

THE HETERONORMATIVE STATE AND THE RIGHT TO HEALTH IN INDIA

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The Supreme Court of India recently upheld the constitutionality of § 377 of the Indian Penal Code and thus recriminalized adult consensual private same sex conduct. In doing so, the judgment overturned a four-year old Delhi High Court decision finding § 377 unconstitutional on the basis that the Section violated the rights to life and personal liberty of lesbian gay bisexual and transgender persons living in India. Evidence shows that anti-sodomy and same sex criminalization laws, such as § 377, have predictable and detrimental health effects. Such laws create legal and social barriers to effective prevention and treatment of HIV/AIDS. The resulting limited access to medical information and treatment for life-threatening conditions (HIV/AIDS) violates the constitutionally guaranteed and internationally recognized right to health of lesbian gay bisexual and transgender persons and men who have sex with men. However, this paper argues that public health arguments to repeal homophobic laws may act as a double-edged sword if not appropriately placed within a human rights framework. Basing the repeal of such laws on a public health rationale (namely, the increased prevalence of HIV/AIDS in these high risk communities as well as amongst the general population) only further associates lesbian gay bisexual and transgender persons and men who have sex with men with sexual diseases and haphazardly premises their rights on medical reports and expertise and not their fundamental human rights. Reports, affidavits and articles submitted on behalf of the petitioners and interveners in Suresh Kumar Koushal v. Naz Foundation indicate that § 377 creates a discriminatory environment through the institutionalization of stigma and police harassment, negatively impacting the access to HIV/AIDS prevention, treatment information and resources for gay bisexual and transgender persons living in India. Furthermore, international comparative studies of countries in which same-sex conduct is criminalized demonstrate consequential reduced access to HIV/AIDS information and services. In such countries,

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high-risk groups (e.g. men who have sex with men) are ashamed and afraid to provide vital sexual information to health providers for fear of social harassment and potential arrest. The Supreme Court's recent decision to reinstate § 377's application to private consensual same sex conduct unfortunately overlooks these important health considerations, and will likely lead to similar negative health outcomes—thus, in turn, resulting in constitutional violations of the right to health and, consequently, the right to life of the sexual and gender minority persons living in India.

I. INTRODUCTION

Criminalizing same sex conduct has been shown to be one of the most damaging institutionalized barriers to efficient prevention and treatment efforts of HIV/AIDS.¹ Laws to this effect have led to inexorable discrimination against and stigmatization of persons living with HIV/AIDS ('PLHA'). This hampers efforts to prevent and treat the condition within the population.²

§ 377 of the Indian Penal Code ('IPC') penalizes any sexual conduct that is 'against the order of nature' including consensual adult same sex conduct.³ The constitutionality of this Section was recently upheld in the Supreme Court decision of *Suresh Kumar Koushal v. Naz Foundation* ('Koushal').⁴ The United Nations AIDS organization ('UNAIDS') released a press statement post the Indian Supreme Court decision, calling on India (and other countries) to repeal all laws criminalizing adult consensual same-sex conduct on the basis that such criminalization hampers efforts to reduce and treat HIV/AIDS.⁵ According to the press statement, treatment sites providing HIV/AIDS services for men who have sex with men ('MSM') and transgender persons increased by more than 50% during the four years following the Delhi High Court judgment decriminalizing adult private same sex intercourse.⁶ Such evidence lends credence to the central argument set forth by the petitioners in *Naz Foundation v. Govt. of NCT of Delhi* ('Naz Foundation') that § 377 interfered with efforts to curtail the spread of HIV/AIDS in India.⁷ UNAIDS expressed

¹ UNAIDS, *Judging the Epidemic: A Judicial Handbook on HIV, Human Rights and the Law*, May, 2013, available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/201305_Judging-epidemic_en.pdf (Last visited on August 14, 2014).

² The Global Forum on MSM and HIV, *Social Discrimination against Men Who Have Sex with Men (MSM): Implications for HIV Policy and Programs*, May, 2010, available at http://www.msmsgf.org/files/msmsgf/Advocacy/Policy_Briefs/Stigma_EN_hi.pdf (Last visited on August 14, 2014).

³ The Indian Penal Code, 1860, § 377.

⁴ (2014) 1 SCC 1.

⁵ UNAIDS, *UNAIDS Calls on India and All Countries to Repeal Laws That Criminalize Adult Consensual Same Sex Sexual Conduct*, December 12, 2013, available at http://www.unaids.org/en/media/unaids/contentassets/documents/pressstatement/2013/12/20131212_PS_India_en.pdf (Last visited on September 25, 2014).

⁶ *Id.*

⁷ (2009) 160 DLT 277.

concern regarding HIV/AIDS prevention and treatment in direct response to the Supreme Court's decision to reinstitute § 377.⁸ According to UNAIDS, provisions such as § 377 "make it more difficult to deliver HIV prevention and treatment services to high risk groups such as MSM".⁹ Criminalizing same sex conduct reinforces the stigmatization of lesbian gay bisexual and transgender ('LGBT'¹⁰) and MSM persons and leaves them vulnerable to harassment, violence and bodily harm.¹¹ The fear of harassment impedes access for LGBT and MSM persons to basic information and services on health.¹²

LGBT activists across the globe have expressed apprehension regarding judgment's potential implications to the basic rights of LGBT persons living in India.¹³ Indeed, the judgment explicitly infringes on the sexual freedom of LGBT persons and MSM. The judgment's curtailment of an entire class of a person's sexual rights, will likely lead to the violation of these persons' rights to bodily integrity and privacy, particularly at the hands of law enforcement agencies.¹⁴ Furthermore, the re-criminalization of same sex intercourse has the potential to produce harmful far-reaching effects to these communities. Activists have rallied against recriminalization arguing that it will likely lead to an increased prevalence of untreated and undiagnosed HIV/AIDS amongst all groups in the population, as gay bisexual and transgender persons ('GBT') and MSM persons may have sexual partners within heteronormative paradigm.¹⁵ This article explores the potential adverse effects of the Supreme Court decision on the GBT and MSM community's access to their right to health. It argues that such damaging health outcomes violate such persons' right

⁸ UNAIDS, *supra* note 5.

⁹ UNAIDS, *supra* note 5. ("MSM are 13 times more likely than the rest of the population to be living with HIV.")

¹⁰ The term 'LGBT' should be understood in the terms employed by the Suresh Kumar Koushal v. Naz Foundation decision. We are aware, in employing this term, that gender or sexuality minorities are not limited to these narrow categories of 'LGBT' as utilized by the Court and, consequently, 'LGBT' as a term may not represent all such groups.

¹¹ Dipika Jain, *Impact of the Decriminalization of Homosexuality in Delhi: An Empirical Study*, ARKANSAS JOURNAL OF SOCIAL CHANGE AND PUBLIC SERVICE (January, 2013).

¹² *Id.*

¹³ See Harmeet Singh, *India's Supreme Court Declares Homosexual Sex Illegal*, CNN, December 11, 2013, available at <http://edition.cnn.com/2013/12/11/world/asia/india-same-sex-relationship/> (Last visited on August 12, 2014); *Celebs Stage Global Rage Protests Against Section 377*, HINDUSTAN TIMES (New Delhi), December 16, 2013; Human Rights Watch, *India: Supreme Court Ruling Undermines LGBT Rights*, December 12, 2013, available at <http://www.hrw.org/news/2013/12/12/india-supreme-court-ruling-undermines-lgbt-rights> (Last visited on August 12, 2014).

¹⁴ Naz Foundation v. Govt. of NCT of Delhi, *Testimony filed by Naz Foundation*, WP (C) No. 7455 of 2001 (Delhi High Court); Suresh Kumar Koushal v. Naz Foundation, *Affidavit filed by National Aids Commission Organisation*, SLP No. 15436 of 2009 (Supreme Court of India).

¹⁵ Shikha Nayyar, *Supreme Court Verdict on IPC Section 377 Impedes Fight Against HIV/AIDS*, December 17, 2013, available at <http://www.healthissuesindia.com/2013/12/17/supreme-court-verdict-ipc-section-377-impedes-fight-hiv-aids/> (Last visited on September 25, 2014); Shaleen Rakesh, *The Long Road Ahead*, December 23, 2013, available at <http://indiahivaidssalliance.wordpress.com/2013/12> (Last visited on August 12, 2014).

to health as protected under the Indian Constitution. The article critically examines studies from across the globe on the effects of such anti-sodomy and criminalization laws and concludes that the recent Supreme Court judgment will negatively impact the right to health of GBT persons and MSM living within India. In the last section, the article explores criticisms of the public health rationale, the argument that anti-sodomy and criminalization laws should be overturned on the basis of resultant negative health outcomes, and argues for including such health arguments into the human right to health framework.

II. THE EVIDENCE ON THE HEALTH EFFECTS OF § 377 AND THE RECENT SUPREME COURT DECISION

HIV positive persons are assumed *a priori* by society to belong to a ‘high risk group’, meaning namely MSM or GBT.¹⁶ This is based on a widespread conflation of HIV and GBT and MSM persons.¹⁷ Furthermore, HIV positive persons are erroneously seen to have contracted the virus as punishment for immoral non-heteronormative sexually deviant behaviour.¹⁸ Harassment by law enforcement agencies adds custodial power to the existing societal stigma.¹⁹ According to the Global Commission on HIV and the Law’s press release on the Supreme Court judgment, § 377 is “onerous for HIV and other health services to be accessed or to reach individuals and groups most at risk of infection”.²⁰ The Commission based this statement on a detailed study conducted in 2009 regarding HIV and the law.²¹ According to the report, the prevalence of HIV amongst MSM is higher in jurisdictions that criminalize same sex conduct than in jurisdictions that do not.²² Data collected from across the world on HIV prevalence shows that laws prohibiting such conduct “promote

¹⁶ Lesbians have been purposefully omitted from this acronym as they are not a high risk group for HIV/AIDS and should not be inappropriately included within this high risk group. Christina A. Muzny et al., *Lower Sexually Transmissible Infection Prevalence Among Lifetime Exclusive Women Who Have Sex With Women Compared With Women Who Have Sex With Women and Men*, 11 (6) *SEXUAL HEALTH* 592-593 (2014).

¹⁷ Gregory M. Herek & John P. Capitanio, *AIDS Stigma and Sexual Prejudice*, 42(7) *AMERICAN BEHAVIORAL SCIENTIST*, 1130-1147 (1999).

¹⁸ AVERT, *Stigma, Discrimination and Attitudes to HIV & AIDS*, available at <http://www.avert.org/aidsstigma.htm> (Last visited on August 12, 2014).

¹⁹ Geetanjali Misra, *Decriminalising Homosexuality in India*, 17(34) *REPRODUCTIVE HEALTH MATTERS* 20-28 (2009).

²⁰ Global Commission on HIV and the Law, *Statement of the Indian Supreme Court Decision on Section 377*, December 16, 2013, available at <http://www.hivlawcommission.org/index.php/follow-up-stories/272-statement-on-the-indian-supreme-court-decision-on-section-377> (Last visited on August 11, 2014).

²¹ Global Commission on HIV and the Law, *HIV and the Law: Risks, Rights & Health*, July, 2012, available at <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf> (Last visited on August 11, 2014).

²² *Id.*

risky behavior, hinder people from accessing prevention tools and treatment and exacerbate the stigma and social inequalities that make people more vulnerable to HIV infection and illness²³. The Commission recommended that all laws criminalizing consensual same-sex intercourse be repealed to respect human rights and dignity, as well as to decrease the prevalence of HIV/AIDS.²⁴ Such societal stigma and institutional discrimination poses a serious potential impediment to the effective treatment and prevention of HIV/AIDS in India.

HIV prevention and treatment programs for India's GBT and MSM community are now functioning in an inhospitable legal environment due to the Supreme Court's recriminalization of same-sex conduct. It was for precisely this reason that the Naz Foundation,²⁵ a Non-Governmental Organization working in the field of HIV/AIDS intervention and prevention, initiated this case in 2003. The Delhi High Court, after being directed by the Supreme Court to re-hear the matter on merits, read down § 377 of the Indian Penal Code and decriminalized private, consensual same sex conduct. According to the Delhi High Court's reasoning, application of the section to this conduct would violate several constitutionally guaranteed fundamental rights including the right to equality²⁶ and the right to personal liberty²⁷. Interveners in the litigation, such as the National AIDS Commission Organization ('NACO') and the Ministry of Health and Family Welfare, filed affidavits urging the Court to read-down § 377 in order to create an 'enabling environment' for GBTs to seek and obtain HIV/AIDS prevention and treatment services.²⁸ According to the Delhi High Court's summary of NACO's submissions, "those in the High Risk Group (for HIV/AIDS) are mostly reluctant to reveal same sex behavior due to the fear of law enforcement agencies [...] thereby pushing the cases of infection underground making it very difficult for the public health workers to even access them".²⁹ This cycle, warned NACO's affidavit, can further increase the spread of HIV both within the MSM and GBT communities as well as in the general population.³⁰ MSM who are forced through stigma and legal sanctions to deny their behavior may have sex with female partners.³¹ This places members outside of the MSM community also at risk for HIV/AIDS.³²

²³ *Id.*, 4.

²⁴ *Id.*, 6-7.

²⁵ Naz Foundation, *Mission Statement*, available at <http://www.nazindia.org/> (Last visited on August 11, 2014).

²⁶ Naz Foundation v. Govt. of NCT of Delhi, (2009) 160 DLT 277.

²⁷ *Id.*

²⁸ *Id.*, ¶ 18.

²⁹ *Id.*, ¶ 62.

³⁰ *Id.*, ¶ 62.

³¹ *Id.*, ¶ 62.

³² *Id.*, ¶ 62.

Although the Supreme Court was dismissive of such claims,³³ arguments made by the petitioner and interveners regarding the adverse health consequences of § 377 were supported by reports, scientific studies and census data. For instance, according to a 2002 Human Rights Watch Report³⁴ cited by the petitioners, police harass and obstruct efforts made by HIV/AIDS outreach workers in India on the basis of § 377.³⁵ The report states that police have at times gone so far as to “attempted to link them [HIV outreach workers] with national security offenses, narcotics offenses and other criminal acts”, and advocated for the repeal of § 377.³⁶ The affidavit submitted to the Court by the Ministry of Health and Family Welfare and Department of AIDS Control stated that in 2006, 10% of MSM were at risk for HIV as compared to 1% of the general population³⁷— thus highlighting the fact that MSM have a much higher risk of HIV/AIDS.³⁸ In addition, National Conference on Human Rights and HIV also submitted a report.³⁹ In the report, the Conference recommends that § 377 be rendered obsolete in order to “more successfully prevent and manage HIV/AIDS among these marginalized populations”.⁴⁰ In spite of the petitioners’ submission of corroborating evidence, the Supreme Court held that there was insufficient support to find that § 377 resulted in discriminatory treatment.⁴¹

III. THE CONSTITUTIONAL RIGHT TO HEALTH AND § 377

In India, the guarantee of health rights remains the principal responsibility of State, as does the implementation of these rights. It is through the Supreme Court’s creative interpretation of Parts III and IV of the Constitution that a right to health has been recognized in India. In the evolution of Supreme Court jurisprudence on the constitutional right to life, the Court has held that such a right is meaningless unless accompanied by the guarantee of certain concomitant rights, including but not limited to, the right to health. Beginning in 1981, in the case of *Francis Coralie Mullin v. Union Territory of Delhi*, the Indian Supreme Court interpreted the right to life expansively to include “the

³³ Suresh Kumar Koushal v. Naz Foundation, (2014) 1 SCC 1, ¶ 63 (“The writ petition [...] miserably failed to furnish the particulars of the incidents of discriminatory attitude. [...] These details are wholly insufficient for recording a finding that homosexuals, gays, etc., are being subjected to discriminatory treatment either by State or its agencies or the society.”)

³⁴ Human Rights Watch, *Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India*, July 9, 2002, available at <http://www.refworld.org/docid/3d4fc51f4.html> (Last visited on August 11, 2014).

³⁵ *Id.*

³⁶ *Id.*

³⁷ Suresh Kumar Koushal v. Naz Foundation, (2014) 1 SCC 1, ¶ 63.

³⁸ *Id.*

³⁹ Naz Foundation v. Govt. of NCT of Delhi, (2009) 160 DLT 277, ¶ 65.

⁴⁰ National Human Rights Commission, *Report of the National Conference on Human Rights and HIV/AIDS*, November 25, 2000, available at http://www.nhrcc.in/report_hiv-aids.htm (Last visited on August 12, 2014).

⁴¹ Suresh Kumar Koushal v. Naz Foundation, (2014) 1 SCC 1, ¶ 63.

right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter.⁴² The Supreme Court addressed the issue of health care as a fundamental right and has imposed an obligation upon the State to not only provide emergency medical care but also to take all steps to create conditions necessary for good health, including facilities for basic curative and preventive health service.⁴³

In 2003, the Supreme Court recognized that a truly effective and rational response to HIV/AIDS must necessarily include a two prong approach: primary prevention for HIV negative persons, on the one hand, and comprehensive support and treatment for HIV positive persons on the other.⁴⁴ In the case of *Sankalp Rehabilitation Trust v. Union of India* ('Sankalp'),⁴⁵ the Supreme Court explicitly addressed the rights of PHLA to receive medical treatment (i.e. anti-retroviral therapy, otherwise known as 'ART'). In 2003, another petition, *Voluntary Health Association of Punjab v. Union of India* ('VHPA') was filed requesting treatment for all HIV positive persons as required by the constitutionally guaranteed right to health.⁴⁶ The VHPA petition was heard along with the Sankalp petition. In response to the batch of petitions, the Government announced free ART drugs in several States and stated that it would increase its treatment rates each year.⁴⁷ In 2008, a Supreme Court order mandated access to ART, required the provision of free treatment for opportunistic infections and ordered that HIV persons not be discriminated against within health care settings. Similarly, the Government of India has acknowledged not only its duty to prevent HIV infection, but also its responsibility to treat HIV positive persons.⁴⁸

The recriminalization of consensual same-sex conduct is contrary to India's national implementation of an effective HIV/AIDS prevention program as well as the Supreme Court's orders issued in Sankalp. There is a clear contradiction between the judicial and government support of HIV/AIDS policy and the now constitutionally sanctioned provision criminalizing same sex conduct. Sankalp and VHPA respect the PHLAs need for effective, non-discriminatory treatment and resources. Yet, the decision in Koushal belies the

⁴² Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 SCC 608, 618-619.

⁴³ See *Consumer Education & Research Centre v. Union of India*, (1995) 3 SCC 42; *State of Punjab v. Mohinder Singh Chawala*, (1997) 2 SCC 83; *Bandhua Mukti Morcha v. Union of India*, (1984) 3 SCC 161.

⁴⁴ *Sankalp Rehabilitation Trust v. Union of India*, WP (C) 512 of 1999 (Supreme Court of India).

⁴⁵ *Id.*

⁴⁶ *Voluntary Health Association of Punjab v. Union of India*, WP (Civil) No. 349 of 2006 (Supreme Court of India); DIPIKA JAIN & RACHEL STEPHENS, *STRUGGLE FOR ANTI-RETROVIRAL MOVEMENT IN INDIA* (2008).

⁴⁷ Human Rights Law Network, *Docket: Voluntary Health Association of Punjab v. The Union of India & Ors.*, available at <http://www.hrln.org/hrln/hiv-aids/pils-a-cases/205-docket-voluntary-health-association-of-punjab-vhap-vs-the-union-of-india-and-others.html> (Last visited on August 11, 2014).

⁴⁸ *Sankalp Rehabilitation Trust v. Union of India*, WP (C) 512 of 1999 (Supreme Court of India).

holdings of Sanklap and VHPA for two main reasons. First, Koushal allows for legal and social discrimination against high risk groups (GBT and MSM) on the basis that such groups practice illegal sexual practices. Second, the Supreme Court's decision to reinstate an anti-same sex discriminatory law will likely increase the prevalence of HIV/AIDS both within the community as well as amongst the general population. Furthermore, this will disincentivize PHLAs from seeking treatment for fear that they will be labeled as a member of an illegal sexual minority and hence, a criminal. Ultimately, criminalization of same-sex conduct leads to reduced access to healthcare. It is evident from existing Supreme Court jurisprudence that it is the responsibility of the State to provide an enabling environment to protect a citizen's right to health. This would logically include the right to a safe environment conducive to obtaining HIV/AIDS information and treatment services.

As reported by UNAIDS, there was a considerable increase in the number of people accessing HIV information and treatment after the Delhi High Court decriminalized consensual same sex intercourse.⁴⁹ Additionally, the judgment has had other positive impacts on the queer community in India.⁵⁰ The re-criminalization is likely to hamper HIV/AIDS prevention and treatment. The next section will discuss international qualitative and quantitative HIV data collected from countries where same sex sexual conduct is prohibited, to illustrate the nexus between sodomy laws and their ability to hinder effective HIV outreach programs. The concluding portion of this section will examine the pitfalls of utilizing public health based arguments (i.e. increased barriers to HIV/AIDS treatment) for repealing anti-sodomy and criminalization laws.

IV. LESSONS FROM OTHER COUNTRIES ON SAME-SEX CRIMINALIZATION AND ITS IMPACT ON HEALTH

In a recent study of HIV risk amongst MSM in Senegal, Africa, researchers found significant reductions in HIV treatment and prevention directly following the well-publicized arrest and prosecution of nine male HIV prevention workers for allegedly violating the countries same-sex conduct prohibition.⁵¹ Under Article 319 of its Penal Code, Senegal criminalizes 'improper or unnatural act with a person of the same sex'.⁵² The study examined the effects of the arrests and prosecution on HIV prevention efforts through in-depth interviews and focus group discussions with MSM and key informants living

⁴⁹ See also Jain, *supra* note 11; Ryan Goodman, *Beyond the Enforcement Principle: Sodomy Laws, Social Norms, and Social Panoptics*, 89 CAL. L. REV. 643 (2001).

⁵⁰ Goodman, *id.*

⁵¹ Tonia Poteat et al, *HIV Risk Among MSM in Senegal: A Qualitative Rapid Assessment of the Impact of Enforcing Laws The Criminalize Same Sex Practices*, 6(12) PLOS ONE (2011).

⁵² Senegal Penal Code, 1965, Art. 319.

in Senegal.⁵³ According to the results, HIV prevention, care and treatment for MSM decreased dramatically directly following the implementation of Article 319 against the outreach workers.⁵⁴ Specifically as a result of the arrests, numerous HIV service providers discontinued HIV services “out of fear that these services would be reported by the media and their organizations would suffer retribution”.⁵⁵ Such disruption of services led to decreased HIV education and reduced access to condoms and treatment for other sexually transmitted infections.⁵⁶ In conclusion, the study urges the government of Senegal (as well as all other countries) to repeal laws criminalizing same sex practices.⁵⁷

Jamaica has seen an increase in HIV/AIDS rates comparable to those recorded in Senegal as a result of the country’s anti-sodomy laws.⁵⁸ Jamaica criminalizes consensual sex between adult men.⁵⁹ Such anti-sodomy laws have been used as a justification for the arrest of HIV service providers and educators.⁶⁰ The implementation and arrests stemming from the country’s anti-sodomy laws “make it difficult for them [health officials] to work directly with men who have sex with men”.⁶¹ In fact, even government-supported peer HIV prevention efforts are met with police interference.⁶² In some cases, the mere possession of condoms can result in police harassment and arrest.⁶³

According to a study⁶⁴ conducted worldwide by the Global Forum on MSM and HIV, the criminalization of homosexuality often intensifies HIV epidemics.⁶⁵ The study found that in countries in which same sex intercourse is criminalized, MSM do not disclose their sexual behavior or HIV status.⁶⁶ This has resulted in reduced HIV ‘prevention information, testing, treatment, care or support services’.⁶⁷ In addition, HIV health care providers and outreach workers often face fallacious charges and arrests for ‘supporting illegal activities’.⁶⁸ The combined effects of the hampered prevention and treatment of HIV and the reduction of HIV services lead to increased HIV prevalence in countries

⁵³ Poteat, *supra* note 51.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Rebecca Schleifer, *Hated to Death: Homophobia, Violence and Jamaica’s HIV/AIDS Epidemic*, 16(6) HUMAN RIGHTS WATCH 1-79 (2004).

⁵⁹ *Id.*

⁶⁰ *Id.*, 4.

⁶¹ *Id.*, 4.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Social Discrimination Against Men Who Have Sex With Men (MSM): Implications for HIV Policy and Programs*, *supra* note 2.

⁶⁵ *Id.*, 2.

⁶⁶ *Id.*, 2.

⁶⁷ *Id.*, 2.

⁶⁸ *Id.*, 2.

that penalize same sex conduct.⁶⁹ The study found support from data collected in several regions. For example, according to the data collected, there are significantly higher rates of HIV in Asia for MSM; a region in which over twenty countries criminalize homosexuality.⁷⁰ In addition, the study found similar results in the Caribbean— with countries with laws criminalizing homosexuality reporting higher rates of HIV among MSM than countries where same sex intercourse is legal.⁷¹ On the basis of such data, the report strongly recommended that laws criminalizing same-sex intercourse be repealed to allow for HIV-related services and information.⁷²

In 2012, the Global Forum on MSM and HIV produced a report on the access to HIV prevention and treatment for MSM⁷³ as well as a related but complementary study on the prevalence of HIV/AIDS amongst young MSM under 30⁷⁴. According to the report, such laws affect MSM's access to condoms, lubes, HIV testing and HIV/AIDS treatment.⁷⁵ Furthermore, in the study's MSM Africa focus group, it was revealed that social prejudice and laws criminalizing same-sex intercourse lead to several negative outcomes impacting the overall health of the MSM community: blackmail and extortion, depression and anxiety, eviction, violence, substance abuse, and interruptions in treatment.⁷⁶ In addition, the study on the health of MSM under the age of 30 found that young MSM are even more likely to be affected by social homophobia than other members of the MSM community; thus, they are even more likely to feel the effects of criminalization laws of same sex conduct in India.⁷⁷

The above studies indicate a relationship between laws that criminalize same-sex iconduct and adverse health effects on HIV/AIDS rates as well as other health indicators for the MSM community (i.e. depression, housing access, etc.). The recent judgment of the Supreme Court re-criminalizing same sex activity is likely to produce similar effects within India. MSM and LGBT, fearful of arrest and prosecution, will be less likely to seek HIV/AIDS prevention programs, information and treatment. This, in turn, will likely raise the

⁶⁹ *Id.*, 2.

⁷⁰ *Id.*, 2.

⁷¹ *Id.*, 2, 3.

⁷² *Id.*, 7, 8.

⁷³ Global Forum for MSM and HIV, *Access to HIV Prevention and Treatment for Men Who Have Sex with Men: Findings From the 2012 Global Men's Health and Rights Study*, 2012, available at http://www.msmsgf.org/files/msmsgf/documents/GMHR_2012.pdf (Last visited on August 14, 2014).

⁷⁴ Global Forum for MSM and HIV, *Young Men Who Have Sex with Men: Health, Access & HIV: Data From the 2012 Global Men's Health and Rights Survey*, 2013, available at http://www.msmsgf.org/files/msmsgf/Publications/MSMGF_YMSM_PolicyBrief.pdf (Last visited on September 25, 2014).

⁷⁵ *Access to HIV Prevention and Treatment for Men Who Have Sex with Men: Findings From the 2012 Global Men's Health and Rights Study*, *supra* note 73, 5.

⁷⁶ *Id.*, 6-7.

⁷⁷ *Young Men Who Have Sex with Men: Health, Access & HIV: Data From the 2012 Global Men's Health and Rights Survey*, *supra* note 74.

rates of HIV/AIDS incidence within the country. Thus, § 377 will serve as a legal and social barrier to MSM persons' access to their constitutionally guaranteed right to health.

Anti-sodomy and criminalization laws produce effects beyond merely public health concerns for the GBT and MSM communities; however such effects have been in the spotlight as the primary basis for these laws.⁷⁸ This, what has been termed as the 'public health rationale'⁷⁹, emphasizes the health effects of homophobia (namely, reduced detection and treatment of HIV/AIDS) whilst circumventing the main issue: homophobia itself.⁸⁰ Anti-sodomy and criminalization laws indeed have negative repercussions for the human rights of LGBT and MSM persons; health is yet merely one of these effects that should be discussed, studied and utilized as an advocacy tool to argue for LGBT and MSM persons' right to equality. The public health rationale is tempting as an advocacy tool for queer rights because the argument offers neutral ground to launch campaigns against homophobic laws wholly avoiding the issue of sexuality and the legal question of whether people have the right to divergent sexualities. However, if left unchecked the argument legitimizes the rights of the LGBT and MSM community through exposure to disease at best, and at worst, predicates their rights on their ability to infect the general 'innocent' heteronormative population.⁸¹ Furthermore, premising the rights of these gender and sexuality minorities on health effects (most predominantly HIV/AIDS) leaves several groups excluded from the debate altogether: women with divergent sexuality (e.g. lesbians).⁸²

The right to health is a human right and should be framed within the human rights discourse. If placed within a purely public health rationale, the argument for repealing homophobic laws is anesthetized into mere medical statistics wholly obfuscating the internationally and constitutionally-recognized rights belonging to these marginalized communities.⁸³ LGBT and MSM persons face tangible and direct detriments to their health as a result of anti-sodomy and criminalization laws. However, sodomy laws and criminalization laws are a human rights issue and not merely a medical question. For example, according to the United Nations 2001 Political Declaration, HIV/AIDS must be addressed through both a health and human rights approach; specifically, "that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic".⁸⁴ Basing

⁷⁸ Neil Cobb, *Contagion Politics: Queer Rights Claims, Biopower and the 'Public Health' Rationale for the Repeal of Sodomy Laws*, 4 (1) JINDAL GLOBAL L. REV. (2012).

⁷⁹ *Id.*

⁸⁰ David Roman, *Negative Identifications* in QUEER REPRESENTATIONS: READINGS LIVES, READING CULTURES: A CENTER FOR LESBIAN AND GAY STUDIES BOOK 162-180 (M.B. Duberman ed., 1997).

⁸¹ Cobb, *supra* note 78, 81.

⁸² *Id.*

⁸³ Jonathan Mann et al, *Health and Human Rights*, 1(1) INT. QUARTERLY J. 6-22 (1994).

⁸⁴ G.A. Res. S-26/2, ¶ 16, U.N. Doc. A/RES/S-26/2 (August 2, 2001) (Declaration of Commitment on HIV/AIDS: Global Crisis - Global Action), available at: <http://www.un.org/ga/aids/docs/>

queer rights on mere public health arguments strips the current violations faced by these communities of their human rights significance and instead demotes them to medical questions (e.g. Is HIV/AIDS increased in countries with anti-sodomy and criminalization laws?).⁸⁵ It also premises the fundamental rights of LGBT and MSM persons on medical proof rather than on a universal right to equality. While medical evidence indeed corroborates the public health rationale for decriminalizing discriminatory laws, such arguments must be premised on the human rights of LGBT and MSM persons. To fail to do so, only further serves to inextricably link these communities with sexual infections and disease and not notions of equality.⁸⁶

V. CONCLUSION

It is apparent that criminalizing same sex conduct adversely impacts the health of the MSM and GBT communities as well as the general population. The Supreme Court's decision to reinstate § 377's application to all same sex conduct will almost certainly have significant effects not only on the sexual freedom, equality and personal liberty rights of LGBT persons living in India but will also likely deter HIV/AIDS prevention and treatment in the country for all persons. These barriers to effective treatment and prevention measures will not only increase the prevalence of HIV in India but will also likely raise questions regarding the potency of the right to health in India. India's Supreme Court jurisprudence has long recognized the right to health under Article 21 of the Constitution. Such precedents recognizing and expanding the right to health to cover basic necessities and access to medical facilities clearly secures in turn the right of persons (LGBT or otherwise) to access to an environment conducive to the dissemination of information and resources for the prevention and treatment of HIV/AIDS. § 377 creates a discriminatory environment in which societal stigma and apprehension of police harassment prevent GBT persons from accessing such resources. This discrimination restricts such persons from realizing and enjoying their right to health and equality. This right to health must be framed within a human rights discourse and not stripped of its rights based significance as a purely public health rationale. While the Supreme Court decides (hopefully positively) on the pending curative petition, steps to prevent the judgment's predictable ill effects on HIV/AIDS rates should begin immediately by health outreach workers, service providers and the GBT community at large. Unfortunately, as verified by international HIV data (such as those cited from Senegal and Jamaica), such efforts may prove to be futile without the protection of the law.

ares262.pdf (Last visited on July 15, 2012).

⁸⁵ Cobb, *supra* note 78.

⁸⁶ Ashley Tellis, *Ethics, Human Rights and the LGBT Discourse in India*, APPLIED ETHICS AND HUMAN RIGHTS: CONCEPTUAL ANALYSIS AND CONTEXTUAL APPLICATIONS 152 (Shashi Motilal ed., 2011).