, by repeating the same mistake vis-a-vis India.

The International Scenario on Travel Bans

Dr. Jonathan Mann, Director of the Harvard project, said at the Amsterdam AIDS Conference, "This epidemic is not just about a virus. It is primarily about people, individuals and society. What speeds the disease's spread", he emphasized, "is discrimination and inequality." Discrimination is rooted by the random statistics given out at conferences and statistics that are pointed to particular countries.

A news item "Ban on immigration of AIDS Victims to Continue" referred to the US federal government's plan to reverse current immigration policy and "allow people infected with the AIDS virus into the US" The four year old policy of excluding such immigrants had been denounced as discriminatory and medically unjustified by public health groups and AIDS activists. However, in the wake of 40,000 overwhelmingly negative letters and strong opposition from conservatives outside and inside the administration, federal officials said that they're likely to let the proposal die. In the light of this the government will retain its original policy of "excluding AIDS infected immigrants." In the Immigration Act of 1990, Congress directed the Health and Human Services (HHS) secretary "to develop a new list in order to continue to exclude people with AIDS from the USA." When the HHS proposed changing the rules "on foreigners with AIDS," Administration officials said that "it would not pose an additional AIDS risk to Americans." (Indian Express 27.5.91)

More recently, President Bill Clinton, in a feeble attempt to fulfill an election promise, wanted to,"...Lift Ban on HIV-infected Aliens" (New York Times, 9.2..93). However, it was not to be so as, "The House followed the Senate...in voting to ban immigration into the United States by people infected with the virus that causes AIDS....But the Clinton Administration

made no detectable efforts to lobby against the House vote..." (New York Times, 12.3.93)

A Spanish-born man carrying the AIDS virus challenged the US law barring entry of AIDS sufferers and was admitted into the country in July 92. Thomas Fabregas, 34 who has lived in the USA for 13 years said at the Amsterdam Conference that he lives in constant fear of not being allowed to return to his home each time he leaves the United States. The AIDS Conference which was to be held in Boston was moved to Amsterdam in protest against US curbs on the movement of people carrying HIV infection. (Pioneer 27.7.92)

At the Amsterdam Conference, Elizabeth Taylor harshly criticized US visa restrictions on foreigners infected with the AIDS virus ."The US Government is too ignorant, too arrogant and too cowardly to grant people with HIV full and free access to travel and immigration in America. Ms. Taylor called on the then President, Mr Bush to lift the"disgraceful" restrictions and remove a" veil of shame" from the United States." Your policy is wrong, dead wrong," she said. "Any country in the world that limits free travel deserves quick, certain and unrelenting condemnation from the civilized world " The British born Ms. Taylor (who still carries a British passport) said that if she tested positive for the HIV virus, she would not be allowed to return home but would be put on a plane for England. (Pioneeer 25.7.92)

Political refugees, who would normally be allowed to enter the U.S. are being refused on grounds of their HIV status, as in the case of 274 Haitians languishing for months in a detention camp at Guantanamo Bay, Cuba. (New York Times,9.2.93). Referring to the plight of these refugees living in miserable conditions, Anna Quindlen writes, "...It is difficult to imagine the same sort of provisions being made by the American government for Irish immigrants or Soviet Jews without considerable public uproar....They won't go back because they fear death. We won't let them in because they face death. So they sit within their cattle enclosure, waiting for death..." (New

York Times, 24.2.93). Yet another example of U.S. callousness and discrimination within discrimination!

What is globally promoted becomes a model for individual nations to use. An item in the Indian Express not too long ago highlighted the fact that Pakistan's immigration authorities deported 10 Indian passengers including three women and three children from Karachi on the ground that they did not possess AIDS free certificates. This condition was created for Indians visiting the country and visas would be issued if these certificates were from a government hospital. A strong protest from Indians who felt that this requirement would cause problems to those who wished to visit their families and friends moved Pakistan to withdraw the no-AIDS certificate requirement it had slapped on Indian visitors to that country.

Indian officials have protested against the discrimination in Pakistan and perhaps in other nations. However, the Indian Government needs to look at its own discriminatory and divisive policies within the nation and towards those entering the country from other nations. Racial overtones have been discussed regarding policies in regard to African nations. However, the tale of this Afghan national narrated to an ABVA member shows that these overtones are extended to other nations and especially refugees." My family and I came to India in 1989 with Afghan passports. recalls this person from Afghanistan. After one week we went to the I.T.O. Police headquarters for our visa. The police gave us a form for blood tests, which included the AIDS test. We were told that if we had AIDS or were found to be HIV positive we would be refused our visas and be sent back to our country. We were then sent to the Maulana Azad Medical College for the test. After one week we were called to the ITO Police Headquarters for our visas. We were neither informed of nor given the medical results. Luckily in our group nobody was HIV positive/AIDS person. But other foreign refugees were being refused their visas on the ground of being HIV positive/AIDS persons.

The situation of Manipur and the whole of the North East further elaborates India's discriminatory responses and policies. Students from Manipur going to other parts of India for higher studies are asked to produce HIV negative certificates prior to admission.

Is this requirement made of all Indians? Why are policies different for that section of the country? Certificates indicating the HIV negative status are required from North Easterners for permission to travel and study in other parts of the country. Why this discriminatory requirement of only Manipur students and other travellers of the North East?

Parliamentary Policies

The controversial AIDS Prevention Bill that the Rajya Sabha on August 16, 1989 secretly introduced came in for scathing criticism from all quarters as it was called the most repressive piece of legislation. The government and health authorities sought for themselves sweeping powers to infringe upon the liberties of private citizens without any rational link to the objective of treating infected individuals or of checking the spread of HIV. The Bill which not a single member of Parliament opposed (to the best of the group's knowledge), gives designated health authorities power over persons (any persons which could include foreigners) frequenting or living in, any area or areas within its local limits, who are exposed to greater risk of transmitting HIV infection. The relevant question here is in what way has parliament helped to eliminate discrimination against persons with HIV infection and AIDS? On the contrary the Bill was one means of furthering discrimination,unethical and unconstitutional practices towards persons with HIV infection.

When finally the Bill was withdrawn in December 1991, Health Ministry Officials stated: "the existing guidelines to screen for AIDS all foreign students and foreigners planning to stay in India for more than a year will continue." (Hindustan Times 4.12.91). Just as Foreigners Registration Act restricted free travel

of people, the AIDS Prevention Bill 1989 sought to isolate, criminalize the oppressed sections of society.

That Parliament is serious about the testing of persons (foreigners or Indians) may be true. However, the rules prescribed and promoted by the Health Ministry Officials for others are not to be applied to ministers and parliamentarians. A noteworthy item in the Nav Bharat Times, 5.8.92, commented on the M.P. Mira Das' (Janata Dal) recommendation in Parliament on 4.8.92. Ms. Das said that the country's AIDS problems would be controlled by testing all members of parliament and ministers returning from abroad. Listening to this suggestion, Fotedar, the then Union Health Minister and others laughed. Ms. Das assured all the ministers that she was serious about her suggestion. However, the laughter did not cease. Ms. Das pressed for response from the ministers. Mr. Fotedar laughingly finally responded by saying," What are you recommending? Should we test both men and women who are returning from abroad? " Ms. Das seriously shook her head and said "Yes". If foreigners travelling to India can spread AIDS, why can't ministers travelling from abroad into India bring the disease?

National AIDS Control Body

The National AIDS Control Body (confusingly described by various names such as Body, Board, Organization, and Association-whatever its name, its policies remain discriminatory) was formed with a view to arresting the HIV infection by stepping up surveillance activities amongst "promiscuous individuals" and providing scope for social mobilization through health education. The constitution of the NACB has assumed urgency so that it can expedite the issue of sanctions under procurement. This body will be assisted by the National AIDS Committee which in turn will advise the government on policy matters. (Times of India, 8.7.92) At a recent meeting on October 28, 1992, the Chief of Mission for this body, Mr. Das Gupta, responding to a query posed by an ABVA member "What was the policy on HIV infection and

AIDS especially with respect to foreigners" said, "the present policies were the same as those created in 1988." To his knowledge, "there were NO new policies now." Clarifying the policy of deportation of foreigners with HIV infection/AIDS the Chief of Mission said, "Foreigners with the HIV infection were sent back to their countries."

ABVA Meets Officials

On visiting the offices of the National Institute of Communicable Diseases members of ABVA spoke at length with the Assistant Director, Dr. Chattopadhya. In responding to the question, "How many students /tourists are tested and what is done with the positive cases," Dr. Chattopadhya said, "If a tourist is found to be HIV positive, then the result is given to the person and embassy concerned." Dr. Chattopadhya stated that all efforts were made to pre-counsel and post counsel tourists tested. Regarding students tested, he said that the matter was dealt with in a confidential manner. The concerned Embassy and University was notified and a report also given to NACO. Dr. Chattopadhya informed the group that the government sent a circular a couple of years ago to Universities/colleges regarding rules and regulations for testing of foreign students and advised ABVA members to meet the NACO (National AIDS Control Organization) for further information.

The Foreigners Regional Registration Office (F.R.R.O.) informed ABVA members that testing of foreigners was done if their stay in the country extended beyond one year. There is no scientific rationale behind this policy. Does it mean then that the HIV infection cannot possibly enter the bodies of foreigners in the 11 month period whilst in India? And should they leave in that period where is the testing and precaution taken? ABVA members also visited the Foreign Advisory Board at the Jawaharlal Nehru University. In response to the query," What is the policy for foreigners - especially Africans - regarding admission, if the said persons are tested HIV positive/AIDS, 'was', if there is no negative certificate produced in regards to HIV/AIDS, the results are withheld. No follow-up records are

maintained in this department." ABVA members found the 1988 circular which was sent by the Human Resource Development Ministry Department of Education here.

The administrative apparatus that deals with HIV/ AIDS persons is as follows:

Union Ministry of Health
Ministry of Home Affairs
Ministry of External Affairs
Ministry of Civil Aviation and Tourism
National AIDS Control Organization/ National AIDS Control Board/National AIDS Control Association
Indian Council of Medical Research
Medical Council of India
National Institute of Communicable Diseases
The Foreigners Regional Registration Office
The Foreigners Advisory Board
Colleges and Universities
University Grants Commission
Police Headquarters

AIDS has become a multi-national industry, financed by multi-lateral agencies like World Bank, World Health Organization, United Nations Development Programmes, United States Aid, Ford Foundation, etc. Could it be that the creation of the administrative apparatus that deals with the AIDS issue is hankering after a piece of the"fund-pie"? Is it also to create confusion and pass the buck so that no single agency has any accountability ? The administrative wings of the modern Indian States seek to tire out concerned citizens seeking justice, in this case the HIV positive/AIDS persons.

The statistics given to ABVA members by Mr. Ravindranathan of the University Grant Commission office on October 16, 1992 are given in the next page.

TABLE

FOREIGN STUDENTS ENROLLED IN UNIVERSITIES AND COLLEGES: COUNTRY GROUPS WISE

	Country Classification	Univ. Deptts./Univ. Colleges	Affiliated Colleges	Total
(A)	Neighbouring	1,356.00 (36.9)	1,485.00 (18.3)	2,841.00 (24.1)
(B)	South, south-East & Central	465.00 (21.7)	1,128.00 (21.7)	1,593.00 (13.5)
(C)	African Countries	797.00 (21.7)	1,752.00 (21.7)	2,549.00 (21.7)
(D)	African Countries	867.00 (23.6)	3,492.00 (43.1)	4,359.00 (37.1)
(E)	Australasian Countries	23.00 (0.6)	17.00 (0.2)	40.00 (0.30)
(F)	European countries	71.00 (1.9)	106.00 (1.3)	177.00 (1.5)
(G)	North-American Countries	80.00 (2.2)	103.00 (1.3)	183.00 (1.6)
(H)	South-American Countries	13.00 (0.4)	13.00 (0.2)	26.00 (0.2)
	Total	3,672.00 (100.0)	8,096.00 (100.0)	1,034.00 (100.0)
	Enrolment for which break-up is not available	182.00	852.00	1,034.00
	Grand Total	3,854.00	8,948.00	12,802.00

Note: Figures within parentheses indicate the percentages to the respective column - Totals.

This table highlights the focus of the Indian government on Asian and African students who happen to form the bulk of those coming to India to study.

ATTITUDE OF INTERNATIONAL BODIES

This chapter deals with the restrictions on the entry of HIV infected travellers and immigrants that are in operation in various countries in the world. These restrictions imply that visitors are required to produce an "AIDS free certificate" as a condition of entry into a country. The chapter also examines the role of international bodies which are responsible for laying the ground rules on the subject.

ABVA believes that forcible HIV testing lacks ethical or legal basis and constitutes a serious violation of the human rights of a traveller or an immigrant.

To understand the problem of the traveller/immigrant it is important to appreciate the ideology of the international state with respect to the AIDS pandemic. The ghettoisation of categories of people (or 'high -risk' groups) believed to be spreading this disease forms the cornerstone of this ideology. The state adopts this approach because it thinks it can contain the spread of the disease by 'eliminating' those who are too weak, economically and socially, to assert themselves. For example, immigration officials would not treat refugees and migrants at par with business persons and politicians because they do not command the same social and economic power.

When the state practices this stigmatisation and in the process makes nonsense of scientific wisdom on the subject, it is doing so as a custodian of bourgeois consciousness. The elite, which exercises control on the state apparatus, finds it convenient to believe that certain 'disreputable' sections of society of 'high-risk' groups are responsible for this disease, and that this problem would be best kept in check if these sections of society are isolated from the rest of the crowd. 'Scientists', also a part of the ruling elite, use their science to mask their bourgeois prejudices, and have legitimised the attack on 'high-risk' groups. These people, now the new untouchables of society, are: women in prostitution, homosexual persons, professional blood donors, intravenous drug users, prisoners and migrants. And, now the

visitor/immigrant from a depressed social and economic position constitutes another stigmatised category.

The state, as is the case with all its actions, is also implementing this policy because it stands to make political gains from it. The targetted groups are ethnic and religious minorities which in a larger sense constitute the working class. It is one of the primary motives of the state, or the ruling capitalist classes which constitute it, to keep the working class a divided lot. So, it constantly rakes up religious and ethnic issues to confuse the masses and distract their attention from key socio-economic issues.

The stringent immigration laws in the case of people with HIV/AIDS must be viewed in this frame work. These laws are applicable to depressed classes and religious and ethnic groups which constitute the working class in capitalist countries. By harassing the immigrants from such minority groups,the state sets the agenda for polarization of the working class along religious and ethnic lines. We are living in times when religious and ethnic confrontations have become frequent and a swing to the right has become manifest.

People from 'high risk' groups are mandatorily tested, quarantined and subjected to all manner of humiliation. However, it is high risk behaviour and not 'high risk'groups which spreads AIDS. It is not just a sex worker who may indulge in "unsafe sex"(or sex with an infected partner without a condom); clients of sex workers, heads of state and business executives are equally likely to do the same, but enjoy greater immunity with respect to state repression.

The state has deliberately stepped up the phobia on the AIDS issue so that right-wing tendencies in the ruling class enjoy an upper hand in the management of society. The United States of America has naturally shown the way in this regard. It reserves the right to deny a tourist or immigration visa to an HIV positive person. How an HIV positive person will spread the disease by simply going about in that country is perplexing.

In the United States, which lays a claim to scientific wisdom, the association of the bar of New York confirmed that court appointed counsel have refused to represent people with AIDS and one judge even required a defendant to wear a mask during the proceedings (Amado Tolentino, Environmental Law Consultant with the Pollution Adjudication Board Phillippines, speaking at the AIDS in Asia and the Pacific Conference, held in Canberra on 5-8 August, 1990).

Even without going into the medial aspect of AIDS, it deserves emphasis that group targeting will not minimise the transmission of HIV. Forcible testing will drive the disease underground and worsen the problem. Instead, a preventive approach that does not stigmatise these groups would yield better results.

We now move to the status of the traveller /immigrant who has also been the target of state attack since the 1980s. A visitor to a country could be a short-term traveller who visits it for, say, 30 days or a long-term traveller who stays on for 90 days. Then, there are some who stay still further either as tourists, students or workers, and establish temporary residence in the 'host country'. Apart from this there are immigrants, or those who wish to establish permanent residence.

The state not only discriminates against visitors and travellers as a whole, but also shows it' s class bias against the less privileged sections of society by harassing these categories of travellers more than the others. Several countries require visa applicants only from Africa to undergo HIV testing. In others, people from certain occupational categories i.e. performing artists, mineworkers and seamen are required to be screened or visa applicants (particularly from the depressed classes) intending to stay longer than a certain period are mandatorily tested, whereas those visiting for just a few days, say as short-term tourists or participants in elite conferences might be let off. In Cuba, all travelling residents are obliged to take a test but tourists are not subjected to the same.

The state comes down sharply on those who want to establish temporary or permanent residence, in accordance with their social and economic status in society. The W.H.O. concedes this dicriminatory attitude in its standard on the long term traveller which has been explained in the following chapter.

According to a study conducted by McGill Centre for Medicine Ethics and Law, Quebec, Canada, "over 50 countries have now restricted the entry of travellers who are HIV infected or who have AIDS for prolonged stays, and sometimes for brief visits, including travel to scientific conference." (A greater portion of the study has been published in a later chapter).

The WHO also asked its 125 member states to submit information on HIV/AIDS specific travel restrictions, whereupon it was discovered that 29 countries explicitly discriminated against short and long term visitors. However, this study cannot be taken as a reference point because it refers to HIV/AIDS specific travel restrictions, whereas many countries use deceptive clauses like 'medical examination' to turn away an HIV positive visitor. The WHO was obviously not formally informed about these deceptive clauses or 'broad instruments and policies', nor one imagines did it make much of an effort to find out. Moreover, it could not gather the courage to name the 29 countries, but instead referred to them in alphabetical form which makes no sense. (The role of WHO on the subject of AIDS merits separate attention and has been examined in the next chapter).

ABVA also sent letters to embassies and high commissions of 93 countries, requesting them to explain their immigration and visiting laws with respect to people with HIV/AIDS. It is a sad commentary on the democratic traditions of governments the world over that only 7 of them chose to respond to a citizen group's query. (See Appendix for ABVA's letter to the Embassies). These seven countries are: Austria, Brazil, France, Germany, Jordan, Poland and Switzerland.

The Austrian embassy clarifies its position as follows: "There are no specific regulations regarding the entry of HIV/AIDS infected persons into Austria. It is noted, however, that regulations regarding infectious diseased would apply to the above mentioned and in case an immigration application is being submitted, a health certificate has to be submitted along with the same ."It seems as though AIDS has been treated as a non-contagious disease in the true sense of the term.

The French 'response' does not address itself to the issue of travel and immigration laws but instead provides general homilies on the 'rights of man' and 'individual freedom', which were not even asked for.

The German reply was more forthright. It says that "Entry into Germany will not be refused on the ground of AIDS infection" and that "in case where local foreigners" offices are involved in the visa procedure they may require medical examination upon entry into Germany." The letter further says that "Other Regulations do not exist on the matter."

Jordan and Poland have merely referred ABVA to the ministries of health in their respective countries, the embassies not providing information on their own.

Switzerland sent back a brief letter and some documentation material on AIDS. The letter says: "Switzerland does not do any checking of HIV/AIDS when entering the country."

Brazil sent a letter with the information that the "Embassy has no material available (AIDS) at present moment." For further information, the address of the Ministry of Health was enclosed.

It appears that a handful of countries which have an overtly progressive position have chosen to respond to ABVA's enquiry, while a number of those who practise discriminatory policies have remained silent.

Discrimination against visitors and immigrants of whatever kind makes no sense, in scientific, legal and ethical terms. Since AIDS is not a "contagious" disease (it doesn't spread through common medium like air, water, or saliva) an HIV positive person should not be looked upon as a menace to public health of a particular country. The targeting of visitors and immigrants, particularly the depressed categories among them, is analogous to group targeting of women in prostitution, intravenous drug users, professional blood donors or prisoners within a national frontier.

At the conclusion of this section, it can be said that about half the governments in the world are hostile towards an HIV positive traveller/visitor/immigrant. The state is compelled by political motives, its own racist instincts or other manifestations of bourgeois consciousness to victimise HIV positive people. The march of superstition on the issue runs contrary to the libertinian principles enshrined in the United Nations sponsored declarations. These principles were thrown up by the movement for bourgeois democracy in modern Europe. They spell out the 'rights' of the individual in the context of the modern nation-state.

The resolutions and declarations adopted by the UN since the 1940's provide a legal and ethical perspective to the issue of discrimination in the name of AIDS. ABVA's intention however is not to shower praise on the UN by referring to these lofty ideals. It is important to disabuse ourselves of any notions regarding the inherent superiority of the UN.

The UN in terms of its bureaucracy and resources, is a natural ally of the nation-state, which acts against the weaker sections of society.

Rather than being a multilateral agency, its actions are controlled by the US since it gets 25 % of its money from that country. Being close to the US it furthers the imperialist tendencies of the US ruling class and enables it to strike deals with its counterparts in poor countries. The role of the UN in

the US bombardment of Iraq is too recent to be forgotten. However, WHO, UNDP and others also act as US representatives but are not really noticed as such. The UN Human Rights resolutions assume importance precisely because a number of governments, with no exceptionable track record on AIDS issues, are signatories to them.

On 10 December, 1948, the General Assembly adopted the Universal Declaration of Human Rights as the first of these projected instruments. The United Nations is proud of this first step, and says that "since 1948, it has been and continues to be the most far-reaching of UN declarations and a fundamental source of inspiration for all national and international efforts to protect human rights and fundamental freedoms. It has set the direction for all subsequent work in the field of human rights.

The Universal Declaration of Human Rights is undoubtedly sweeping in scope as it covers a gamut of issues relating to discrimination. Article 2 explains the principle of discrimination itself in the following manner. "Everyone is entitled to all the rights and freedoms set forth in this declaration without distinctions of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Needless to say, even though it is not a clause specific to the issue of travel, it does state the ground rules involved.

Article 7 of the declaration sets forth the right to equal protection of the law, stating: "All are equal before the law and are entitled without discrimination to equal protection of the law. All are entitled to protection against discrimination in violation of this declaration and against any incitement to such discrimination."

Article 12 and 13 could be interpreted directly and specifically in the context of travel. Article 12 says: "No one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such

interference or attacks." Article 13 further elaborates that "everyone has the right to freedom of movement and residence within the borders of each state." The rights underscored in articles 2-21 of the Declaration of Human Rights were incorporated into the International Covenant on Civil and Political Rights (1976) and articles 22-27 in the International Covenant on Economic, Social and Cultural Rights (1976).

Since the 1948 declaration, many other resolutions have been passed almost as if to remind the peoples of the world of the international state's 'commitment' to human rights. Article 81 of the International Health Regulations (1969) states: "No health document other than those provided for in these regulations shall be required in international traffic." Neither HIV infection nor AIDS is specified in the regulations. It is not relevant that the regulations were brought it force before the onset of the AIDS epidemic, as subsequent WHO resolutions have only emphasized the same.

The 41st World Health Assembly adopted resolution WHA 41-24 in Geneva on May 13, 1988, which deals specifically with "Avoidance on discrimination in relation to HIV infected people and people with AIDS."

The resolution among other things, "urges member states to protect the human rights and dignity of HIV infected people and people with AIDS, and members of population groups, and to avoid discriminatory action against and stigmatisation of them in the provision of services, employment and travel."

While the WHA 41-24 resolution and the Universal Declaration of Human Rights comprehensively spell out the theoretical stand of the state (and superstate) on AIDS discrimination, there are many other pious statements which reiterate the same. We can go through these statements of intent, if only to understand for ourselves how grievously these have been disrespected and violated by the state itself, in a typically schizophrenic fashion.

The General Assembly of the UN passed resolutions 43/15 of October 27, 1988 and 44/236 of December 22, 1989, recognising the imperative necessity of universal respect for human rights to the prevention and control of AIDS.

Similarly, the "Report of an International Consultation on AIDS and Human Rights" observes that travel restrictions "raise a range of human right issues, and necessitate tackling the complex area of the rights of aliens. Though these restrictions have often been invoked on public health grounds, no screening of international travellers can prevent the introduction and spread of HIV infection."

It is interesting to note that even within this 'same' theoretical framework these esteemed world bodies are unable to take a clear stand. The report of an international consultation on AIDS and human rights, for instance, contradicts itself on the subject of AIDS and public health. While the above mentioned quote expresses the appropriate position, the report also says that a restriction on aliens could be imposed in a general context in the interest of public health. The authors of the report have glossed over the fact that general provisions, or 'brand instruments and policies' as WHO calls them, could well be invoked against HIV positive aliens and, by doing so, the nations concerned can even claim to have a good human rights record on the subject of AIDS related discrimination.

If all the noise is only against HIV/AIDS specific legislation, which many countries needn't adopt anyway, then it serves no purpose. The WHO also refuses to go beyond the bogus 'lakshman rekha' of HIV specific legislation, taking the plea that it cannot trample upon the rights of any state to keep an alien out of its country in another context. It also offers the shocking excuse that "there is no recognised human right of a person to enter a foreign country, nor is there any human rights plea which obligates a state to allow the entry of aliens on to its territory."

Why not go beyond HIV/AIDS specific legislation and do something about the rights of the alien? If the Universal Declaration of Human Rights says nothing about an alien why can't the UN brace itself for another one of its epic 'resolutions'? It is obvious that the present set of resolutions, particularly the significant WHA 41-24 lack contextual basis. The ineptitude of the WHO in the area of AIDS and travel has been dealt with separately.

It is surprising that not many international human rights organisations have considered it important enough to research human rights violations of people with HIV/AIDS. However, ASIA WATCH and Amnesty International have recently contacted ABVA for information related to such violations.

To sum up this section, one can say that international bodies resort to extreme ambiguity on the subject of AIDS related travel restrictions. Their lofty statements do not translate into practical benefits. But as tentacles of the international state, one can scarcely expect more from them. Their loftiness is no more than a fig leaf on a gorilla's body.

THE ROLE OF THE WORLD HEALTH ORGANISATION

The World Health Organisation is the health arm of the UN bureaucracy and it justifies its existence by providing overall guidelines to governments on health related issues. In a manner typical of UN organisations, it maintains a diplomatic neutrality on all matters, giving advice so general as to remain free of ideological and political considerations. But like all UN outfits, it only succeeds in formulating a statist approach to the issue of health. Other organizations like Food and Agriculture Organisation and UNICEF diligently observe this format and talk of hunger and deprivation without relating them in any way to the inherent exploitative nature of the state and the principal class contradictions in a society. There is a definite reason behind this diplomatic neutrality. The WHO, or for the matter the UN organisations which constitute a super-government, do not exist in a political or ideological vacuum. Their purse strings are controlled by the US state as they get 25 per cent of their money from that country. Hence, UN organisations are bound to promote the political interests of the US and the economic interests of US transnational capital. Since the UN is a front structure for the rich countries, it vacillates when the interests of the poorer countries and their people come into focus.

A mention needs to be made at this stage about the politics of funding. The caucus of multilateral agencies, ranging from the UN to the IMF - World Bank, favours soft loans to poor countries for AIDS prevention, so that multinational companies are provided with a ready market for their 'AIDS kits', and equipment which is no longer acceptable in the West. The Rs. 200 crore loan given given by the World Bank for AIDS prevention in India will be recycled back into the coffers of multinational companies.

Tfie WHO, which is a part of this club, examines the AIDS issue from the point of view of the power elite in the West. Its strenuous deliberations do not reflect an understanding of the

role of the state and the ruling classes in the ocntext of the AIDS epidemic, an aspect we had examined in the initial part of the previous chapter. In practice it acts as an arm of the USA, while its literature is at best an exercise in 'Third World' rhetoric.

Apart from the divide between thought and practice, its literature is full of internal inconsistencies. An analysis of all this forms the subject matter of this chapter.

The WHO remains bound to the reactionary ideology of 'high risk' groups even though it is too shy and cultivated to say so in as many words. But in its educational material "Broadcasters' questions and answers on AIDS" the slip shows. The booklet is full of simulated educational programmes. In the course of one such programme called the 'National (AIDS) Scenario', homosexual persons are singled for attack. After enumerating the health status of one country 'X' it says that "until recently the unusually large homosexual community that exists in one big city said that it did not believe in AIDS". And just a few lines later, the programme laments that "foreigners are blamed" and that people in country 'X' unjustly believe that "some tourists and travellers come looking for sexual adventures." The message that filters through is: take care of the homosexual persons within your country before putting the blame on foreigners.

The WHO has performed the remarkable conceptual feat of linking its ideology of 'high risk' groups to a supposedly liberal stand on foreigners. In simple terms, it is saying that foreigners cannot be bad because the native population (or specific, squalid segments of it) are more filthy. If we assume country 'X' to be a non-white nation, as it most probably is, then the WHO stand reveals itself to be not just illogical but also racist.

That the WHO is not opposed to creating 'high risk' groups is illustrated by the fact that it funds government programmes which promote this reasoning. It sponsors conferences wherein the proponents of the target group approach are given a

dominant hearing. At the 2nd International Conference on AIDS in the Asia and Pacific region, held in New Delhi from November 8-12, 1992 this was starkly apparent. If the WHO does not believe in all this, why does it not discontinue funding on this ground? It is regrettable that cultural programmes soaked in the 'high risk'groups philosophy were shown in the New Delhi Conference, thereby reinforcing bourgeois myths about AIDS. The WHO cannot even disassociate itself from such conferencing, so it is far-fetched to accept it to distance itself from programme activities as a whole.

How can it disassociate itself from a conference, where multinational and other big drug companies are present to make a killing? AIDS for them is a fresh frontier for making profits, and each of them will come out with their wonder drugs which promise to prolong life, obviously at a forbidding cost. These conferences are meant for providing publicity to such companies; the elite crowd of medical professionals and establishmentarian social organisations is called to fix deals and establish equations. It is after all a party of the ruling class to consolidate its control on the subject. The WHO simply has to be there to facilitate these transactional activities and its progressivism recedes into the background in this context.

In fact, the WHO has evolved an elaborate philosophy on conferences which apart from being an exercise in prevaricating does not address any of the gut issues. It shows a blinkered concern for the short-term traveller, as if other categories of travellers and visitors did not exist, and even within this limited focus, its literature reveals limitations.

The short-term traveller is a favoured person only because s/he would be attending WHO conferences. The reasoning is stated as follows: "Because many of the participants in International Conferences on AIDS were short-term travellers, WHO's policy ... focussed on discriminatory short-term travel restrictions as the basis for WHO's decisions not to sponsor an international conference on AIDS. The magnification of the issue of short-term travel restrictions reflected a particular decision to protect

and insure the full participation of HIV infected people and people with AIDS in international conferences on AIDS."

The WHO Policy of Non-Sponsorship of International Conferences on AIDS - called PNSICA in its literature, seeks the "achievement of a specific objective (unlimited participation of HIV infected persons in International Conferences)." Almost as an after thought it is stated that "another objective of PNSICA could be a linking of the rationale of not testing and excluding conference participants (who are in reality short-term travellers) to the nearly identical rationale of not testing and excluding short-term travellers."

The WHO position, simply stated, is that it will not sponsor or participate in conferences held in the countries which excludes short-term travellers on the basis of their having HIV/AIDS. For ascertaining such discrimination, it will look for "HIV/AIDS laws" which many governments need not bring into force to throw out HIV/AIDS travellers.

So, in effect, the jamboree of the WHO conferences and discrimination will proceed hand in hand, with WHO not doing a whit about it.

The WHO comes close to saying that it is not bothered about travellers and visitors who are innocent of its conferences.

It took a long time for WHO to even formally link the human rights of conference participants to those of the short-term traveller. In 1989, it was content with the realisation that "the active participation of HIV infected people and people with AIDS is an absolute requirement for international AIDS conferences. WHO will not co-sponsor, contribute to, or participate in the annual international AIDS conference if it is held in any country which prevents the full and active participation of HIV infected people and people with AIDS in conference." By 1990, it realised that a mere reference to conference participants was 'elitist' and that it must address itself to all short-term travellers.

In 1987, the Director-General of WHO circulated a memo to the senior staff stating that if governments insist on screening in contravention of WHO guidelines, "the WHO will have no alternative but to relocate the programme activity concerned."

These guidelines, which condemn screening programmes in general, were sweeping in scope and the WHO was found to have clay feet when it came to implementing them. The Director General's directive was systematically rendered ineffective as the WHO introduced its narrow categories of "conference participants, "short-term travellers" and "HIV specific laws", as if the overall picture did not matter. The WHO concedes this fact in its bureaucratic language: "the elaboration of a more defined policy (in 1990) followed previous suggestions ...(that its 1987 directive) went so far as to prohibit many of the Systems (UN Systems Organisations) Operations."

It is obvious that despite the World Health Assembly resolution 41-24, passed in May 1988, the WHO has not been able to raise itself above its obsession with conferences. It is not concerned about the rights of a long term traveller because s/he does not fall into the ambit of conferencing.

Instead, it justifies HIV testing on long term travellers in the following manner: "These countries (which impose such restrictions) claim not to automatically exclude such persons soley on the basis of their HIV status. Rather, it is the policy of these countries to use information about person's HIV positive sero-status to weigh the potential costs and benefits associated with granting an HIV person permission to enter the host country for the term requested."

This remark, when decoded, signifies that if an HIV positive person brings capital into another country it is worth allowing entry to such a person. In an economy and polity engineered by capital, an individual is only worth her/his money in the bank. What about migrants, refugees and other members of the working class and other under privileged sections of society who

have to move to another country for a considerable length of time? The quota is a testimony to WHO's alliance with capital. ABVA not only condemns this pro-rich bias which is the true face of the WHO, but also believes that this casually made observation in one of it's internal proceedings firmly puts its liberal public pronouncements in the shade.

One can cite further instances of not only bad drafting, but confused thinking. At one point in it's 'edited' draft on HIV/AIDS and travel, it says that, the "core of WHO statements and actions on mandatory HIV testing and declarations has been aimed at discouraging resort to such measures because, in general, they are not supported or justified by public health principles or epidemilogical evidence." This statement does not live beyond four subsequent pages where it states: "Human rights principles require that laws,which, on the basis of HIV status restrict the exercise of fundamental rights of persons with HIV infection must be clear and based on sound principles of public health."

At another place in this draft it says that "aliens showing symptoms of HIV or AIDS may be subjected to testing." When it refers to "symptoms" shouldn't it elaborate whether it is referring to say "a common cold or pulmonary tuberculosis? Or else one is apt to get the impression that AIDS is a contagious disease. These observations run contrary to the cannons of scientific argument that WHO claims to stand for.

In conclusion, we can say that the WHO stand on the long-term traveller is a real giveaway. We could ask it to change its stand, but that in effect would be of no use if it continues to believe in discrimination. Giving the matrix of political and economical alliances, there is no reason to believe that a super-bureaucracy like WHO will change its attitude. It is time we proceeded to work against the WHO and its nation-state allies on a campaign basis, rather than exhorting it to amend or pass this or that resolution. The WHO is our adversary, not our benevolent ally.

A WORLDWIDE SURVEY OF HIV/AIDS-RELATED ENTRY RESTRICTIONS

Excerpts of the Study conducted by McGill Centre for Medicine, Ethics and Law, Canada Entry Restrictions Project

The McGill Centre for Medicine, Ethics and Law, in collaboration with the Norwegian Red Cross Society, is carrying out a world-wide survey and analysis of HIV/AIDS-related entry restrictions. The objective of this project, which is funded by the Norwegian Ministry for Development Cooperation (NORAD), is to obtain data on entry restrictions which will be analyzed for relevant characteristics such as grounds and criteria for exclusion, categories of foreigners who are excluded and remedies against exclusion. Importantly, this will include analysis after experience of countries which have not imposed HIV/AIDS-related entry restrictions. The results of these projects will provide a basis for on-going monitoring of entry restrictions and efforts to halt them. It will also provide a model to study entry restrictions in greater detail, both related to disease in general and to HIV/AIDS in particular.
The project is described in detail below:

Objective: To support and strengthen efforts against HIV/AIDS-related entry restrictions by (I) collecting data, worldwide, on restrictions (2) providing a model for further study and regular monitoring of entry restrictions related to disease in general and to HIV/AIDS in particular; and (3) establishing approaches by which the International community can respond to this health and human rights threat.

Methods: A questionnaire has been developed and is being pretested. It will be sent to all diplomatic missions accredited in Canada. Responses will be verified by a similar questionnaire sent to Canadian missions in the corresponding countries and to select international organisations. Secondary and tertiary sources of information will also be used to verify and supplement the

data. The data will be analyzed by time of application of restrictions; categories of foreigners to which restrictions apply; exemption and exceptions to restrictions; grounds and criteria for exclusion; detection of excludable persons; authorities responsible for interpreting and applying restrictions; effects of restrictions and remedies for persons affected by them. Restrictions will also be analyzed for chronological and geographical trends, compatibility with international legal standards, and their impact, including whether restrictions have been introduced as a deterrent or are consistently applied.

The analysis and the data will form the basis of a model for future studies of entry restriction. This model will be applicable to diseases in general and HIV/AIDS in particular, will define the categories of entry restrictions, and provide the criteria for data collection.

Supporting and strengthening efforts against entry restrictions will include: (1) providing accurate, uptodate, authoritative information; (2) monitoring the success and effectiveness of efforts to rescind or prevent the imposition of restrictions; (3) promoting international communications, leadership, and accountability for these efforts.

Results : A strategy has been developed to support and strengthen efforts against HIV/AIDS-related entry restrictions. The first phase of this strategy includes a framework and a methodology for questionnaire development, data collection that includes multiple sources of information , and the verification and analysis of the data. Contacts providing data will form a nucleus for dissemination of results, for advocacy and for future studies, in particular on the impact of restrictions and on ways to prevent or remove them.

Conclusion: This project will provide simple, field tested questionnaire; the methodology for collecting data on restrictions; an analytical model for studying and monitoring restrictions, and data with which international, national and

community groups can advocate more effectively against restrictions and promote and protect the respect and dignity of HIV infected people.

ABVA received the following additional information from the McGill Centre for Medicine that is pertinent to their study.

AIDS-related migration and travel policies and restrictions:
A global survey
Margaret Duckett and Andrew J. Orkin

Introduction

Travel restrictions have become a significant feature of the response to the AIDS epidemic by a growing number of countries around the world: over 50 countries now restrict the entry of one or more categories of migrants or travellers with HIV infection or AIDS. Migrant workers and students have been refused entry into numerous states; people carrying zidovudine have been refused entry into at least one major western country; and deportations of people with HIV infection or AIDS have occured.

Data regarding AIDS-related migration and travel policies and restrictions have been incomplete and often based on anecdotal reports. The most recent listings prepared by government report data in respect of or fewer countries with AIDS-related travel restrictions.

We requested 166 governments to provide data on AIDS-related migration and travel policies and restrictions. These data, combined with information from other sources, show a significant and growing pattern of restrictions on the mobility of persons with HIV infection or AIDS.

Method

A questionnaire was forwarded to representatives and/or governments of 166 states, requesting information on restrictions, if any, on the mobility of persons with HIV infection or AIDS.

Our request for information was designed not to appear to legitimate or validate such restrictions as a necessarily appropriate response to HIV infection or AIDS. Details of exact statutory authority for restrictions, if any, were not sought in this phase of our research. In addition, our inquiry was addressed where possible to consular offices in Canada or at the next nearest mission, in order to obtain a response that was most likely to reflect implemented policy. In many cases, however, our inquiry was forwarded to authorities in the home country. Where no local representative was available, we corresponded directly with health authorities in the home country.

We asked the following questions:
(1) Is certification of HIV antibody status required of any of the following applicants for entry to your country (a) tourists/visitors, (b) students (c) foreign workers, (d) immigrants and/or (e) refugees ?
(2) Is retesting of any of the groups of persons in question 1 required at any time after entry ?
(3) Are there any policies or provisions in effect with respect to foreign nationals/potential entrants suspected of having, or known to have, AIDS?
(4) Are there any policies or provisions in effect with respect to returning nationals (citizens of your country) and HIV/AIDS?
(5) What provisions are there, if any, for the deportation, expulsion or exclusion of persons with AIDS/HIV infection?

Responses were analysed and compared and correlated with information from other official and unofficial sources . Where responses from governments were contradicted by reports from other sources, we addressed a further inquiry in this regard to the home government concerned.

Analysis of data

As of September 1989, 102 (61%) of the 166 countries approached have responded to our questionnaire. Data on 122 countries can be reported at this time. No responses to requests for further clarification have been received.

Countries with no restrictions

Seventy two countries (59%) appear to have no HIV or AIDS specific testing requirements for any class of entrant (tourist/visitor, student, foreign worker, immigrant, refugee). It should be noted, however, that a medical examination is often a standard requirement of those seeking entry, and many countries with no apparent HIV antibody testing requirements may not admit entrants with symptomatic HIV disease, acting under general immigration laws. A number of countries specifically referred to such provision and the possibility of their application with respect to HIV infection and/or AIDS.

Countries with restrictions

Fifty countries (41%) restrict one or more classes of entrants. Foreign workers are tested in the case of 36 countries (30%) students in 34 (28%) and tourists/visitors in 16 (13%). Entry has been or will be refused into, and/or deportations are known to have occured from 32 countries (26%).

Much of the data obtained from sources other than our enquiry was confirmed by the responses from governments themselves. In 13 cases, however (Algeria, Belize, Chile, Colombia, Czechoslovakia, Federal Republic of Germany, Greece, Hungary, Kuwait, Liberia, New Zealand, UK and the USA), governments asserted the absence of restrictions in law or policy, but other information indicates that in practice HIV antibody testing is required and/or exclusion or deportation has occured. The USA advised that it had no HIV antibody certification requirements in respect of short term visitors but exclusions of people found by customs officers to be carrying zidovudine have occured on a number of occasions.

There is no apparent association between the national rates of reported AIDS cases and the presence or absence, of restrictions. Restrictions are reported in, or by, both countries with very high, and countries with very low, numbers of reported AIDS cases.

In many countries, restrictions appear to be based on symbolic, sterotypical or apparently arbitrary reasoning or are wrongfully discriminatory. In the cases of Cyprus and Egypt, for example, it appears that cabaret artists or defence contractors, respectively are the only workers required to be tested for HIV. South Korea and Iraq exempt married people or those over 65 years of age respectively from testing. Many other countries exempt tourists/visitors from testing, and define this class of entrant on the basis of a maximum length of stay ranging from 5 days to 2 years. Finally, restrictions are applied only against applicants for entry from named countries, regions or endemic areas in the case of at least eight countries.

A number of countries reported the existence of HIV or AIDS specific legislation and/or policy restricting migration and/or travel, while others apply existing immigration health requirements to test one or more classes of entrants.

At least eleven countries report that they are considering the imposition of AIDS-related migration or travel restrictions.

Conclusion

This survey reveals that at least 50 countries now restrict the entry of people with AIDS or infected with HIV. In addition, 11 countries reported that they are considering restrictions. Data has yet to be obtained in respect of 44 countries.

It can be concluded that while a significant number of countries have, or claim to have, rejected travel restrictions as a measure to control the spread of HIV, an increasing number of countries are imposing such restrictions.

The use of restrictive measures as a response to infectious diseases has been discouraged since the mid 19th Century and especially since the establishment of the WHO. The International Health Regulations require WHO member states to refrain from enforcing restrictions for non-regulation diseases; HIV infection and AIDS are not included in the regulations.

Further, in March 1987, a WHO consultation concluded that AIDS-related travel restrictions are ineffective as a public health measure, impractical and wasteful. Jamaica is typical of the countries that reported full implementation of the WHO Global Programme on AIDS recommendations in this regard: 'The Ministry of Health has adopted the WHO's principle on International Travel with regard to AIDS/HIV infection and will therefore not be introducing HIV testing for international travel purposes.' (Correspondence with Ministry of Health in Jamaica, June 1989).

The WHO Assembly has urged all individuals, organisations and governments to protect the human rights of people with HIV infection or AIDS, and in particular to avoid discriminatory action against them in travel and employment. Restrictions that discriminate against people with HIV infection or AIDS cases violate a number of provisions of national and international law prohibiting discrimination. A number of countries reported deliberate policies of non-discrimination: 'The keystone of our AIDS Prevention and control Programme is information, education and counselling, and avoidance of stigmatization and discrimination.' (Correspondence with Government of Republic of Zimbabwe, June 1989).

Each year, over a billion people travel or migrate for business, tourism or economic survival. The imposition and enforcement of AIDS related travel restrictions by a growing number of countries can be expected to have a serious impact on social, economic and cultural exchange.

N.B. A copy of the questionnaire used in the survey conducted by the McGill Centre is available with ABVA.

CHARTER OF DEMANDS

ABVA urges the Government of India to take cognizance of the following demands and take urgent steps towards their implementation:

1. Establish a commission to document and prevent harassment of foreigners/immigrants with HIV/AIDS at the hands of the police, the medical establishment, the judiciary and the state administration.

2. Release all people with HIV/AIDS, particularly foreigners/immigrants, detained in jails and vigilance homes all over the country and stop further arrests of such persons.

3. a) Stop the requirement of HIV negative certificates from students, foreign and Indian, particularly those from African countries and North East India;
   b) Stop the requirement of HIV negative certificates for tourists/immigrant for visas.

4. Encourage the Press Council of India to issue guidelines for respectful, sensitive and representative reporting on people with HIV/AIDS especially foreigners/immigrants.

5. Ensure the following for all foreigners/immigrants and Indian nationals:
   a) Termination of all forcible HIV testing.
   b) Availability of voluntary and anonymous HIV testing.

6. a) Repeal Article 13 of the Code of Ethics of the Medical Council of India under which doctors refuse treatment to select patients. Take action on doctors or other health personnel who refuse to treat people with HIV/AIDS.
   b) Provide sufficient number of gloves and disposal syringes and needles in all medical centers throughout the country.

7. Permit citizen groups to visit jails and mental hospitals so as to promote understanding of the conditions of people detained there.

8. Constitute a group comprising people with HIV/AIDS and professionals from various backgrounds to be part of policies/decision-making on AIDS-related issues.

9. Encourage coordination between the Finance, Tourism, Social Welfare, Health, External Affairs and Home Ministries to deal with foreigners/immigrants with HIV/AIDS.

10. Pressurize International Bodies, especially the WHO and UNO to take steps regarding all the above within their member countries.

Ref No. ABVA/93 September, 1993

PETITION

The Centre for Human Rights
U.N. Office at Geneva
8-14, Avenue de la Paix
1211 Geneva 10, Switzerland

Sub: Petition regarding discrimination faced by foreigners who have AIDS or are HIV positive in the area of travel.

Sir:

ABVA is deeply concerned about the ever-increasing discrimination faced by HIV positive foreigners in the area of travel from one country to another. We strongly feel that such discrimination should have no place in a sane and civilised society.

According to a study over 50 countries have now restricted the entry of travellers who are HIV positive or have AIDS for prolonged/brief stays. Many countries use deceptive clauses like medical examination to turn away an HIV positive visitor. For example, the tracking down and final deportation of HIV positive foreigners from India is in conformity with and compliance of a clear cut policy of the Indian Government.

Such discrimination makes no sense in scientific, legal and ethical terms. Since AIDS is not a "CONTAGIOUS" disease (it doesn't spread through common medium like air,water) an HIV positive person should not be looked upon as a menace to public health of a particular country.

Such discrimination is violative of the following:

1. Articles 2, 7, 12 and 13 of the Universal Declaration of Human Rights adopted by the General Assembly of the United Nations (1948)

2. International Covenant on Civil and Political Rights (1976)
3. International Covenant on Economic, Social and Cultural Rights (1976)
4. Article 81 of the International Health Regulations (1969)
5. World Health Assembly Resolution W.H.A. 41-24 in Geneva (1988)
6. U.N. General Assembly Resolution 43/15 (1988) and 44/236 (1989)

Necessary steps should be initiated so that the member States of the U.N. bring a halt to the discrimination faced by HIV positive persons/AIDS patients in the context of travel from one member country to another.

Yours sincerely,
Sd.

(ARUN BHANDARI)
On behalf of AIDS Bhedbhav Virodhi Andolan
Post Box 5308, Delhi 110053, India.

NGOs /INDIVIDUALS ALL OVER THE WORLD ARE URGED TO SEND SIMILAR PETITIONS TO THE UNITED NATIONS

Ref: ABVA/Rep/July '92

July 29, 1992

Dear Sir/Madam,

AIDS Bhedhav Virodhi Andolan is a citizen's group involved in community work in education, health, law, women, gay, professional blood donors, drugs abuse and AIDS-related issues.

We request you to send us any material/documents related to 'International Travel HIV infection/AIDS' at the earliest. In this connection, we would like to know your country's stance on entry of HIV/AIDS infected persons. Being a non-funded group, we would appreciate you sending us complimentary copies of the same.

Thanking you,

Yours truly,

Sd/-

Shalini SCN
On behalf of AIDS Bhedbhav Virodhi Andolan

Letters sent to the following Embassies/High Commissions:

1. Afghanistan
2. Algeria
3. Arab States Mission
4. Argentine
5. Australia
6. Austria*
7. Bangladesh
8. Bhutan
9. Brazil*
10. Britain
11. Bulgaria
12. Cambodia
13. Canada
14. Chile
15. China
16. Colombia
17. Cuba
18. Czechoslovakia
19. Denmark
20. Domnica
21. Egypt
22. Ethiopia
23. Finland
24. France*
25. Germany*
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27. Greece
28. Guyana
29. Hungary
30. Indonesia
31. Iran
32. Iraq
33. Italy
34. Japan
35. Jordan*
36. Kenya
37. Korea
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39. Kuwait
40. Laos
41. Lebanon
42. Libya
43. Malaysia
44. Mauritus
45. Mexico
46. Mongolia
47. Morocco
48. Morocco
49. Myanmar
50. Nepal
51. Netherland
52. New Zealand
53. Nicargua
54. Nicargua
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58. Pakistan
59. Palestine
60. Panama
61. Peru
62. Phillipines
63. Poland*
64. Portugal
65. Qatar
66. Romania
67. Saudi Arabia
68. Singapore
69. Somali
70. Spain
71. Sri Lanka
72. Sudan
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75. Syria
76. Tanzania
77. Thailand
78. Trinidad & Tobago
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80. Turkey
81. U. A. E.
82. U. S. A.
83. U.S.S.R.
84. Uganda
85. Venezuela
86. Vietnam
87. Yemen
88. Yugoslavia
89. Zaire
90. Zambia
91. Zimbabwe

Letters were also sent to the following Ministries of the Government of India:

1. Ministry of Home Affairs.
2. Ministry of External Affairs
3. Director General of Health Service
   Union Health Ministry
4. Minister for Health & Family Welfare
5. Secretary, Home Ministry
6. Secretary Health, Delhi Administration
7. World Health Organisation-New Delhi

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Report Prepared by:
Four Months ago, Jagdish Bhardwajee,
a Professional Blood Donor, joined
AIDS BHEDBHAV VIRODHI ANDOLAN
(AIDS ANTI-DISCRIMINATION MOVEMENT)
It is through his eyes that the report is written in collaboration
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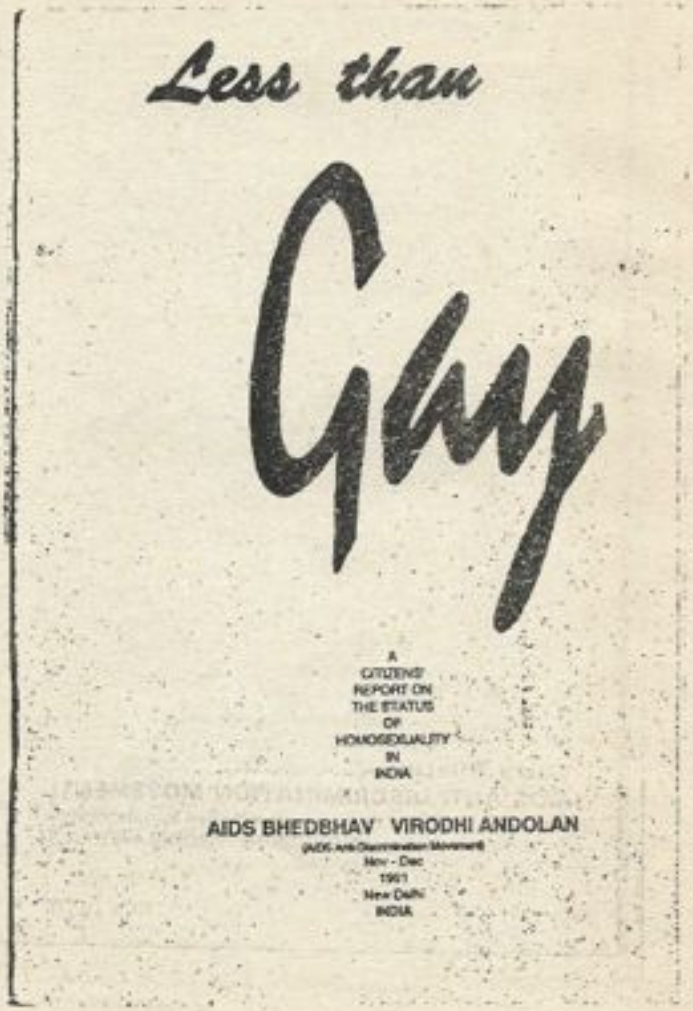

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