कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मंत्रालय, भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment, Govt. of India)

मुख्यालय
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Website : www.esic.nic.in / www.esic.in

No. U-12011/3/2022-Med-I

Date :27.05.2024

To,

All **Dean**
ESIC Medical Colleges
& Hospitals
ESI Corporation

All **DIMS / AMO**
ESI Scheme
State Govt.

All **Medical Superintendent**
ESIC Hospitals
ESI Corporation

Subject : Compliance of the order of Hon'ble Supreme Court of India (Provisions of the HIV Act).

With reference to above cited subject, kindly find attached the judgement of Hon'ble Supreme Court of India, Civil Appeal No. 7175 of 2021, CPL. Ashish Kumar Chauhan (Retd.) Vs Commanding Officer and ORS. vide which the Hon'ble Supreme Court of India has issued certain directions to the Central and State Governments. In r/o of the above mentioned judgement the following guidelines are issued to the ESIC / ESIS Hospitals for strict Compliance.

1. All ESIC & ESIS Hospitals to ensure provisions of treatment, diagnostic facilities relating to HIV or AIDS, Anti-retroviral therapy and Opportunistic Infection Management to people living with HIV or AIDS.
2. The guidelines regarding National AIDS Control Programme in ESIC Medical Institutions/ Hospitals for preventive, diagnostic and treatment services issued vide letter no. U-16013/180/2023/Med-I(E-491176) dated 03.11.2023 (copy enclosed) are to be ensured for strict Compliance.
3. All ESIC & ESIS Hospitals to formulate HIV and AIDS related information, education lectures and communication programmes which are age-appropriate, gender-sensitive, non-stigmatic and non-discriminatory.
4. All ESIC & ESIS Hospitals to ensure that the personnel with significant risk of occupational exposure to HIV, for the purpose of ensuring safe working environment, shall (i) provide, in accordance with the guidelines, firstly, universal precautions to all persons working in such establishment who may be occupationally exposed to HIV; and secondly training for the use of such universal precautions; thirdly post exposure prophylaxis to all persons working in such establishment who may be occupationally exposed to HIV or AIDS; and (ii) inform and educate all persons working in the establishment of the availability of universal precautions and post exposure prophylaxis.
5. All ESIC & ESIS Hospitals to ensure compliance with the provision of HIV Act.
6. All Hospitals to designate a Complaint Officer who shall dispose of the complaint on the violation of the HIV Act. The details of the Complaint Officer for compliance of

the HIV Act provision to be displayed in prominent location of the Hospital(s). The Hospital may also devise SOP to deal with such complainas per the provision of the HIV Act.

All the ESIC and ESIC Hospital are to ensure strict compliance of above instructions / guidelines and to submit the Action Taken Report within 15 days of receipt of this letter.

This issues with the approval of Medical Commissioner (Medical Services).

Encl. :

1. Judgement of Hon'ble Supreme Court of India
2. Guidelines regarding National AIDS Control Programme in ESIC Medical Institutions/ Hospitals for preventive, diagnostic and treatment services

27/05/24

(Dr. Manoj Kumar)
OSD Medical Services

Copy to :

1. All Zonal Medical Commissioner, Zonal Offices, ESI Corporation.
2. All Regional Directors, Regional Offices, ESI Corporation.

2023INSC857

REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO(S). 7175 OF 2021

CPL ASHISH KUMAR CHAUHAN (RETD.) …APPELLANT(S)

VERSUS

COMMANDING OFFICER & ORS. …RESPONDENT(S)

J U D G M E N T

S. RAVINDRA BHAT, J.

1. The present civil appeal challenges an order of the National Consumer Disputes Redressal Commission, New Delhi[1] (hereafter, "Commission"). The application by – CPL Ashish Kumar Chauhan (hereafter, "appellant") for compensation was dismissed by the Commission. The Commanding Officer, 171 Military Hospital is arrayed as the first Respondent; the Medical Officer at the 171 Military Hospital ("171 MH") is the second respondent; the Principal Director, Directorate of Air Veterans is impleaded as the third respondent; the Commanding Officer of the South Western Air Command (Gandhinagar HQ) is arrayed as fourth respondent, and the Senior Medical Officer at the said Military facility is impleaded as the fifth respondent. The first, second and fifth

[1] In Consumer Complaint No. 647 of 2017.

respondents are, hereafter, referred to (unless the context otherwise requires) as "Indian Army"; and the third and fourth respondents, as "IAF".

I. Relevant Facts

2. The aftermath of the attack on Indian Parliament, (i.e., on 13 December 2001) was followed by heightened tensions at the Indo-Pak border. There was troop mobilization at the border; what is termed as a prolonged "eyeball to eyeball" confrontation between Indian armed forces and Pakistani armed forces. During this deployment and engagement, known as "Operation Parakram", the appellant, who was a radar operative/ technician -with the IAF, was deployed at the border. He had enrolled in the IAF from 21.05.1996 in a permanent position and held a combatant rank. His medical category was A4 GI [which is Category A].

3. In July 2002, as his services were needed, he was posted at 302 TRU (Transportable Radar Unit), Pathankot. He fell sick whilst on duty during the operation (Parakram) and complained of weakness, anorexia and passing high colored urine. He was, therefore, admitted to 171 MH, Samba. On 10.07.2002, whilst undergoing treatment at the aforementioned facility, Lt. Col Devika Bhat, posted as MO (Physician), advised him to undergo a blood transfusion. One unit of blood was therefore, transfused to the appellant, for the management of severe symptomatic anemia. The said military hospital facility did not have a license for a blood bank but has been termed by the Indian Army as an "*ad-hoc blood bank".* Apparently neither any pathologist nor transfusion expert was posted at the facility as it was specifically opened up during *Parakram*. The appellant alleges that 171 MH did not possess any facility to check markers of blood, including HIV before transfusion and the blood was indented from another military hospital – 166 Military Hospital ("166 MH") as per the SoP[2] on "*Adhoc Blood Bank*". The

[2] SoP for ad-hoc blood bank 171 Military Hospital

treatment papers of the appellant were entrusted to the Senior Medical Officer of the 302 TRU, Pathankot, for maintenance purposes. In August 2002, the appellant was again admitted to 171 MH; and this time, his hemoglobin level was found to have increased from 11.5gm% to 13.0gm%.

4. In April 2014, the appellant again fell ill. This time, he was admitted to Station Medicare Centre, Head Quarter, South West Air Command (U), Gandhinagar. The test report dated 05.03.2014, reported *"negative"* for the HIV virus. While undergoing treatment at this facility, he suffered some complications and was consequently, transferred to Military Hospital, Ahmedabad. On further deterioration of his health at the Ahmedabad center, he was further transferred to INHS Asvini, Mumbai, an Indian Naval establishment. While undergoing treatment, his blood samples were taken and on diagnosis, the Lab reports (dated 21.05.2014 and 23.05.2014), revealed that the appellant was suffering from Human Immunodeficiency Virus (hereafter, "*HIV*"). According to the appellant, these two lab reports meet the required parameters for a valid medical document, including mention of the lab reference number and name of the medical officer. The finding of the lab report returns as: "*Positive for HIV – I Antibodies by NACO Strelegy*".

5. The appellant endeavored to trace the source of the virus and realized that the transfusion of virus infected blood at 171 MH Samba in 2002 was the cause of his condition. After the detection of the HIV virus, the first medical board was held on 11.06.2014 and as per the findings of the Medical Board, the infection with HIV was made – "*non-attributable to service*". On being dissatisfied with the decision of the first Medical Board, the appellant demanded a copy of the documents relating to his blood transfusion at 171 MH, Samba in July 2002; access was however refused by the respondents on account of their unavailability.

6. In February of 2015, the appellant was hospitalized at a military facility in Ahmedabad owing to H1N1 (Swine) Influenza, Macrocytic Anaemia,

Subhyalodid, and Haemorrhage along with Immune Surveillance. He requested information about his Personal Occurrence Report (POR) at 171 Military Hospital, Samba in 2002 which had to be kept by the Commanding Officer of the concerned unit. Pursuant to the request, the fifth respondent, on 24.09.2014, wrote to the IAF record office, in New Delhi and by letter dated 29.09.2014, the appellant's medical case sheet was provided to him. The case sheet shows that though on 10.07.2002, one unit of blood was transfused to the appellant, but whether Enzyme Linked Immunosorbent Assay (ELISA) test was conducted before infusing the blood in the appellant's body was conspicuously absent from that medical case sheet.

7. Thus, Medical Boards were held on 12.12.2014 and 24.06.2015 and in terms of the medical board proceedings, the appellant's disability was attributable to service owing transfusion of one unit of blood at 171 Military Hospital on 10th July 2002. His disability and the disability qualifying elements for the purpose of disability pension were also assessed by the medical board @ 30% for two years. By letter dated 22.03.2016[3], PCDA (P) Allahabad endorsed the findings of the Release Medical Board and agreed with the sanctioned disability pension. Based on the findings of the medical boards, the appellant was sent to INHS, Asvini Mumbai, for his further medical classification, and the specialist[4] suggested that the appellant should be excused from physically exhaustive activities (including PT, Parade, and standing duties).

8. On 10.09.2015, the appellant requested for the release of certified copies of his medical records. They were not provided to him despite the fact that said records were essential for his treatment post discharge from the service. In fact, the appellant alleges that a condition was insisted on him to sign on the proceedings of a Release Medical Board which allegedly never took place. On

[3] Letter No RO/3305/3/Med.
[4] Opinion of Specialist dated 16.12.2015

31.05.2016, the appellant was denied extension of services and was discharged from service, without the due proceedings of the Release Medical Board. At the time of release, the appellant was not provided with the Ex-Servicemen Contributory Health Scheme (hereafter, "ECHS") card within a reasonable time and an ECHS temporary card was issued only after an application[5] was moved by him. Further, Rs. 15,000 were also deducted from the dues owed to him post-retirement in the absence of an ECHS card for undergoing medical treatment.

9. On 22.09.2016, the appellant wrote a letter to obtain his disability certificate. That was denied to him by a letter dated 14.12.2016[6], which stated that no such provision exists for issuance of printed disability certificate in the format as desired by the appellant and subsequently on 29.08.2017, the appellant's disability pension was sanctioned in addition to his service pension. Pertinently, the letter dated 14.12.2016, also mentioned that:

> "*3. Notwithstanding above it is certified that as per records held with this office,* ***the disability "Immune Surveillance (HIV)" got afflicted due the blood transfusion that you received at 171 MH in July 2002. The disability is attributable to service.***"

10. Aggrieved by the denial of medical reports as to his blood transfusion, the appellant preferred an RTI application[7] requesting for: (i) copies of his willingness certificate as to blood transfusion; (ii) information as to whether risks were disclosed to him about blood transfusion and whether appellant consented to those risks; and (iii) copies of blood test report to ascertain blood group and Rh factor test report of that one unit of blood. PIO RTI Cell[8] informed the appellant that the information sought by him was exempted under Section 8(1) of

[5] Application dated 26.04.2016.
[6] Vide Air HQ/99798/1/741570/DAV(DP/RMB).
[7] Dated 05.05.2017.
[8] Vide letter no 6004/A/GS (Edn).

the Right to Information Act, 2005 (hereafter, "RTI Act"). Dissatisfied with the information provided, he appealed to the First Appellate Authority.

11. The Appellate Authority by its order[9] rejected the appeal and observed that best efforts were made by the respondent authorities to trace the appellant's medical document and even admission and discharge documents were supplied to him whenever available with the respondent. It was further observed by the Appellate Authority that 171 MH is not an authorized military hospital facility and it was established as an 'adhoc blood bank' with necessary blood being requisitioned from 166 MH. It was further observed by the Appellate Authority that old documents (including the appellant's medical records) have been destroyed as per the necessary policy and while disagreeing with the findings of the Release Medical Board (where HIV was attributed to the service), observed that in absence of any causative factor between blood transfusion and acquiring HIV infection, HIV infection cannot be attributed to the service and thus found no negligence on behalf of the hospital authorities. Relevant findings of the Appellate Authority are reproduced below:

> "*10. It is informed that as per the PE of the hospital, 171 Military Hospital is not authorized any blood bank and hence no Pathologist is authorized or posted, at any time. However, an adhoc blood bank was established during 'Op Parakram' i.e. in 2002. Blood would be requisitioned from 166 MH and stored at 171 MH.*"
>
> ****
>
> *"16. It is pertinent to ask here as to how a blanket & an assured statement be made that a blood transfusion carried out in 2002* ***is the only causative factor*** *for acquiring HIV infection in 2014 without ascertaining facts about the same."*

12. Meanwhile, proceedings of the Court of Inquiry (CoI) were held on 01.07.2018 to investigate circumstances under which the appellant was transfused blood at the 171 Military Hospital, Samba and the CoI concluded by its findings

[9] Dated 12.06.2018.

that blood provided to the appellant was duly screened for the HIV and other markers in vogue at the relevant time and on examination of all the witnesses, no negligence or lapse can be attributed on the part of physician or the support staff at the said military facility. During the proceedings, Lt Col Devika Bhat, posted as MO (Physician) at the 171 MH, Samba deposed that the blood transfused to the appellant was duly screened as per the guidelines and all necessary precautions were taken to prevent HIV transmission. It was further observed by the CoI that while the Release Medical Board has opined that infection can be attributed to service, but the specialist opinion before the Release Medical Board failed to mention essential details to establish a causative link between the blood transfusion in 2002 and the detection of infection in 2014.

13. The CoI further observed that:

> "*6. It is further emphasized that Specialist Opinion given during RMB has not mentioned about history of any sexual exposure, administration of IV Fluids or injections or any prolonged Hospital treatment which are other modes of transmission by HIV in the intervening period between Jul 2002 to may 2014 (period between blood transfusion at 171 MH and detection as HIV positive). Hence categorically attributing HIV infection of the individual to blood transfusion given in Jul 2002 may not be in order.*"

The CoI also observed that:

> "*8. [..] (d) All the available documents have been examined and it emerges that there were no lapses or negligence on the part of treating physician and supporting staff at 171 MH Samba and the blood bank staff of 166 MH Jammu as all policy/guidelines were followed for blood bank, screening of blood before Transfusion of one unit of blood to 741570B Ex Cpl Ashish Kumar Chauhan*."

14. The appellant filed a complaint before the Commission seeking compensation of ₹ 95,03,00,000 (₹95 crores 3 lakhs) plus litigation expenses of ₹ 10,000 per hearing and suitable pecuniary punishment to the delinquent officers.

II. Commission's Findings

15. The Commission dismissed the appellant's complaint and observed that no expert opinion was adduced or proved before it for establishing medical negligence during the blood transfusion against the respondent/opposite parties. It was also observed that no reason existed for the opposite parties to deny sharing of the appellant's medical records, and in fact, the discharge certificate, when found was duly supplied to the appellant.

16. The Commission also relied on provisions of Indian Medical Council (Professional Conduct Etiquettes and Ethics) Regulations, 2002 (hereafter "*IMC Professional Conduct Regulations*")[10] to observe that the hospital facility was not bound to preserve the appellant's medical records beyond the period of three years and thus there is no reason to believe that the authorities deliberately denied the appellant's medical records to him. The Commission also relied on the blood test report dated 05.03.2014 to hold that the appellant was not infected at the 171 Military Hospital, Samba, while denying the Medical Board's opinion dated 12.12.2014 and 24.06.2015 and a letter dated 14.12.2016 (as the same were not based on any evidence) and thus, no negligence was attributable to the respondents. Aggrieved by the findings of the Commission, the appellant has preferred an appeal before this court.

III. Proceedings in the present appeal

17. This court by an order dated 08.04.2022, considering the nature of the controversy involved in the impugned case, appointed Ms. Meenakshi Arora, learned senior counsel and Ms. Vanshaja Shukla, as *amici curiae* to appear on behalf of the appellant and assist the court.

18. By a letter order dated 25.04.2022, this court directed the respondents to submit the entire record pertaining to transfusion of blood on 10.07.2002 to the

[10] Clause 1.3.1 of Indian Medical Council (Professional Conduct Etiquettes and Ethics) Regulations, 2002.

appellant. As a consequence, 171 MH and 166 MH again searched their records and by letter dated 14.06.2022 and 13.06.2022 (from 171 MH and 166 MH respectively), submitted that they were unable to detect the appellant's medical records as they were destroyed in compliance with the policy of destruction of old documents.

IV. Submissions by the Appellant

19. The *amici* and the appellant argued that it is the onus of the respondents to establish that the two armed forces (Indian Army and IAF) were not negligent, because of the direct acts of their doctors and the hospital. Reference to a letter dated 12.06.2018 was made in which the Respondent No 1 admitted in writing that 171 MH was not authorized to operate any blood bank and therefore, no pathologist was authorized or appointed at the facility. The appellant also referred to an RTI reply[11] stating that "*there was no transfusion medicine expert (doctor) available and no blood grouping and cross-matching test report is available*".

20. The *amici* further argued that the respondents failed to provide any material evidence, such as the ELISA/HIV test and blood compatibility report of the blood unit that was transfused to the appellant in 2002, to demonstrate that they followed their own exhibited 'Transfusion Medicine Technical Manual and Standard Operating Procedures' that is to say that before any blood transfusion took place, it was compulsory to conduct an ELISA test of the blood unit to determine whether it was HIV infected or not, ensuring that it is safe for transfusion to HIV negative person. The appellant placed reliance on cases like *Smt. Savita Garg vs. The Director, National Heart Institute (hereafter, "Savita Garg")*[12]; *V. Kishan Rao v Nikhil Super Speciality Hospital & Another*[13]; *Nizam Institute of Medical Sciences v Prasanth S. Dhananka & Ors*. (hereafter, "*Nizam*

[11] Letter no. 4180/Adm./RTI/2019, dated 3.7.2019.
[12] [2004] SUPP. 5 S.C.R. 359.
[13] [2010] 5 S.C.R. 1.

Institute of Medical Sciences")[14], related to medical negligence, to support his contention that in cases of medical negligence, the burden of proof lies with the respondents and not with the appellant.

21. The *amici* and the appellant submitted that the respondents failed to secure a written informed consent bearing his signature both before the Commission as well as this court. As a consequence, the HIV negative report dated 5.3.2014 cannot be accepted. It was also contended that the report presented by the respondents is fraudulent and baseless since it was produced by them after a significant delay of more than seven years, which is contrary to Section 1.3.1 – "*Maintenance of Medical Records*" of the IMC Professional Conduct Regulations.[15] Additionally, the report lacks important details such as part-I, Lab Reference number, the name of the specific pathologist, and is mentioned as referred by *"self"*. To further counter the accusation that the appellant had concealed the HIV negative report dated 05.03.2014, he argued that the medical sheet and related documents were in the possession of the respondents. He was never given access to it, or a copy of it; hence, he could not have produced the same.

22. Reference was made to Chapter 16 of "*The Guidelines for HIV Testing, March 2007*", published by the National AIDS Control Organisation, Ministry of Health and Family Welfare, to highlight the importance of informed consent for HIV testing. The guideline states that any physician conducting an invasive procedure on a patient must obtain informed consent; in other words, the patient must be provided with adequate information about the necessity of blood

[14] [2009] 6 S.C.C. 1.

[15] Section 1.3.1 Maintenance of medical records**:**
1.3.1 *Every physician shall maintain the medical records pertaining to his/ her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India* [..]

transfusion, available alternatives, and the potential risks associated with both transfusion and non-transfusion options so as to make an informed decision.

23. Different medical opinions[16], medical board proceedings[17], and official letters[18] received by the appellant from respondents after his discharge from service, including the legal opinion of the command judge advocate, HQ SWAC[19], having categorically admitted the connection between the appellant's disability contracted due to reasons attributable to service and the blood transfusion of 10.07.2002, were relied upon. The appellant also challenged the disputed medical board proceeding dated 11.06.2014, which stated that the condition was not attributed to military services, by placing reliance on policies of respondents[20], the Drugs & Cosmetics Act, 1940 and rules thereunder including IMC Professional Conduct Regulations, and the guidelines for HIV testing along with 'Standards for Blood Banks & Blood Transfusion Services'.

24. It was further argued that since the respondents have explicitly admitted that the appellant contracted his disability due to the blood transfusion, there is no need for further deliberation on the matter, as per Section 58 of the Indian Evidence Act, 1872; an admitted fact need not be proven.

25. The appellant argued that the respondents claimed to have no records related to the appellant and the blood transfusion pertaining to the year 2002, stating that they were destroyed. However, they presented a receipt, issue, and expense voucher dated 12.01.2002 for two units of B-negative human blood, which was supplied by 166 Military Hospital (Blood bank) to 171 Military Hospital. The appellant questioned how the respondents were able to produce this document, which is available on record, after a gap of more than 20 years. The

[16] Dated 24.5.2014 by the Surg Capt. Vivek Hande of HIV Physician/expert, INHS Ashvini, Mumbai.
[17] Dated 12.12.2014, 24.6.2015, 21.12.2015.
[18] No. Air HQ/99798/1/741570/DAV(DP/RMB) dated 14.12.2016 and 29.8.2017.
[19] Letter no. SWAC/S1276/1/AD, dated 24.5.2016.
[20] IAP-4303 & GMO-2008.

appellant also referred to Section 18B[21] of the Drugs and Cosmetics Act, 1940, and the Drugs and Cosmetics Rules, 1945, which pertains to maintaining of the records and providing the information. According to this section, every person holding a license under clause (c) of Section 18 is obligated to keep and maintain prescribed records, registers, and other documents.

26. It was further argued that the CoI conducted by the respondents was with the participation of the Indian Army officers and witnesses, without involving or summoning the appellant. It appeared to be a mere formality as no documents were presented before this court. It was argued that this entire procedure was not only violative of principles of natural justice, and fair play but a ruse to discount the medical certificates and conclusions recorded which pointed to negligence of the Indian Army. This suggests that the records produced by the respondents were added as an afterthought. The respondents' contradictory statements about not maintaining records beyond three years, while at the same time also producing documents that are 7 to 20 years old, further weaken their case. Further, these records cannot be taken on record because the affidavit is signed by Capt. Alokesh Roy, officer In-charge of the Legal cell, Army Hospital (R & R) Delhi Cantt, claiming to be filed on behalf of the respondent. The respondents have failed to produce the copy of the notice/summons served to the appellant under Section 135 of the Army Act, 1950 regarding the CoI, which alleged that the appellant was called for the inquiry but did not attend its proceedings. Furthermore, the respondents never challenged the Medical Board proceedings dated 12.12.2014, 24.01.2015 and 21.12.2015, or the certificates issued by it, before the appellant initiated legal proceedings against them.

[21] 18B. Maintenance of records and furnishing of information. —Every person holding a licence under clause (c) of section 18 shall keep and maintain such records, registers and other documents as may be prescribed and shall furnish to any officer or authority exercising any power or discharging any function under this Act such information as is required by such officer or authority for carrying out the purposes of this Act.

27. The appellant further argued that the HIV expert's report cannot be considered as the said expert is a regular employee of the respondent's organization, and hence his opinion cannot be free from biases. He placed reliance on this court's decisions in *Fakruddin versus Principal, Consolidation Training Institute & Ors.*[22]; *State of Uttaranchal & Ors. Vs. Kharak Singh*[23], and *A. K. Kraipak & Ors. Vs. UOI & Ors*.[24] Arguing further on biases, the appellant turned the Court's attention to the fact that one of the members of the Commission bench was a retired Defence Secretary.

28. It was further argued that due to him being HIV positive, the appellant was deemed unfit for re-employment and extension of service. Consequently, he was discharged from permanent service in the Indian Air Force. In fact, he was later selected by the Food Corporation of India. But, due to his HIV positive status, the Food Corporation of India rejected the appellant on medical grounds. Additionally, his medical condition led to divorce and the loss of family support.

29. The appellant relied on Chapter 3 of the National Guidelines for HIV testing to assert that antibody detection tests are not effective during the window period when antibodies are not yet detectable. Additionally, the appellant referred to *Guidelines on HIV Testing* (March 2007) published by the National AIDS Control Organisation (hereafter "NACO"), which states that the disease's rate of progression depends on viral characteristics and host factors, ranging from 1 year to more than 15-20 years. NACO has also certified that around 5% of HIV-infected individuals, known as *"long term non-progressors"* (hereafter, "LTNPs"), do not experience disease progression for an extended period. It was urged that the appellant's case fell under such a category. To further substantiate this submission, the appellant cited a judgment from the Supreme Court of New

[22] [1995) SUPP. 1 S.C.R 389.
[23] [2008] 12 S.C.R. 54.
[24] [1970] 1 S.C.R. 457.

Jersey in the case of *State ex rel. J. G., N. S. & J. T*[25]. wherein, the court observed that a negative HIV test result for the accused does not necessarily mean they are not infected with HIV. It could be due to the "window period", during which HIV tests may provide inaccurate results.

30. It was argued that respondents had, through various letters[26] admitted that the appellant qualifies as a consumer under Section 2 (l) (d) (ii) of the Consumer Protection Act, 1986, (hereafter "CPA 1986") as the appellant, being a permanent employee of the IAF, availed medical services from the respondents as defined under the same section. The appellant placed reliance on the judgments of this court, including *M/S. Spring Meadows Hospital & Anr. versus Harjol Ahluwalia Through K.S. Ahluwalia & Anr. (hereafter, "Spring Meadows")*[27]; *Kishore Lal vs. Chairman, Employee State Insurance Corporation (hereafter, "Kishore Lal")*[28]; *Laxman Thamappa Kotgiri v G. M., Central Railway (hereafter, Laxman Thamappa Kotgiri")*[29]; and *Savita Garg vs. The Director, National Heart Institute*[30], to further substantiate his submission.

31. The *amici* and the appellant urged the court that the facts show that there was negligence and reckless disregard of the ordinary care expected of the medical experts, when the blood transfusion took place. It was contended that the court should grant all the reliefs available in law, such as monetary compensation towards loss of income, till the date of normal superannuation, taking into account that he would have been in a position to retire as a Junior Commissioned Officer, at the age of at least 58 years. At the very least, his services as non-commissioned personnel would have been ordinarily extended for another seven years. The

[25] Decided on September 25, 1997.
[26] Vide Letter No. SWAC/ 3451 / 1103 / PIO, dated 20th Feb 2017; vide Letter No. SWAC / 3451 / 1103 / PIO, dated 14.03.2017; vide Letter No. Air HQ / 23401/2O4/ 4 / 11245 /E / PS, dated 26.04.2017; vide Letter No. DCA / Pen -III / Court Case /2018, Dated 07.01.2019.
[27] [1998] 2 S.C.R. 428.
[28] [2007] 6 S.C.R. 139.
[29] (2007) 4 SCC 596.
[30] [2004] SUPP. 5 S.C.R. 359.

amici submitted that the present condition of the appellant is fraught as his condition has worsened and he is almost in a state of dependency as he has to rely on the assistance of a support person, cannot move about freely and is frequently fatigued. It was further submitted that the transfusion, without seeking informed consent, without ensuring observance of minimum safeguards and later, stonewalling the appellant, denying access to his medical records, and even seeking to deny their liability, by holding a CoI, - the reason for whose setting up was only to discount previous medical certification- and the insinuations aimed at the appellant, caused him immense mental agony, for which suitable and deterrent compensation is warranted. It was also submitted that the attitude and behaviour of the respondents in providing treatment to the appellant, which he is entitled to in accordance with the applicable rules, as a person discharged on medical grounds, and certified to a certain extent of disability, has eroded his confidence. Therefore, the court should issue suitable directions for his continued medical treatment, in an alternative manner, or suitably compensate him. It was highlighted that the response and indifference of the respondents has caused intense mental agony to the appellant, which should be separately compensated. The *amici* also highlighted that the appellant's effort to secure employment has turned to naught, because though he was almost selected for a post, the future employer, i.e., the Food Corporation of India (FCI), rejected his application, when it became aware that he was HIV positive. A response to the appellant's RTI query, given by the FCI on 17.02.2018 in this context was placed on the record.

V. Submissions on Behalf of Respondents

32. Learned counsel appearing for the Indian Army and IAF, Additional Solicitor General – Mr. Vikramjit Banerjee (hereafter "ASG") submitted that the appellant failed to prove medical negligence attributable to the respondents and that no medical report submitted on record establishes negligence on their part.

33. It was submitted by the ASG that the appellant is not a 'consumer' in terms of Section 2(1)(d)[31] of the CPA 1986, he was entitled to, and availed medical services from armed forces hospitals free of cost and the services provided by the armed forces hospital is not a service under the Section 2(1)(o)[32] of the CPA 1986. Such services are provided without any consideration. Reliance was placed on following observations of this court's judgment in *Nivedita Singh v Dr Asha Bharti*[33]:

> *"6. A reading of the above para shows that a medical officer who is employed in a hospital renders service on behalf of the hospital administration and if the service as rendered by the Hospital does not fall within the ambit of 2(1)(o) of the Act being free of charge, the same service cannot be treated as service Under Section 2(1)(o) for the reasons that it has been rendered by medical officer in the hospital who receives salary for the employment in the hospital. It was thus concluded that the services rendered by employee-medical officer to such a person would therefore continue to be service rendered free of charge and would be outside the purview of Section 2(1)(o) of the Act."*

34. The learned ASG relied on the judgment of *Jacob Mathew v State of Punjab*[34] and *Martin F D'Souza v Mohd Ishfaq (hereafter, "Martin F.*

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[31] (d) "consumer" means any person who,--
(i) buys any goods for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any user of such goods other than the person who buys such goods for consideration paid or promised or partly paid or partly promised, or under any system of deferred payment, when such use is made with the approval of such person, but does not include a person who obtains such goods for resale or for any commercial purpose; or
(ii) [hires or avails of] any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who [hires or avails of] the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person [but does not include a person who avails of such services for any commercial purpose]; [Explanation.--For the purposes of this clause, "commercial purpose" does not include use by a person of goods bought and used by him and services availed by him exclusively for the purposes of earning his livelihood by means of self-employment.]

[32] (o) "service" means service of any description which is made available to potential [users and includes, but not limited to, the provision of] facilities in connection with banking, financing insurance, transport, processing, supply of electrical or other energy, board or lodging or both, [housing construction,] entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service."
[33] 2021 SCC OnLine SC 3165.
[34] [2005] Supp 2 SCR 307; (2005) 6 SCC 1.

D'Souza")[35] to contend that in cases of medical negligence, courts must refer the matter to a competent doctor or a specialized committee in the relevant field and only on the recommendation of such expert giving prima facie finding of medical negligence that doctor should be summoned. And in the present case, the appellant has not produced any expert opinion to substantiate his claim of medical negligence.

35. Reliance was also placed on the medical report dated 05.03.2014, issued when the appellant was admitted to the hospital facility at MH Ahmedabad, owing to Pneumonia. This medical report stated that the appellant was detected HIV negative, which shows that the appellant was HIV negative for a period of 12 years (i.e., from July 2002 to March 2014).

36. It was further submitted that IMC Professional Conduct Regulations requires consent only for the purpose of surgical treatment, and blood transfusion not being a surgical treatment, consent of the appellant is not mandatory and at no point of time treatment was forced upon the appellant. It was further argued that Medical Boards are not the primary source of evidence in relation to the detection of HIV infection disease, and the test report dated 05.03.2014 must be considered as primary evidence.

37. Learned ASG further submitted that the appellant failed to show any connection between the transfusion of blood and HIV positive status of the appellant. It was argued that the findings of the Medical Board as to the disability of the appellant being attributed to service was solely for the purpose of granting disability pension and the same findings cannot be used to infer negligence on the part of the respondent authorities. Further, the CoI too, after examining all witnesses and their statements and evidence, observed that not only the documents pertaining to blood transfusion and screening of blood were not

[35] [2009] 3 SCR 273; (2009) 3 SCC 1.

available with the 171 MH but also observed that blood was properly screened prior to being transfused to the appellant.

38. It was further argued that the appellant failed to show any causation between the blood transfusion and his eventually being infected with the virus. There was a *'novus actus interveniens'* that led to the appellant being infected with the HIV virus. To substantiate this, the ASG urged that even when the appellant was admitted to the hospital on 31.04.2002 (i.e., before blood transfusion), he showed symptoms of 'macrocytic anaemia' and even in February 2014, when he was admitted to the Military Hospital, Ahmedabad, symptoms of 'macrocytic anemia' were present. Relying on research papers in the field[36], it was submitted that anemia is the most frequent and common abnormality associated with HIV, which the appellant had in 2002, even before he was admitted to the hospital for blood transfusion and thus, it cannot be ascertained with conviction that appellant acquired HIV due to blood transfusion and not from any other source.

39. It was further submitted that no adverse inference against the respondent can be drawn from the non-availability of the appellant's medical reports with the respondents as the same have been weeded out. Additionally, the respondents are not required to maintain the appellant's medical record beyond a period of three years as per IMC Professional Conduct Regulations and there is no obligation to preserve the said medical documents beyond this period specially when 171, Military Hospital itself is a temporary hospital.

Regulation 1.3 of the IMC Professional Conduct Regulations reads as:

> *"Section 1.3 Maintenance of medical records:*
>
> *1.3.1 Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of*

[36] Including – "*Haematological changes in HIV infection with correlation to CD4 cell count*" published in Australasian Medical Journal and a Lancet Article titled "*Prevalence of anemia among people living with HIV: A systematic review and meta analysis*".

commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3."

40. Learned counsel also placed reliance on communication dated 24.05.2016[37], wherein legal opinion of the case was provided by Command Judge Advocate (CJA). The opinion states that the appellant is wrong in blaming the organization for his divorce as the Family Court passed the divorce decree with the mutual consent of both the parties under Section 13B of the Hindu Marriage Act, 1955 and the same cannot be attributed to the respondent authorities.

41. Learned ASG further contended that the consumer complaint filed by the Complaint before the Commission is grossly time barred and he has failed to demonstrate any sufficient cause for condoning the delay. Impugning the *bona-fides* of the appellant, it was argued that he had discovered HIV infection in the year 2014 itself but approached the Commission only in 2017 and the appellant had symptoms of immunodeficiency during 2002 and 2014. Yet he has attempted to conceal those facts at earlier stages. It was further argued that it was not possible for the appellant to remain asymptomatic for a period of 12 years after being infused with the virus specially when an infection is transmitted through blood transfusion as in such cases, viral load is greater and disease manifests comparatively early.

42. It was submitted that HIV can be caused because of various reasons, such as unprotected sexual intercourse with an HIV infected person; blood transfusion; sharing of HIV infected needles; transfer of HIV virus by infected mother to her baby before birth, or after birth, by breastfeeding. In the facts of this case, the appellant did not establish any definite causal relationship between infection in 2002 and his acquiring HIV positive status in 2014 as a direct and only result of his being admitted and given the blood transfusion in 171 MH. The records reveal

[37] Forwarding of personal application 741570-B CPL AK Chauhan ADSO in Letter no. SWAC/S1276/1/AD, dated 24.5.2016.

that the appellant was referred to 171 MH in 2002 as he was afflicted with microcytic anemia; loss of appetite, discoloration of urine, 5 kg weight loss in 5 months, fever and dyspepsia. When admitted in February 2014, at MH Ahmedabad, the appellant was suffering from conditions such as H1N1 virus (swine flu); macrocytic anemia; subhyalodid hemorrhage. The effect of transfusion in 2002 led to considerable improvement in the appellant's overall medical condition. It was submitted that during the CoI, the concerned pathologist of 166 MH at the relevant time, produced records showing that two units of B-negative blood were indented to 171 MH on 12.01.2002. No records showing blood units given to 171 MH for June- July 2002 were available. Therefore, at best, there was no evidence which could establish to any extent that HIV infected blood was transfused. In these circumstances, there is no question of negligence by the respondents or vicarious liability for their negligence of the IAF or the Indian Army.

VI. ANALYSIS

(i) Jurisdiction

(a) Is appellant's case covered under CPA 1986:

43. The first question that the court has to consider is whether the appellant's case is under the CPA 1986. The respondents contend that the appellant cannot claim to be a consumer, and the medical facilities extended to him, through the IAF and army hospitals, do not fall within the ambit of the CPA 1986, because all armed force personnel are required, as part of their duties, to show fitness, and are subjected to periodic mandatory medical tests. The terms and conditions of engagement of armed forces personnel, and the army/IAF ecosystem are geared to ensure the fitness and sound medical shape of its personnel. Therefore, even the doctors and other personnel within the medical system are subjected to

army/IAF discipline and rules and regulations. In these circumstances, Army hospitals and similar facilities cannot be considered as covered by CPA 1986.

44. It would be useful to extract the relevant regulation (applicable to Indian army personnel), which is contained in Regulation 173 of the Pension Regulations for the Army, 1973 (hereafter "*Army Pension Regulations*"):

> *"173. Primary Conditions for the grant of Disability Pension*
> *Unless otherwise specifically provided a disability pension consisting of service element and disability element may be granted to an individual who is invalided out of service on account of a disability which is attributable to or aggravated by military service in non-battle casualty and is assessed at 20 per cent or over."*

45. Chapter III of the IAF Pension Regulations, 1961, applies to airmen, i.e., non-commissioned personnel and officers, such as the appellant, which spells out its application by Rule 101. Rule 111 renders all service, rendered up to the date of discharge of the airman, eligible for counting of pensionary service. Rule 153 reads as follows:

> *"153. Unless otherwise specifically provided, a disability pension may be granted to an individual who is invalided from service on account of a disability which is attributable to or aggravated by air force service and is assessed at 20 per cent or over. The question whether a disability is attributable to or aggravated by air force service shall be determined under the regulations in Appendix II"*

Appendix II deals with the principles to be applied for deciding disability.

46. In *Pani Ram vs. Union of India*[38], this court, while upsetting a decision of the Armed Forces Tribunal rejecting a claim for disability pension, for an army personnel, held, inter alia, on a reading of the Army Pension Regulations that:

> *"18. The perusal thereof will reveal that an individual who is invalided out of service on account of disability, which is attributable or aggravated by Military Service in non-battle casualty and is assessed 20% or more, would be entitled to disability pension. The Respondents are not in a position to point out any*

[38] 2021 (9) SCR 1024.

> *Rules or Regulations, which can be said to be inconsistent with Regulation No. 292 or 173, neither has any other Regulation been pointed out, which deals with the terms and conditions of service of ETF."*

Further, the court had remarked, poignantly that:

> *"23. As held by this Court, a Right to Equality guaranteed Under Article 14 of the Constitution of India would also apply to a man who has no choice or rather no meaningful choice, but to give his assent to a contract or to sign on the dotted line in a prescribed or standard form or to accept a set of Rules as part of the contract, however unfair, unreasonable and unconscionable a Clause in that contract or form or Rules may be. We find that the said observations rightly apply to the facts of the present case. Can it be said that the mighty Union of India and an ordinary soldier, who having fought for the country and retired from Regular Army, seeking re-employment in the Territorial Army, have an equal bargaining power. We are therefore of the considered view that the reliance placed on the said document would also be of no assistance to the case of the Respondents."*

47. Certain decisions of this court, in this regard, are illuminating. *Savita Garg* (Supra) dealt with this aspect, and referred to the previous ruling in *Indian Medical Assn.* v. *V.P. Shantha* (hereinafter, "V.P. Shantha")[39]:

> *"This Court has dealt with all aspects of the medical profession from every angle and has come to the conclusion that the doctors or the institutes owe a duty to the patients and they cannot get away in case of lack of care to the patients. Their Lordships have gone to the extent that even if the doctors are rendering services free of charge to the patients in government hospitals, the provisions of the Consumer Protection Act will apply since the expenses of running the said hospitals are met by appropriation from the Consolidated Fund which is raised from taxes paid by the taxpayers. Their Lordships have dealt with the definition of "service" given in Section 2(1)(o) of the Consumer Protection Act, 1986, and have observed as follows:*
>
> *"The services rendered free of charge to patients by doctors/hospitals, whether non-government or government, who render free service to poor patients but charge fees for services rendered to other patients would, even though it is free, not be excluded from definition of service in Section 2(1)(o). The Act seeks to protect the interests of consumers as a class. To hold otherwise would mean that the protection of the Act would be available to only those who can afford to pay and such protection would be denied to*

[39] 1995 Supp (5) SCR 110.

those who cannot so afford, though they are the people who need the protection more. It is difficult to conceive that the legislature intended to achieve such a result. Another consequence of adopting a construction, which would restrict the protection of the Act to persons who can afford to pay for the services availed by them and deny such protection to those who are not in a position to pay for such services, would be that the standard and quality of services rendered at an establishment would cease to be uniform. It would be of a higher standard and of better quality for persons who are in a position to pay for such service while the standard and quality of such service would be inferior for persons who cannot afford to pay for such service and who avail the service without payment. Such a consequence would defeat the object of the Act. All persons who avail the services by doctors and hospitals who give free service to poor patients but charge fee for others, are required to be treated on the same footing irrespective of the fact that some of them pay for the service and others avail the same free of charge. Most of the doctors and hospitals work on commercial lines and the expenses incurred for providing services free of charge to patients who are not in a position to bear the charges are met out of the income earned by such doctors and hospitals from services rendered to paying patients. The government hospitals may not be commercial in that sense but on the overall consideration of the objectives and the scheme of the Act it would not be possible to treat the government hospitals differently. In such a situation the persons belonging to 'poor class' who are provided services free of charge are the beneficiaries of the service which is hired or availed of by the 'paying class'. Service rendered by the doctors and hospitals who render free service to poor patients and charge fees for others irrespective of the fact that part of the service is rendered free of charge, would nevertheless fall within the ambit of the expression 'service' as defined in Section 2(1)(o) of the Act."

48. *Laxman Thamappa Kotgiri* (supra) was a case where a railway employee was aggrieved by the negligent treatment of his wife, resulting in her death. His complaint was rejected, on the premise that the railway hospital where the treatment was given, was a part of his condition of service wherein he and his dependents were provided medical advice and treatment, free of charge. This court upset those findings and held the complaint maintainable:

"6. There is no dispute that the hospital in question has been set up for the purpose of granting medical treatment to the railway employees and their dependants. Apart from the nominal charges which are taken from such an employee, this facility is part of the service conditions of the railway employees. V.P. Shantha case [(1995) 6 SCC 651] has made a distinction between non-

governmental hospital/nursing home where no charge whatsoever was made from any person availing of the service and all patients are given free service [vide para 55(6) at p. 681] and services rendered at government hospital/health centre/dispensary where no charge whatsoever is made from any person availing of the services and all patients are given free service [vide para 55(9)] on the one hand and service rendered to an employee and his family members by a medical practitioner or a hospital/nursing home which are given as part of the conditions of service to the employee and where the employer bears expenses of the medical treatment of the employee and his family members [para 55(12)] on the other. In the first two circumstances, it would not (sic) be free service within the definition of Section 2(1)(o) of the Act. In the third circumstance it would (sic not) be.

7. Since it is not in dispute that the medical treatment in the said hospital is given to employees like the appellant and his family members as part of the conditions of service of the appellant and that the hospital is run and subsidised by the appellant's employer, namely, the Union of India, the appellant's case would fall within the parameters laid down in para 55(12) of the judgment in V.P. Shantha case [(1995) 6 SCC 651] and not within the parameters of either para 55(6) or para 55(9) of the said case.

8. It is true that the decision in State of Orissa v. Divisional Manager, LIC [(1996) 8 SCC 655] relied upon by the learned counsel for the respondents appears to hold to the contrary. However, since the decision is that of a smaller Bench and the decision in V.P. Shantha [(1995) 6 SCC 651] case was rendered by a larger Bench, we are of the opinion that it is open to this Court to follow the larger Bench which we will accordingly do."

Even in the case of employees who had contributed in part, the other contributions being from employers, under the Employees State Insurance Corporation scheme, this court had held that the services rendered by ESI hospitals were not gratuitous and that the ESI doctors fell within the ambit of the CPA 1986, in *Kishore Lal* (supra):

"13. On a plain reading of the aforesaid provisions of the ESI Act, it is apparent that the Corporation is required to maintain and establish the hospitals and dispensaries and to provide medical and surgical services. Service rendered in the hospital to the insured person or his family members for medical treatment is not free, in the sense that the expense incurred for the service rendered in the hospital would be borne from the contributions made to the insurance scheme by the employer and the employee and, therefore, the principle enunciated in Conclusion (11) in para 55 in Indian

> *Medical Assn. [(1995) 6 SCC 651] will squarely apply to the facts of the present case, where the appellant has availed the services under the insurance policy which is compulsory under the statute. Wherever the charges for medical treatment are borne under the insurance policy, it would be a service rendered within the ambit of Section 2(1)(o) of the Consumer Protection Act. It cannot be said to be a free service rendered by the ESI hospital/dispensary.*
> *14. The service rendered by the medical practitioners of hospitals/nursing homes run by ESI Corporation cannot be regarded as a service rendered free of charge. The person availing of such service under an insurance scheme of medical care, whereunder the charges for consultation, diagnosis and medical treatment are borne by the insurer, such service would fall within the ambit of "service" as defined in Section 2(1)(o) of the Consumer Protection Act. We are of the opinion that the service provided by the ESI hospital/dispensary falls within the ambit of "service" as defined in Section 2(1)(o) of the Consumer Protection Act. ESI scheme is an insurance scheme and it contributes for the service rendered by the ESI hospitals/dispensaries, of medical care in its hospitals/dispensaries, and as such service given in the ESI hospitals/dispensaries to a member of the Scheme or his family cannot be treated as gratuitous."*

49. Section 1 (4) of CPA 1986, (which was in force when the appellant preferred his complaint) reads as follows:

> ***"1. Short title, extent, commencement and applications:***
>
> .....
>
> *(4) Save as otherwise expressly provided by the Central Government by notifications, this Act shall apply to all goods and services."*

50. Earlier, keeping in line with the reasoning that furthered the objectives of the CPA 1986, spelt out in *V.P. Shantha,* this court had rejected, in *Regional Provident Fund Commissioner v Shiv Kumar Joshi*[40]*:*

> *"We cannot accept the argument that the Regional Provident Fund Commissioner, being Central Government, cannot be held to be rendering "service" within the meaning and scheme of the Act. The Regional Provident Fund Commissioner, under the Act and the Scheme discharges statutory functions for running the Scheme. It has not, in any way, been delegated with the sovereign powers of the State so as to hold it as a Central Government, being not the authority rendering the "service" under the Act. The Commissioner is a separate and distinct entity. It cannot legally claim that the facilities provided by the "Scheme" were not "service" or that the*

[40] 1999 (5) Suppl. SCR 294.

> *benefits under the Scheme being provided were free of charge. The definition of "consumer" under the Act includes not only the person who hires the "services" for consideration but also the beneficiary, for whose benefit such services are hired. Even if it is held that administrative charges are paid by the Central Government and no part of it is paid by the employee, the services of the Provident Fund Commissioner in running the Scheme shall be deemed to have been availed of for consideration by the Central Government for the benefit of employees who would be treated as beneficiaries within the meaning of that word used in the definition of "consumer".*

51. In *Haryana Urban Development Authority v Vidya Chetal*[41], this court, speaking through a three-judge bench, held that:

> *"..if the statutory authority, other than the core sovereign duties, is providing service, which is encompassed under the Act, then, unless any statute exempts, or provides for immunity, for deficiency in service, or specifically provides for an alternative forum, the consumer forums would continue to have the jurisdiction to deal with the same. We need to caution against over-inclusivity and the tribunals need to satisfy the ingredients under Consumer Protection Laws, before exercising the jurisdiction."*

52. In the latest decision, *Joint Labour Commissioner v Kesar Lal*[42], this court, dealt with the issue of whether a construction worker registered under the Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 and a beneficiary of the scheme made under the rules framed under the enactment, is a 'consumer' within the meaning of Section 2(d) of the CPA 1986. The court rejected the statutory authority's appeal, after reviewing a host of precedents:

> *"14. [..] Public authorities such as the appellants who have been constituted under an enactment of Parliament are entrusted with a solemn duty of providing welfare services to registered workers. The workers who are registered with the Board make contributions on the basis of which they are entitled to avail of the services provided in terms of the schemes notified by the Board. Public accountability is a significant consideration which underlies the provisions of the Consumer Protection Act 1986. The evolution of jurisprudence in relation to the enactment reflects the need to ensure a sense of public accountability by allowing consumers a redressal in the context of*

[41] 2019 (12) SCR 516.
[42] 2020 (5) SCR 176.

the discharge of non-sovereign functions which are not rendered free of charge. This test is duly met in the present case."

(b) Alternative basis for exercising jurisdiction:

53. There are several precedents of this court, which justify the exercise of jurisdiction under Article 32 of the Constitution. The most celebrated decision is that of *Nilabati Behara v State of Orissa*[43], where the jurisdiction of the court was highlighted in the following terms:

> *"'a claim in public law for compensation' for contravention of human rights and fundamental freedoms, the protection of which is guaranteed in the Constitution, is an acknowledged remedy for enforcement and protection of such rights, and such a claim based on strict liability made by resorting to a constitutional remedy provided for the enforcement of a fundamental right is 'distinct from, and in addition to, the remedy in private law for damages for the tort' resulting from the contravention of the fundamental right. The defence of sovereign immunity being inapplicable, and alien to the concept of guarantee of fundamental rights, there can be no question of such a defence being available in the constitutional remedy. It is this principle which justifies award of monetary compensation for contravention of fundamental rights guaranteed by the Constitution, when that is the only practicable mode of redress available for the contravention made by the State or its servants in the purported exercise of their powers, and enforcement of the fundamental right is claimed by resort to the remedy in public law under the Constitution by recourse to Articles 32 and 226 of the Constitution."*

54. This court declared the importance of reaching out to injustice and using its powers, including under Article 142 of the Constitution, in the following terms, in *Delhi Development Authority v. Skipper Construction Co. (P) Ltd*[44]*:*

> *"It is conceived to meet situations which cannot be effectively and appropriately tackled by the existing provisions of law. As a matter of fact, we think it advisable to leave this power undefined and uncatalogued so that it remains elastic enough to be moulded to suit the given situation. The very fact that this power is conferred only upon this Court, and on no one else, is itself an assurance that it will be used with due restraint and circumspection, keeping in view the ultimate object of doing complete justice between the parties."*

[43] 1993 (2) SCC 746.
[44] 1996 (2) Suppl. SCR 295.

Earlier, in *Anadi Mukta Sadguru Shree Muktajee Vandas Swami Suvarna Jayanti Mahotsav Smarak Trust v. V.R. Rudani*[45], this Court examined the development of the law of mandamus and held as under:

> *"[…] mandamus cannot be denied on the ground that the duty to be enforced is not imposed by the statute. Commenting on the development of this law, Professor de Smith states: 'To be enforceable by mandamus a public duty does not necessarily have to be one imposed by statute. It may be sufficient for the duty to have been imposed by charter, common law, custom or even contract.' (Judicial Review of Administrative Action, 4th Edn., p. 540). We share this view. The judicial control over the fast expanding maze of bodies affecting the rights of the people should not be put into watertight compartment. It should remain flexible to meet the requirements of variable circumstances. Mandamus is a very wide remedy which must be easily available 'to reach injustice wherever it is found'. Technicalities should not come in the way of granting that relief under Article 226. We, therefore, reject the contention urged for the appellants on the maintainability of the writ petition."*

This court, very aptly expressed, in the larger Bench decision, reported as *P.S.R. Sadhanantham v. Arunachalam*[46], the jurisdiction of the court, to entertain a criminal appeal by the informant, where the accused was acquitted, and no appeal had been entertained by the state (without any statutory basis or *locus* for such complainant/petitioner) alluding to considerations of justice:

> *"3. The jural reach and plural range of that judicial process to remove injustice in a given society is a sure index of the versatile genius of law-inaction as a delivery system of social justice. By this standard, our constitutional order vests in the summit Court of jurisdiction to do justice, at once omnipresent and omnipotent but controlled and guided by that refined yet flexible censor called judicial discretion. This nidus of power and process, which master-minds the broad observance throughout the Republic of justice according to law, is Article 136."*

55. This court is conscious that if there are any statutory conditions or limitations, its exercise of Article 142 jurisdiction would have to weigh that in; further, the *kind of relief* to be given in any one case is entirely fact dependent

[45] 1989 (2) SCR 697.
[46] 1980 (2) SCR 873.

and involves taking into account all relevant factors, subjective to the record in that case.

(c) Can the court consider questions of fact:

56. This aspect, i.e., the court's ability and jurisdiction to appreciate facts, really is uncontestable; even in writ proceedings, the so-called "hands off" bogey of "disputed questions of fact" which ordinarily constrain the courts, under Articles 32 and 226 from exercising jurisdiction, are to be seen in the context of the facts of each case. No doubt, usually the courts would not primarily exercise jurisdiction to enter into the arena of disputed facts. Yet, on occasions, the court has underlined that such an approach is dictated by considerations of convenience, rather than a rigid rule calling for universal application. Therefore, in *Gunwant Kaur v Municipal Committee Bhatinda (hereafter, "Gunwant Kaur")*[47], this court held:

> *"The High Court has jurisdiction to determine questions of fact, even if they are in dispute and the present, in our judgment, is a case in which in the interests of both the parties the High Court should have entertained the petition and called for an affidavit-in-reply from the respondents, and should have proceeded to try the petition instead of relegating the appellants to a separate suit."*

57. This court applied the *ratio* in *Gunwant Kaur*, in *ABL International Ltd. & Anr. V Export Credit Guarantee Corporation of India Ltd. & Ors.*[48]*:*

> *"19. Therefore, it is clear from the above enunciation of law that merely because one of the parties to the litigation raises a dispute in regard to the facts of the case, the court entertaining such petition under Article 226 of the Constitution is not always bound to relegate the parties to a suit. In the above case of Gunwant Kaur [(1969) 3 SCC 769] this Court even went to the extent of holding that in a writ petition, if the facts require, even oral evidence can be taken. This clearly shows that in an appropriate case, the writ court has the jurisdiction to entertain a writ petition involving disputed questions of fact and there is no absolute bar for entertaining a writ petition*

[47] 1969 (3) SCC 769.
[48] (2004) 3 SCC 553.

> *even if the same arises out of a contractual obligation and/or involves some disputed questions of fact"*

The *ratio* of these decisions was also followed in *Unitech v Telangana State Industrial and Infrastructural Development Corporation*[49].

58. In the light of these decisions, this court holds that even if, *arguendo* for some reason, appellate jurisdiction is contested, this court deems that it would be unfair to drive the appellant to a fresh civil proceeding, particularly having regard to his vulnerability, and would instead, combine its power, drawing the source of its jurisdiction under Articles 32 and 142 of the Constitution, especially since the respondents are the armed forces and its authorities. The exercise of jurisdiction is legitimate and warranted, since the court has before it, all the factual material, supported by the affidavit of the parties.

(ii) Facts as appearing from the record

59. The blood transfusion in the present case, took place on 10.07.2002. The appellant was admitted to 171 MH on medical advice, in the third week of June 2002; after his transfusion, his overall condition improved; he was admitted as a case of anorexia with a low Hb count of Hb 6.3 % g; which improved on the date of his discharge (31-07-2002); he was found fit for discharge. When he felt discomfort, he was admitted to a Military Hospital Ahmedabad; the blood test did not indicate abnormality. Early, in the year 2014, he was admitted to the Military Hospital, Ahmedabad, on 14.03.2014 and diagnosed with *"Acute Gastroenteritis"* and *"Sceptic shock".* The ultrasound report indicated *"Hepatic disease"*. The blood report did not indicate any abnormality, other than an unusual hemoglobin level (9.3g%). He was later required to report to INHS Ashvini, and declared fit for travel in the entitled class, on diagnosis of *"Sepsis Secondary to Pneumonia"* and *"Azotemia"* by medical advice issued by Military

[49] 2021 (1) SCR 1064.

Hospital Ahmedabad, on 19.05.2014. He was admitted to the naval ship INHS Ashvini, when on 21.05.2014, he was detected for the first time, to be infected with Positive HIV-1 antibodies, as a result of the ELISA test. He was prescribed medication; he started taking treatment. The medical board proceedings dated 11.06.2014 detected disability; however, it stated that the *"disability is not attributable to service".* The next medical board proceeding certificate dated 12.12.2014 described the appellant as suffering from a disability which was described as having been caused by *"one unit of blood transfusion on 10.7.2002 in 171 MH."* Against the column whether the disability was attributable to service, the certificate stated that *"yes. One unit of blood transfusion on 10.7.2002 in 171 MH"*. By the medical board proceedings dated 24.06.2015, the cause of the appellant's condition was described as (Col. 17) which was caused by *"one unit of blood-transfusion on 10 Jul 2002 in 171 MH".* The opinion of the Surgeon Commander dated 16.12.2015 was that the petitioner was a *"39 years old serving air warrior is an old case of above-mentioned disability in LMC A4G4 (P) w.e.f 24 Jun 15 and due on 29 May 15. Individual reported. To SMC for 06 monthly review at INHS Asvini Release medical board. Individual was admitted and transferred to INHS Asvini for the opinion of Gastroenterologist. He was opined and recommended to be place in LMC P3 (p). Now individual reported back to SMC for holding Release medical board"*. Based on this, and the medical record, the opinion of the board dated 21.12.2015 was that *"Disability developed due to one unit of blood transfusion on 10 Jul 2002, 171 MH. Hence consider Attributable".* The letter (dated 21.12.2015) indicated that the appellant was to be discharged on 31.05.2016. This assessment was accepted by the IAF, which approved his medical fitness category and also rated his disability percentage on 22 January 2016 (by Group Capt. N.T. Manikantan), the approving authority. The sanction of the disability element of the pension letter, dated 29.08.2017 (EX/741570 CPL Ashish Kumar Chauhan) issued by Air Headquarters described

the disability element sanctioned by the discharge letter, based on the attributability found by the previous boards.

60. The learned ASG sought to attribute some sympathy, as the basis for maintaining that the disability was attributable to service. However, the conduct of the respondents points to entirely different facts. Initially, the respondents' endeavor was to deny access to relevant information altogether, to the appellant. His repeated RTI queries were turned down; for quite some time, he was also denied access to his medical records. The IAF does not appear to have communicated the discharge order, separately to him. No doubt, he refused to sign the medical board proceedings; however, there is nothing forthcoming on the record, to show that the IAF delivered the discharge order, on any particular date, or communicated it to him. The affidavits of IAF also do not disclose that there was ever any such communication.

61. In this background, it is significant to notice some facts and developments. The notice of the appellant's complaint was issued by the Commission/NCDRC on 20.06.2017. The documents placed on the record, demonstrate and establish that the CoI was constituted in response and an answer to the appellant's complaint. This is clear from the letter (No. B/76779/AK Chauhan/DGMS-5B/GC-75) dated 04.05.2018 written by the Directorate General Medical Service, (Army Adjutant Branch) to the HQ Western Command (Medical). After instructing the relevant officials to trace the documents necessary to prepare the counter affidavit, to the appellant's complaint, it was suggested that:

> *"In view of the above, it is requested to order a C of I under the aegis of your HQ for the following:*
>
> *(a) to bring out the detailed facts pertaining to blood transfusion done at 171 MH in 2002*
>
> *(b) To investigate and bring out the authority which provided the unit of blood and whether the same was duly screened as per the policy/guidelines in vogue at that time.*

(c) to bring out all supporting documents pertaining to blood demand, blood transfusion and screening of blood along with SOP/guidelines in vogue at that time.

(d) to investigate into the matter and pin point the lapses or negligence if any and the individuals responsible thereto."

62. It was in these circumstances, that the CoI was constituted. It is an undisputed fact that though the appellant was the subject matter of that proceeding, none of the respondents cared to involve him or inform him about it. The proceedings scrupulously excluded him, despite the real likelihood of an adverse consequence as the likely outcome. What is clearly discernable from the proceedings in the CoI therefore, is that:

(a) Many of the documents, pertaining to appellant's treatment were denied, and repeatedly the respondents denied access to him. However, many documents emerged- selectively, including the admission and discharge slips signed by the treating doctor (Lt. Col. Devika Bhat).

(b) The documents which respondents stated were missing, somehow were traced and produced during the CoI. These included extracts of registers, containing details of records destroyed; selective production makes the inquiry and its conclusions suspect to say the least.

(c) *After* categorically denying the existence of any records, somehow the respondents were able to retrieve them. These included a register containing details of the transfer of blood units from 166 MH to 171 MH.

(d) The deposition of Col. Nijhawan admitted that the responsibility of testing/screening blood for markers was that of 166 MH. He also admitted that there was no document to prove that the blood had been tested for markers. (Reply to Question 9[50]). However, Lt. Col Devika

[50] Col. Nijhawan was asked – "*Can you produce Case Sheet With document stating that blood has been duly screened for markers as per policy including HIV?*" and it was replied that "*No records are available*".

Bhat asserted that the blood was "duly screened as per guidelines then in vogue: (Reply to Question No. 4[51]).

(e) The deposition of Lt. Col. Jyoti Borpujari states that 171 MH was transferred one unit of B Negative blood on 12.01.2002; she further deposed that there was no other record of transfer of blood to 171 MH later, or during July 2002. She mentioned the relevant markers to test blood. However, she nowhere stated that such procedures were in fact used to test the blood actually transferred to 171 MH.

63. The final opinion of the CoI, based on the (allegedly scanty) documentary evidence presented to it, and the testimonies of Col. Sanjay Nijhawan, Lt. Col Devika Bhat, Lt. Col. Jyoti Borpurari (of 166 MH) is summarized as follows, in that document:

> *"As per the statements of Col. Sanjay Nijhawan, (171 MH) Lt. Col Devika Bhat, and Lt. Col. Jyoti Borpujari OIC Blood Bank 166 MH the following facts emerge:*
>
> *(a) One unit of blood transfusion was given to 741 41570 B Ex-Cpl Ashish Kumar Chauhan, at 171 MH (Samba) in July 2002 for severe Macrocytic aneamia along with conservative treatment.*
> *(b) No records are available at 171 MH pertaining to screening of blood for HIV, Blood demand and Blood transfusion during the period Jun-July 2002.*
> *(c) No records are available at 166 MH regarding issue of blood during the period Jun-July 2002.*
> *(d) An SOP for ad-hoc Blood Bank was promulgated at 171 MH (Samba) for Transfusion of blood during the 'OP PARAKRAM' as 171 MH was not authorised Blood bank /Pathologist during that period. As per SOP the Blood was screened tor HIV infection at 166 MH and then issued to 171 MH Samba. 171 MH only stored the blood being issued for Transfusion.*
> *(e) 74141570 B Ex-Cpl Ashish Kumar Chauhan contracted HIV in May, 2014 which may be for reasons other than blood tansfusion."*

64. These findings were accepted. However, those conclusions were not in fact acted upon: as is evidenced by the fact that the appellant's categorization as a

[51] Lt Col Devika Bhat was asked – "*Was the screening of blood for HIV before transfusion dispensed with?*" and she replied that –"*The requisite blood was duly screened as per existing guidelines in vogue at that time. The same may please be confirmed from 171 MH.*"

person discharged on account of disability attributable to service, entitling him to pension has not been revoked or cancelled. Now, as far as manifestation of the HIV positive condition is concerned, medical opinions, and those of organizations such as WHO appear to be unanimous that after the point of infection (known as Stage 1), the second phase (Stage 2) can be for a long period. At Stage 1 *"the virus replicates using the body's CD4 T cells and spreads throughout the body. In doing so, it destroys CD4 T cells. Eventually, this process stabilizes. The immune system reduces the number of viral particles, and levels of CD4 T cells may rise. However, the number of these cells may not return to its original level."*[52] The second stage is described as follows:

> *"After the acute stage has ended — and if the person has not received treatment — the virus remains active, reproducing at very low levels but continuing to damage immune cells.*
> *At this stage, there are usually no symptoms or very mild ones. This is why doctors sometimes call stage 2 "asymptomatic HIV infection" or "clinical latency." The virus can still pass to others during this stage, even if it causes no symptoms.*
> *Without treatment, this stage can last for 10 years or more before the person develops stage 3 HIV."*

65. The *Guidelines on HIV Testing* issued by Central Government[53], the Union Ministry of Health and Family Welfare, National Aids Control Organization (NACO), March 2007 similarly describes the second phase as the *"latent phase"* and *"the asymptomatic stage"*, a *"period on average lasts for 8-10 years."* According to those guidelines, the long-term survival of most afflicted persons (80-90%) was 10 years or more, and a small percentage (5%) *"do not experience clinical progression of HIV."* Such persons are described as *"long term non-progressors (LTNPs)"*. The respondents strongly relied on the Ministry of Defence's *Guide to Military Officers (Military Pensions),* 2008, which contained a tabular chart (in Appendix to Chapter VI titled *"INCUBATION PERIODS IN*

[52] https://www.medicalnewstoday.com/articles/316056, HIV timeline: What are the stages, (last accessed on 16.09.2023 at 05.17 AM).
[53] *Guidelines on HIV Testing* issued by the Union Ministry of Health and Family Welfare, National Aids Control Organization (NACO), 2007

RESPECT OF CERTAIN INFECTIOUS DISEASES"). Against the column containing HIV, the initial *"usual incubation period"* was described to be 4 to 6 weeks. The *"minimum and maximum period for deciding attributability"* against HIV was *"1 year".* In this court's opinion, the guide, issued by the Ministry of Defence cannot be conclusive; as it does not show, what was the basis for the maximum attribution period of one year; and on the other hand, the prevailing guidelines of the national expert body indicated entirely different, and nuanced seroprevalence periods, for different kind of individuals. Therefore, this court holds that such a guide to military officers cannot be accepted, at least in this case, to reject the petitioner's claim.

66. A review of the evidence and the materials on record reveals that the appellant was transfused with one unit of blood on 10 July 2002, at the advice of Lt. Col. Devika Bhat, who also deposed during the CoI proceedings. There is no indication in her deposition that the appellant was informed of the likely consequences- or even reasonable likelihood or the possibility of contamination or infection due to the transfusion. Likewise, he was not informed about *any potential risks.* By all accounts, the appellant really had no choice because the transfusion took place under medical advice. At some stage, the respondents argued that if the appellant so wished, he could have opted not to go in for transfusion. That is, in the realm of theory, no such alternative option is shown to have been made available to him, when in fact the transfusion did take place.

(iii) The law on negligence

67. In India, medical negligence is said to have been established by an aggrieved plaintiff or complainant when it is shown that the doctor or medical professional was in want of, or did not fulfil the standard of care required of her or him, as such professional, reasonably skilled with the science available at the relevant time. In other words, a doctor is not negligent if what he has done would be endorsed by a responsible body of medical opinion in the relevant speciality

at the material time. This test is known as the *Bolam* test[54] and has gained widespread acceptance and application in Indian jurisprudence. It finds resonance in several decisions. Recently, in *Arun Kumar Mangalik v Chirayu Health and Medicare Ltd.*[55], this court outlined that though *Bolam* has been the bulwark principle in deciding medical (and professional negligence) cases, it must adapt and be in tune with the pronouncements relating to Article 21 of the Constitution and the right to health in general:

> *"41. Our law must take into account advances in medical science and ensure that a patient-centric approach is adopted. The standard of care as enunciated in the Bolam case must evolve in consonance with its subsequent interpretation by English and Indian Courts. [..]"*

68. In United Kingdom itself, the duty of care has evolved beyond the *Bolam* approach; in *Sidaway v Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital*[56] and more significantly, in *Montgomery v Lanarkshire Health Board*[57] (the latter decision drawing upon the reasoning of the Australian High Court in *Rogers v Whittaker*[58]), the UK Supreme Court outlined the duty of a doctor, surgeon or physician, and address the right of a patient as follows:

> *"An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."*

[54] So called, due to the case: *Bolam v Friern Hospital Management Committee* 1957(2) All.ER 118.
[55] [2019] 3 SCR 281.
[56] [1985] AC 871.
[57] 2015 UKSC 11.
[58] 1992 175 CLR 479.

69. In the present case, what was the duty of care of the treating professional? Whilst this court cannot be oblivious of the fact that the times during which the incident occurred were fraught in the sense that a warlike situation prevailed at the border, at the same time, it cannot also ignore, or be blind to certain realities. These are firstly that nothing was shown on the record to establish that 171 MH was licensed, even as an *ad hoc* blood bank. Secondly, there is no material on record as to whether the nature of equipment available at 171 MH for storing blood and blood products was in accordance with the standards and guidelines prevailing then, in 2002. Thirdly, during the testimony of witnesses i.e., before the CoI, 171 MH and 166 MH, there was no specific mention about what kind of markers were used to determine whether the transfused blood was in fact safe. Fourthly, apart from mentioning of the guidelines by the concerned doctors, there is nothing on record to show that such guidelines were, in fact, adhered to when the testing as well as the transfusion took place. Fifthly, there is no evidence in the form of deposition by the officer in charge of 166 MH, Lt Col Jyoti Borpujari to rule out the possibility of contaminated blood-which was in fact sent to 171 MH had taken place.

70. In the opinion of this court, all the above, cumulatively point to the rather casual and if one may say so, superficial attention paid to the entire episode involving blood transfusion. It is a matter of record that the concerned doctors-who were professionals, i.e., either at 171 MH or 166 MH, felt so pressured by the absolute necessity to follow the drills that the safeguards preceding safe transfusion to the appellant appears to have been a given a go by, or dispensed with. In these circumstances, the normal duty of care which would have ordinarily applied and did apply as well, was that at both ends i.e., 166 MH and 171 MH, there should have been no doubt that blood had been filtered and found safe for transfusion. Equally, something in the form of other material on record or in the form of the oral testimony by the medical cadre personnel, such as Lt Col Devika Bhat of 171 MH who was present in 2002 or Col Sanjay Chauhan, to show what

kind of equipment such as refrigerating unit or other chemical matter to preserve the blood and blood products, even within the safe. When constituted or read together, all these lapses-which may be seen singly as small or minuscule, add up to one thing: lack of adherence to or breach of the relevant standards of care reasonably expected from a medical establishment. Therefore, whilst pinpointed accountability of one or some individuals is not possible, nevertheless the systemic failure in ensuring a safe transfusion of blood to the appellant, is the only irresistible inference. These facts establish medical negligence, and therefore, vicarious liability on the part of the IAF and the Indian Army. The former is the appellant's immediate employer; the latter was the organization controlling and in charge of 166 MH and 177 MH.

71. The principle of *res ipsa loquitur* has been described in *Charlesworth & Percy on Negligence*[59] in the following terms:

> *"6-25. It has been said that "a prima facie case" should be the preferred terminology. It means essentially a case which calls for some answer from the defendant and will arise upon proof of: (1) the happening of some unexplained occurrence; (2) which would not have happened in the ordinary course of things without negligence on the part of somebody other than the claimant; and (3) the circumstances point to the negligence in question being that of the defendant, rather than that of any other person"*
>
> *6-26 The third requirement is usually fulfilled by showing that the instrument causing the damage was in the management and control of the defendant at the time of the occurrence, but this is not essential. Where an object which causes an accident has, at all material times, been under the control of the defendants and there is no evidence to show how the accident happened, the presumption of negligence cannot be displaced by evidence of the general care that has been taken."*

This court has, on several occasions in the past, particularly in cases involving allegations of medical negligence, invoked the principle of *res ipsa loquitur* ("the thing speaks for itself"). In *V. Kishan Rao v Nikhil Super Speciality Hospital & Anr.*[60]*, it was observed:*

[59] Charlesworth & Percy on Negligence, 14th Edition (2018) Sweet and Maxwell @ 6-25, page 400.
[60] [2010] 5 SCR 1.

> *"In a case where negligence is evident, the principle of res ipsa loquitur operates and the complainant does not have to prove anything as the thing (res) proves itself'. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence."*

72. All these facts and circumstances, in the opinion of this court, prove and establish that by reasonable standards of evidence, the appellant has justified the invocation of the principle of *res ipsa loquitor*. The principle was applied in the *Nizam Institute of Medical Sciences* (supra) wherein this court held that:

> *"77. [..] in a case involving medical negligence, once the initial burden has been discharged by the complainant by making out a case of negligence on the part of the hospital or the doctor concerned, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the Court that there was no lack of care or diligence."*

Earlier, in *Savita Garg* (supra), the court had ruled that once the complainant or aggrieved party had adduced some evidence that the patient suffered (or died, as in that case) due to lack of care (or as in this case, suffered irremediable injury due to want of diligence) *"then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken [..]."*

73. At the same time, this court has cautioned that *res ipsa loquitur* cannot be the only basis to fasten liability. This view has been advocated (and applied) in *Martin F. D'Souza* (supra) and *Bombay Hospital and Medical Research Centre v Asha Jaiswal (hereafter, "Asha Jaiswal")*[61]. In *Asha Jaiswal* (supra), this court outlined the caution needed to apply *res ipsa loquitur:*

> *"an application of the general method of inferring one or more facts in issue from circumstances proved in evidence". In this view, the maxim res ipsa loquitur does not require the raising of any presumption of law which must shift the onus on the defendant. It only, when applied appropriately, allows the drawing of a permissive inference of fact, as distinguished from a mandatory*

[61] 2021 (10) SCR 1118.

> *presumption properly so-called, having regard to the totality of the circumstances and probabilities of the case. Res ipsa is only a means of estimating logical probability from the circumstances of the accident."*

The above analysis leads this court to the conclusion that the condition in which the appellant found himself, was the direct consequence of the two hospital-establishments and their breach of the standards of care, resulting in the transfusion of the HIV positive infected blood into the appellant, which was the causative factor. The necessary foundational facts, to hold that the application of *res ipsa loquitur* was warranted, were proved in all detail. The respondents failed to discharge the onus which fell upon them, to establish that due care was in fact exercised and all necessary care standards, applicable at the time, were complied with. As a result, it is held that the respondents are liable to compensate the appellant for the injuries suffered by him, that are to be reckoned in monetary terms.

(iv) The relief of damages

74. Medical negligence, or negligence is tied to two concepts. At the one end is the duty of care - and establishing its breach, and thereby fault - and resultant injury. At the other end is remedial - usually restitution, in monetary terms, by payment of damages. The ingenuity of common law has been to adapt - and evolve, through refinement, and reinvention, the idea of duty to care. In the case of medical professionals, or other professionals, for instance, their duty to care not only involves the professionals' assessment of the suitability of treatment, or use of technology, but the concomitant duty to inform the patient (or consumer) of the likely results, or even the risk(s) because the service recipient, so to say, has to bear the consequent consequences. Damages, in theory, can have no limit. Yet, the duty of care is woven with the idea of *causation* or proximity. Thus, only one is liable in law to the extent of one's actions, which cause the injury. Equally, damages are limited to consequences which are reasonably foreseeable.

75. The judgment in *Raj Kumar v. Ajay Kumar*[62] had discussed and declared the general principles relevant for the assessment of compensation or damages for personal injuries. These principles have been applied, in cases involving claims under the Motor Vehicles Act, 1988 as well as other cases, including medical negligence cases. The court observed:

> *"The court or the Tribunal shall have to assess the damages objectively and exclude from consideration any speculation or fancy, though some conjecture with reference to the nature of disability and its consequences, is inevitable. A person is not only to be compensated for the physical injury, but also for the loss which he suffered as a result of such injury. This means that he is to be compensated for his inability to lead a full life, his inability to enjoy those normal amenities which he would have enjoyed but for the injuries, and his inability to earn as much as he used to earn or could have earned. [See C.K. Subramania Iyer v. T. Kunhikuttan Nair (1969) 3 SCC 64, R.D. Hattangadi v. Pest Control (India) (P) Ltd. (1995) 1 SCC 551 and Baker v. Willoughby (1969) 3 All ER 1528 (HL)].*
> *6. The heads under which compensation is awarded in personal injury cases are the following:*
> *Pecuniary damages (Special damages)*
> *(i) Expenses relating to treatment, hospitalisation, medicines, transportation, nourishing food, and miscellaneous expenditure.*
> *(ii) Loss of earnings (and other gains) which the injured would have made had he not been injured, comprising:*
> *(a) Loss of earning during the period of treatment;*
> *(b) Loss of future earnings on account of permanent disability.*
> *(iii) Future medical expenses.*
> *Non-pecuniary damages (General damages)*
> *(iv) Damages for pain, suffering and trauma as a consequence of the injuries.*
> *(v) Loss of amenities (and/or loss of prospects of marriage).*
> *(vi) Loss of expectation of life (shortening of normal longevity).*
> *In routine personal injury cases, compensation will be awarded only under heads (i), (ii)(a) and (iv). It is only in serious cases of injury, where there is specific medical evidence corroborating the evidence of the claimant, that compensation will be granted under any of the heads (ii)(b), (iii), (v) and (vi) relating to loss of future earnings on account of permanent disability, future medical expenses, loss of amenities (and/or loss of prospects of marriage) and loss of expectation of life."*

[62] 2010 (13) SCR 179.

76. The principles discussed and commended for general application have endured and have been consistently followed by this court, in calculating and awarding damages.

77. This court, in *Nizam Institute of Medical Sciences* (supra), outlined, briefly, what damages a person who has suffered due to medical negligence, can be awarded. This court held that:

> *"92 [..] The kind of damage that the complainant has suffered, the expenditure that he has incurred and is likely to incur in the future and the possibility that his rise in his chosen field would now be restricted, are matters which cannot be taken care of under the multiplier method."*

78. The court had emphasized on the applicability of the *cumulative effect* upon the patient, of the medical negligence, in the decision reported as *Malay Kumar Ganguly v Dr. Sukumar Mukherjee (hereafter "Malay Kumar Ganguly")*[63] and held that negligence of each treating contributory fact resulting in the patient's condition, has to be seen: *"in a case of this nature, the court must deal with the consequences the patient faced, keeping in view the cumulative effect." Malay Kumar Ganguly* (supra) is also an authority for the reasoning that while awarding compensation, the court should consider "*loss of earning or profit up to the date of trial"* including any loss *"already suffered or is likely to be suffered in future".* Recently, in *Sidram v Divisional Manager*[64], this court underlined the rationale for just compensation:

> *"32. This Court has emphasised time and again that "just compensation" should include all elements that would go to place the victim in as near a position as she or he was in, before the occurrence of the accident. Whilst no amount of money or other material compensation can erase the trauma, pain and suffering that a victim undergoes after a serious accident, (or replace the loss of a loved one), monetary compensation is the manner known to law, whereby society assures some measure of restitution to those who survive, and the victims who have to face their lives."*

[63] (2009) 13 SCR 1.
[64] [2022] 8 S.C.R 403.

In *K. Suresh v. New India Assurance Co. Ltd.*[65], this court observed that:

> *"10. It is noteworthy to state that an adjudicating authority, while determining the quantum of compensation, has to keep in view the sufferings of the injured person which would include his inability to lead a full life, his incapacity to enjoy the normal amenities which he would have enjoyed but for the injuries and his ability to earn as much as he used to earn or could have earned. Hence, while computing compensation the approach of the Tribunal or a court has to be broad-based. Needless to say, it would involve some guesswork as there cannot be any mathematical exactitude or a precise formula to determine the quantum of compensation. In determination of compensation the fundamental criterion of "just compensation" should be inhered."*

79. Recently, in *Abhimanyu Partap Singh v. Namita Sekhon & Anr.*,[66] this court held that:

> *"compensation can be assessed in pecuniary heads i.e. the loss of future earning, medical expenses including future medical expenses, attendant charges and also in the head of transportation including future transportation. In the non-pecuniary heads, the compensation can be computed for the mental and physical pain and sufferings in the present and in future, loss of amenities of life including loss of marital bliss, loss of expectancy in life, inconvenience, hardship, discomfort, disappointment, frustration, mental agony in life, etc."*

80. The appellant has claimed a total sum of ₹ 95,03,00,000/- (Rupees ninety-five crores, three lakhs only), under various heads:

(i) ₹1.5 crores as travelling expenses, for his treatment, incurred- every month from his house to New Delhi, (ii) ₹ 50 lakhs as the expenses for his medicines, (iii) ₹ 1.53 crores for loss of salary, from the date of his retirement due to not giving extension till the age of superannuation, (iv) ₹1.5 crores as medical -expenses which he is required to incur due to the non-availability of medical services and an immunologist at his home town, (v) ₹10 crores for violation of his human rights, ₹ 40 crores for mental and social agony, and ₹40 crores for his defamation.

[65] (2012) 11 SCR 414.
[66] 2022 (16) SCR 1.

(ii) The total salary claimed per annum was ₹ 10,89,052 / - (i.e. ₹ 89,921/- per month multiplied by twelve months); *to the total salary for the "leftover period of service from 31 May, 2016 to 31 May 2033.)"* calculated @ ₹ 5,44,526/-; plus a sum of ₹ 10,89,052 multiplied by 12 (number of years left, till the age of 58 years) ₹ 2,80,97,541.60, added to which the appellant claims a factor of 1.6 (for future prospects). The total thus worked out is ₹ 50,57,55,748.80.

81. The appellant's claim of ₹ 89,921/- per month, is based on the calculation that he would have earned, had he been in service if the seventh pay commission pay fixation and adjustment were provided. However, he was discharged from service on 31.05.2016. He claimed, in addition, a host of allowances (dearness allowance, family assistance, house rent allowance, good conduct allowance, etc.). No doubt these factors have to be considered when loss of earnings or income is to be calculated. However, *all allowances* cannot be granted, towards loss of earnings. This court is cognizant of the fact that the appellant has also been drawing pension (including disability pension which is now in the range of about ₹ 6000/- per month). Even if the appellant's calculation about loss of future earnings were to be taken into account, given that he has been a pensioner, for the past 7 years, adjustment of the base compensation figure for compensation for loss of earnings has to be given. Therefore, *taking a conservative* consolidated figure of ₹ 65,000/- per month, if the average pension earned is pegged @ ₹ 25,000/- per month, the total figure he would be entitled towards loss of earning, for seven years, would be about ₹ 33,60,000/-. The figure could be rounded off, appropriately, to ₹ 35,00,000/-. The court would then, have to take into account, the appellant's age, as of date, which is 47 years. Again, if a multiplier of 12 is applied to determine compensation for loss of future income, including adding 40% towards loss of future prospects, the figure would be ₹ 80,64,000/-. The total amount, (i.e., ₹ 35,00,000/- plus ₹ 80,64,000/-) would be ₹ 1,15,64,000/- (Rupees

one crore fifteen lakhs sixty four thousand only). Of this, a deduction for the expenses of the appellant, calculated @ 25% would have to be made. The figure to be deducted would be ₹ 28,91,000/-. The total amount, towards loss of earnings, including future earnings, would then be ₹ 86,73,000/- (Rupees eighty six lakhs seventy three thousand only).

Mental agony

82. This court has repeatedly emphasized that mental agony is an important factor to be taken into account while calculating compensation. In the present case, there are multiple facts, which in the opinion of this court, establish that the appellant suffered from callousness and insensitivity of the respondents, who persisted in being in denial. These may be briefly set out:

a. Firstly, the appellant received the biggest jolt, when he was informed that he was an HIV positive infected person, in May, 2014. The subsequent tests and certifications were mere palliatives. The respondents' effort was to somehow get rid of his services, which they did with effect from 31.05.2016.
b. Secondly, the appellant was virtually stonewalled in his efforts to secure documents, and information; most of his queries under the Right to Information Act (RTI) were turned down; he had to go in appeals.
c. Even the appellate authority 171 Military Hospital stated in its letter (dated 12.06.2018) *"is not authorized any Blood Bank and hence no Pathologist is authorized nor posted, at any time. However, an ad-hoc blood bank was established during 'Op Parakram' i.e. in 2002. Blood would be requisitioned from 166 MH and stored at 171 MH."*
d. A tabular chart, showing the appellant's queries, and their outcome, with relevant particulars, is reproduced below, based on the admitted documents placed on record:

S No	RTI Filing Date	RTI Reply Date	Contents of Reply
1.	30.12.2016	18.01.2017	RTI was filed by the appellant on 30.12.2016 seeking confirmation regarding availability of immunologist empaneled with ECHS Polyclinic Ajmer and by response dated 18 Jan 2017, it was confirmed that no immunologist is available in hospital at Ajmer which is empanelled with ECHS Polyclinic Ajmer.
2.	14.01.2017	20.02.2017	RTI filed by appellant regarding allotment of service quarter/married accommodation and the IAF replied, in the reply to the appellant's RTI query, that service quarter/married accommodation was allotted to a married air-warrior to live out with his family after registration for married accommodation by the respective individual and brought within authorized married establishment as per seniority in waiting list. It was further stated in reply that diagnosis and treatment mentioned against "*patient must be duly signed by CMO of concerned Government Hospital*".
3.	14.02.2017	14.03.2017	It was stated that in the RTI reply that the information sought is '*interrogatory in nature*' and does not fall within the definition of "information". It was admitted by HQ South Western Air Command, IAF, Gandhinagar that "*Medical facility is the part of service conditions of the Indian Air Force for Air warriors.*"
4.	05.05.2017	13.07.2017	RTI application filed on 05.05.2017 seeking for copies of the appellant's willingness certificate for blood transfusion at the 171 MH facility and whether the treating doctor informed the appellant about the risks associated with the blood transfusion. The reply was that no such records are available with the hospital as same fell under exemption under Section 8(1) of the RTI Act, 2005 and the respective records were forwarded to respective records office after discharge from the hospital.
5.	18.06.2017	18.08.2017	An RTI was filed on 18 Jun 2017 wherein amongst other things, appellant asked for maximum age an airman can serve in IAF and when will seventh pay commission be effective from. It was replied by reply dated 18.08.2017 that revised 7th pay commission is effective from 01.01.2016 and maximum age airman can serve in IAF is 57 yrs. (subject to extension on meeting eligibility criteria and service exigencies).
6.	03.07.2017	11.07.2017	RTI application also filed on 03.07.2017 by the appellant to Ministry of Finance, Department of Economic affairs seeking details about the ongoing inflation rate as per the Consumer price index for the financial year 2014-15 and response was provided for the same vide letter dated 11.07.2017.
7.	02.12.2017	04.01.2018	BH, Delhi Cantt -10 replied that no Immunologist is posted at BH, Delhi Cantt-10. However, doctors were available who could treat HIV/AIDS patient at BH, Delhi Cantt-10.

8.	26.10.2018	05.12.2018	RTI by the appellant on 26.10.2018 to CPIO, Indian Army regarding his blood group and RH Factor Test report in respect of blood transfusion at the 171 Military facility in 2002, and by reply dated 05.12.2018 the respondent admitted that Blood Group and RH Factor Test Report of appellant in respect to Blood transfusion was NOT available.
9.	22.04.2019	Date unclear	On 22.04.2019, another RTI application by the Appellant requesting for medical records in respect of the medical board proceedings dated 12.12.2014 and any correspondence between the IAF and the Registry of the military facility at MH 171 and the reply (undated) stated that that no such information was available.
10.	27.04.2019	Date Unclear	RTI application dated 27.04.2019 to CPIO Food Corporation of India wherein he asked for reasons for exclusion of HIV category patients from the category of Persons with Disability and reference was made to a reply letter dated 29.05.2018. It was admitted by the Food Corporation that HIV disease/ HIV positive applicants were not considered in category of Persons with disability and in the Online Application Form. No option was available there to disclose the HIV positive status of the appellant.
11.	17.05.2019	21.05.2019	RTI application dated 17.05.2019 filed by appellant asking for copy of correspondence between 171 MH facility and Senior Medical Officer, SMC, HQ, SWAC (U) Gandhinagar in 2014 regarding medical board proceeding dated 12.12.2014, and by reply, it was informed that no such correspondence existed.
12.	18.07.2019	16.08.2018	On 18 July 2019, Appellant filed RTI application for written correspondence between Air Force and Registrar at 171 MH Medical facility in respect of his letter dated 21 Jul 2014 and 16 Sep 2014. By letter dated 16.08.2018, he was informed that no such correspondence in respect of the above stated letter was exchanged between the IAF and the Registrar of the military facility (i.e., MH 171).
13.	27.06.2019	03.07.2019	RTI filed on 27th June 2019 seeking for details of availability of transfusion medicine expert at the 171 MH Military facility and vide reply letter dated 03.07.2019, it was admitted by the first respondent that no such transfusion medicine expert (doctor) was available and no blood grouping & Cross matching test report is available at the said 171 Military hospital facility.
14.	13.05.2022	23.05.2022	RTI application filed on 13.05.2022 by the appellant to 171 Military Hospital requesting for the medical records pertaining to transfusion of blood on 10.07.2002 and information relating to source of the donor and vide reply dated 23.05.2022. The appellant was informed that no such information is available with the respondents' without assigning any reasons for same.
15.	31.07.2022	11.08.2022	Another RTI dated 31.07.2022 filed by appellant to ECHS Cell, Station headquarters, Ajmer asking for his eligibility to become ECHS (Ex-Service Contributory Health Scheme) and it was replied vide letter dated 11.08.2022 that no provision exist by which Appellant can become member of ECHS prior to retirement which falls on

			31.05.2016, and even after retirement, Appellant had to register himself to become a member of the ECHS and it was never mentioned in office letter dated 25.07.2022 that he had become member of ECHS from his date of retirement i.e. on 31 May 2016.
16.	(Unclear)	06.05.2022	Another RTI was filed by the Appellant where appellant asked for information to be provided to him about name of laboratory test through which he is likely to be infected with virus. AIIMS vide letter dated 06.05.2022, while referring to NACO Guidelines for HIV testing, 2015, stated that "*none of the diagnostics modalities can ascertain or dig out the cause of action for HIV virus that later became HIV positive*".
17.	24.07.2022	11.08.2022	RTI application dated 24 Jul 2022 filed by the appellant asking if any circular/letter/memorandum/order exists which exempts defense personnels from complying with NACO circular and guidelines to which it was responded vide letter dated 11 Aug 2022 that no such circular/order/memorandum/letter exists.
18.	23.10.2022	24.11.2022	RTI application dated 23.10.2022 (received by Base Hospital, Delhi Cantt-10 on 01.11.2022) filed by Appellant u/s 7(1) of RTI Act (which further provides that when an information concerns life or liberty of a person, same information shall be provided within 48 hrs of receipt of the request). Amongst other thing), he has asked whether the hospital lab has facility for CD-4 counts. Hospital replied that though they have facility for laboratory test for HIV RNA for HIV defense personnel, however lab does not have facility for CD 4 counts. (In their reply, they also mentioned that provisions of section 7(1) of RTI Act should not have been invoked by the Appellant as no imminent danger to life or liberty was demonstrably proven by Appellant in case information is not supplied within 48 hrs.)

e. The same appellate authority's order clearly went beyond its remit, and- as discussed earlier, went on to highlight entirely external factors, such as the appellant's alleged marital discord; it even mentioned the name of his spouse.

f. Once the appellant approached the Commission, and notice was issued, in 2017, the respondents decided that the issue had to somehow be dealt with; by orders issued in *May 2018, after notice was received, and when the reply was being planned,* the CoI was constituted.

g. The CoI did not involve the appellant at all; the entire effort was to somehow see how the respondents could absolve themselves from liability.

83. This court has, in the past, highlighted that the head of mental agony has to be assessed and granted while awarding compensation (Ref. *Spring Meadows*; *V. Krishna Kumar v State of Tamil Nadu*[67]). In the latter case, the High Court had awarded damages, upon a finding of negligence on account of lack of care due to blood transfusion to the baby at the time of her premature birth, which led to a medical condition, i.e., progressive retinal disease. The court not only granted damages under the head of mental agony, but also towards past medical expenses, and future medical expenses, after factoring an annual inflation rate of 1% per annum. The total sum awarded was ₹1.38 crores.

84. In the present case, the shock and agony faced by the appellant, the trauma which he felt because of the virtual denial of his condition, the stonewalling attempts of the respondents, in firstly denying his requests for information, and then, holding a CoI behind his back, are actionable. Whilst individuals' roles cannot be pinpointed, the overall inference one is left to draw is overwhelming prejudice- despite the appellant's unblemished track record of service in the IAF. The premature retirement, and to cap it all (in an incident for which the respondents cannot be held responsible) his rejection by a public sector company, the Food Corporation of India (FCI) *on the ground of his being HIV positive* are aggravated factors. The IAF could certainly have taken pro-active steps to ensure that the appellant was provided with some alternative employment, within its organization, or as part of the armed forces' rehabilitation programmes for veterans and ex-servicemen. The overall result was acute mental agony caused to the appellant. This court is of the opinion, that the appellant is entitled to ₹ 50,00,000/- (Rupees fifty lakhs only) towards this head.

85. The appellant had highlighted how his attempt to secure employment elsewhere has been thwarted and relied upon the correspondence with FCI. The respondents cannot be fastened with liability on that score, however, at the same

[67] 2015 (8) SCR 100.

time, it would be relevant to highlight that Parliament has enacted the HIV and AIDS (Prevention and Control) Act, 2017 (hereafter, "*HIV Act*") which protects and promotes the rights of persons affected by HIV and AIDS. The Act came into force on September 10, 2018. Its objectives are the prevention and control of the spread of HIV and AIDS and the reinforcement of legal and human rights of HIV infected persons and those affected by AIDS. It protects the rights of healthcare providers as well.

86. The HIV Act addresses stigma and discrimination[68] (Section 3); and aims at the creation of an environment enabling or enhancing access to services. Section 5 of the HIV Act elaborately imposes obligations upon persons to seek *informed consent* of concerned persons, before HIV related testing or procedures are undertaken, and before any line of medical treatment is to be given. Other provisions enabling access to diagnostic facilities related to Anti-Retroviral Therapy (ART) and opportunistic infection management for people living with HIV and AIDS have been made. Further, the HIV Act provides for a grievance redressal mechanism in the form of an Ombudsman at the state level and a Complaints Officer at the establishment level for providing speedy redressal. ***Section 34 of the HIV Act imposes obligations upon courts to anonymise the name of the individual concerned affected by HIV positive or AIDS, and also expedite legal proceedings.***

[68] Section 2 (d) (b) defines discrimination as something where a person *"denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related ground"* Section 3, *inter alia*, states that:
"3. No person shall discriminate against the protected person on any ground including any of the following, namely:— (a) the denial of, or termination from, employment or occupation, unless, in the case of termination, the person, who is otherwise qualified, is furnished with— (i) a copy of the written assessment of a qualified and independent healthcare provider competent to do so that such protected person poses a significant risk of transmission of HIV to other person in the workplace, or is unfit to perform the duties of the job; and Prohibition of discrimination. (ii) a copy of a written statement by the employer stating the nature and extent of administrative or financial hardship for not providing him reasonable accommodation; (b) the unfair treatment in, or in relation to, employment or occupation;…"

87. This court is conscious of the fact that the provisions of the HIV Act cannot be applied to the facts of this case. Yet, it enacts standards and imposes obligations upon several authorities, including the justice delivery system, to take specified measures to ease and mitigate the hardships and barriers which HIV or AIDS affected persons, would ordinarily face. In the light of its provisions, this court proposes its effective implementation, through operative directions to be issued hereafter.

Future care

88. The HIV positive condition is such that it can lead to slow and debilitating results. The steady weakening and degenerative form of the condition has been described as follows[69]:

> *"Acute infection*
> *An HIV-positive person may not have many serious symptoms during this stage, but there are usually large quantities of virus in their blood as the virus reproduces rapidly. Acute symptoms can include: (a) fever (b) chills (c) night sweats (d) diarrhea; (e) headache (f) muscle aches (g) joint pain (h) sore throat (i) rash (j) swollen lymph nodes (k) mouth or genital ulcers*
>
> *Chronic HIV infection*
> *The next stage is called the chronic infection stage. It can last for as long as 10 to 15 years An HIV-positive person may or may not show signs or have symptoms during this stage. As the virus advances, the CD4 count decreases more drastically. This can lead to symptoms such as: fatigue; shortness of breath; cough; fever; swollen lymph nodes; weight loss; diarrhea; rash.*
>
> *AIDS*
> *If untreated HIV advances to AIDS, the body becomes prone to opportunistic infections. AIDS increases a person's risk for many infections, including a herpes virus called cytomegalovirus (CMV). It can cause problems with the eyes, lungs, and digestive tract. Kaposi sarcoma, another possible complication, is a cancer of the blood vessel walls. It's rare among the general population, but it's more common in people with advanced HIV. Symptoms include red or dark purple lesions on the mouth and skin. It can also cause*

[69] https://www.healthline.com/health/hiv-aids/effects-on-body#respiratory-and-cardiovascular-systems, last accessed at 05:41 AM on 25th September, 2023.

problems in the lungs, the digestive tract, and other internal organs. HIV and AIDS also put a person at higher risk for developing lymphomas. An early sign of lymphoma is swollen lymph nodes.

Respiratory and cardiovascular systems
HIV makes it hard to fight off respiratory problems such as the common cold and flu. In turn, an HIV-positive person may develop related infections, such as pneumonia Without treatment for HIV, advanced disease puts an HIV-positive person at an even greater risk for infectious complications, such as tuberculosis and a fungal infection called pneumocystis jiroveci pneumonia (PJP). PJP causes trouble breathing, cough, and fever. The risk of lung cancer also increases with HIV. This is due to weakened lungs from numerous respiratory issues related to a weakened immune system. According to available research, lung cancer is more prevalent among people with HIV compared to people without it.
People with HIV are more likely to develop high blood pressure. HIV also raises the risk of pulmonary arterial hypertension (PAH). PAH is a type of high blood pressure in the arteries that supply blood to the lungs. Over time, PAH will strain the heart and can lead to heart failure.
If a person has HIV with a low CD4 count, they're also more susceptible to tuberculosis (TB).
TB is an airborne bacterium that affects the lungs. It's a leading cause of death in people who have AIDS. Symptoms include chest pain and a bad cough that may contain blood or phlegm. The cough can linger for months."

89. In the present case, the appellant was diagnosed HIV positive, and immediately placed under ART which continues till date. His immune system has gone down, due to the untreated condition, for some undetermined time. He complains of reduced mobility; the IAF itself has characterised his disability, though assigned it a figure of 30% disability; that was, however, sufficient for them to dispense with his service. As time progresses, he would need the assistance of a helper. Even conservatively calculated, such a helper would have to be paid about ₹ 10,000/- to ₹ 15, 000/- per month. If a calculation of average of ₹ 10,000/- to ₹ 15,000/- (i.e., ₹ 12,500/-) for twelve years is taken into account, the total sum would be ₹ 18,00,000/- (Rupees eighteen lakhs only).

Future medical care

90. The respondents, through the available medical facilities, have till date provided medical assistance. Repeatedly during the hearing, the appellant had been complaining of obstruction and delay, and denial of his requests. The court had intervened. Oftentimes, the appellant – perhaps due to his condition, and repeated feeling of exclusion, might have overreacted. Yet, it is undeniable that the respondents owe a duty to ensure that the appellant's requests are met in a compassionate and timely manner. To avoid any future friction, this court hereby directs the respondents to extend fullest co-operation to the appellant, in regard to his future medical treatment. Furthermore, the appellant shall be entitled to bi-monthly medical check-ups at the relevant departments, in the Research and Referral Centre (R&R) in New Delhi; for that purpose, the respondents shall ensure that the necessary travel expenses, in accordance with the appellant's entitlement are disbursed. It is also clarified that the appellant should fill out whatever forms are necessary for the timely disbursement of his pension, and entitlement, on a monthly basis.

91. Before issuing concluding directions, this court would like to record some relevant observations. People sign up to join the armed forces with considerable enthusiasm and a sense of patriotic duty. This entails a conscious decision to put their lives on the line and be prepared for the ultimate sacrifice of their lives. A corresponding duty is cast upon all state functionaries, including echelons of power *within* the armed forces to ensure that the highest standards of safety (physical/mental wellbeing, medical fitness as well as wellness) are maintained. This is absolutely the minimum required of the military/air force employer for not only assuring the *morale* of the forces but also showing the sense of how such personnel matter and their lives count, which reinforces their commitment and confidence. Any flagging from these standards – as the multiple instances in the present case have established, only entails a loss of confidence in the personnel,

undermines their morale and injects a sense of bitterness and despair not only to the individual concerned but to the entire force, leaving a sense of injustice. When a young person, from either sex (as is now a days the case) enrols or joins any armed forces, at all times, their expectation is to be treated with dignity and honour. The present case has demonstrated again and again how dignity, honour and compassion towards the appellant were completely lacking in behaviour by the respondent employer. Repeatedly the record displays a sense of disdain, and discrimination, even a hint of stigma, attached to the appellant, in the attitude of the respondent employer. Although this court has attempted to give tangible relief, at the end of the day it realizes that no amount of compensation in monetary terms can undo the harm caused by such behaviour which has shaken the foundation of the appellant's dignity, robbed him of honour and rendered him not only desperate even cynical.

Concluding directions

92. As a result of the above discussion, it is held that the appellant is entitled to compensation, calculated at ₹ 1,54,73,000/- (Rupees one crore fifty four lakhs seventy three thousand only) towards compensation on account of medical negligence of the respondents, who are held liable, for the injury suffered by the appellant. It is also held that since individual liability cannot be assigned, the respondent organizations (IAF and Indian Army) are held vicariously liable, *jointly*, and severally, to the above extent. The amount shall be paid to the appellant within six weeks by the IAF, his employer; it is open to the IAF to seek reimbursement, to the extent of half the sum, from the Indian Army. All arrears related to disability pension too shall be disbursed to the appellant within the said six weeks period.

93. In keeping with the mandate of the HIV Act, the following directions are issued to the Central and State Governments:

1) Under Section 14 (1) of the HIV Act, the measures to be taken by the Central Government and all the State Government are, to provide, (as far as possible), diagnostic facilities relating to HIV or AIDS, Anti-retroviral therapy and Opportunistic Infection Management to people living with HIV or AIDS.
2) The Central Government shall issue necessary guidelines in respect of protocols for HIV and AIDS relating to diagnostic facilities, Anti-retroviral therapy and opportunistic Infection Management *applicable to all persons and shall ensure their wide dissemination* at the earliest, after consultation with all the concerned experts, particularly immunologists and those involved in community medicine, as well as experts dealing with HIV and AIDS prevention and cure. These measures and guidelines shall be issued within three months, and widely disseminated, in the electronic media, print media and all popularly accessed public websites.
3) Under Section 15 (1) & (2) of the HIV Act, the Central government and every State Government shall take measures to facilitate better access to welfare schemes to persons infected or affected by HIV or AIDS. Both the Central and State Governments shall frame schemes to address the needs of all protected persons.
4) Under Section 16 (1) of the HIV Act, the Central and all the State Governments, shall take appropriate steps to protect the property of children affected by HIV or AIDS. By reason of Section 16 (2) of the HIV Act, the parents or guardians of children affected by HIV and AIDS, or any person acting for protecting their interest, or a child affected by HIV and AIDS may approach the Child Welfare Committee [within the meaning of that expression under Section 29 of the Juvenile Justice (Care and Protection of Children) Act, 2000] for the safe keeping and deposit of documents related to the property rights of such

child or to make complaints relating to such child being dispossessed or actual dispossession or trespass into such child's house.

5) The Central and every State Government shall formulate HIV and AIDS related information, education and communication programmes which are age-appropriate, gender-sensitive, non-stigmatising and non-discriminatory.

6) The Central Government shall formulate guidelines [under Section 18(1) of the HIV Act] for care, support and treatment of children infected with HIV or AIDS; in particular, having regard to Section 18 (2) *"notwithstanding anything contained in any other law for the time being in force"*, the Central Government, or the State governments shall take active measures to counsel and provide information regarding the outcome of pregnancy and HIV- related treatment to the HIV infected women. The Central Government shall also notify HIV and AIDS policy for establishments in terms of Section 12 of the HIV Act.

7) It is further directed that under Section 19 of the HIV Act, every establishment, engaged in the healthcare services and every such other establishment where there is a significant risk of occupational exposure to HIV, for the purpose of ensuring safe working environment, shall (i) provide, in accordance with the guidelines, *firstly,* universal precautions to all persons working in such establishment who may be occupationally exposed to HIV; and *secondly* training for the use of such universal precautions; *thirdly* post exposure prophylaxis to all persons working in such establishment who may be occupationally exposed to HIV or AIDS; and (ii) inform and educate all persons working in the establishment of the availability of universal precautions and post exposure prophylaxis.

8) By reason of Section 20 (1) of the HIV Act, the provisions of Chapter VIII[70] of the HIV Act apply to all establishments consisting of one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be. In keeping with proviso to Section 20 (1) of the HIV Act, in the case of healthcare establishments, the said provision shall have the effect as if for the words "one hundred or more", the words "twenty or more" were substituted.

9) Every person who is in charge of an establishment, mentioned in Section 20 (1) of the HIV Act, for the conduct of the activities of such establishment, shall ensure compliance of the provisions of the HIV Act.

10) Every establishment referred to in Section 20 (1) of the HIV Act has to designate someone, as the Complaints Officer who shall dispose of complaints of violations of the provisions of the HIV Act in the establishment, in such manner and within such time as may be prescribed. The rules in this regard may be formulated by the Central Government at the earliest, preferably within 8 weeks from today.

11) The Secretary, Department of Labour of every state shall ensure the collection of information and data relating to compliance with Sections 19 and 20 of the HIV Act, in regard to designation of a complaint officer, in all the factories, industrial establishments, commercial establishments, shops, plantations, commercial offices, professional organizations, and all other bodies falling within the definition of "establishments" [under Section 2 (f) of the HIV Act] which reads as follows:

> *""establishment" means a body corporate or co-operative society or any organisation or institution or two or more persons jointly carrying out a systematic activity for a period of twelve months or*

[70] Dealing with "Safe Working Environment".

more at one or more places for consideration or otherwise, for the production, supply or distribution of goods or services."

Such information shall be forwarded to the Secretary, Union Ministry of Labour and Employment, within 10 weeks. The Union Labour and Employment Secretary shall file an affidavit of compliance containing a tabular statement, with respect to implementation of provisions of the Act, within 16 weeks from today.

12) Every court, quasi-judicial body, including all tribunals, commissions, forums, etc., discharging judicial functions set up under central and state enactments and those set up under various central and state laws to resolve disputes shall take active measures, to comply with provisions of Section 34[71] of the HIV Act. Chief Justices of all High Courts, shall compile information, and device methods of collecting information in that regard, anonymizing identity of persons affected, appropriately and also complying with provisions of Section 34 (2) of the HIV Act. The Registrar General of the Supreme Court shall also look into the matter, and frame relevant guidelines which, after approval be issued and implemented.

94. Before concluding, this court would place on record its appreciation and gratitude to the *amicus,* Ms. Meenakshi Arora Senior Advocate, for her valuable assistance; the assistance given by Mr. Vikramjit Banerjee, the ASG; and Ms. Vanshaja Shukla, the *amicus* who painstakingly compiled the paper-book, and patiently heard the appellant with the aim of addressing all his concerns and assisted Ms. Arora. The court would also acknowledge the appellant's

[71] *34.(1) In any legal proceeding in which a protected person is a party or such person is an applicant, the court, on an application by such person or any other person on his behalf may pass, in the interest of justice, any or all of the following orders, namely:—*

(a) that the proceeding or any part thereof be conducted by suppressing the identity of the applicant by substituting the name of such person with a pseudonym in the records of the proceedings in such manner as may be prescribed;

(b) that the proceeding or any part thereof may be conducted in camera;

(c) restraining any person from publishing in any manner any matter leading to the disclosure of the name or status or identity of the applicant.

perseverance and the diligent research and scholarship put in by him, in the relentless quest for justice. The respondents are directed to bear the costs quantified at ₹ 5,00,000/- (Rupees five lakhs only) which shall also be paid to the appellant, within six weeks. The Supreme Court Legal Services Committee shall bear the honorarium of ₹ 50,000/- (Rupees fifty thousand only) to be paid to the *amicus* Ms. Shukla.

95. The appeal is allowed and any pending applications are disposed of in the above terms.

.....J.
[S. RAVINDRA BHAT]

.....J.
[DIPANKAR DATTA]

NEW DELHI;
SEPTEMBER 26, 2023

मुख्यालय/HEADQUARTER
कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मन्त्रालय भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment, Govt. of India)

क.रा.बी.नि.
E.S.I.C.

सत्यमेव जयते

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No.:U-16013/180/2023-MED-I(E-491176) Dated: 03.11.2023

To
DEANs/Medical Superintendents/DIMS/
Zonal Medical Commissioner
ESIC Medical College & Hospitals

Subject: Integration of National AIDS Control Programme in ESIC Medical Institutions/ Hospitals for preventive, diagnostic and treatment services

Madam/Sir,

The National AIDS Control Programme (NACP) is being implemented as a comprehensive programme for prevention and control of HIV/AIDS in India and National AIDS Control Organization (NACO) is the organization set up by the Government to implement the project.

The Guidelines for ESIC Hospitals for integrating with the National AIDS Control Programme (NACP) through NACO are issued as enclosure for wide circulation and adherence.

This issues with the approval of the Competent Authority

Dr. Manoj Kumar
OSD (MS)

Copy to: -

- All Regional Directors

Recommendations of committee constituted for integration of National AIDS Control Programme in ESIC Medical Institutions/ Hospitals for preventive, diagnostic and treatment services

National AIDS Control Organization is a division of the Ministry of Health and Family Welfare that provides leadership to HIV/AIDS control programme in India through 35 HIV/AIDS Prevention and Control Societies. In 1986, following the detection of the first AIDS case in the country, the National AIDS Committee was constituted in the Ministry of Health and Family Welfare. As the epidemic spread, need was felt for a nationwide programme and an organization to steer the programme. In 1992 India's first National AIDS Control Programme (1992-1999) was launched, and National AIDS Control Organization (NACO) was constituted to implement the programme.

At present, National AIDS and STD Control Programme (NACP) Phase-V is ongoing and is a Central Sector Scheme fully funded by the Government of India. The NACP is providing comprehensive package of prevention, detection and treatment services directed towards the attainment of United Nations' Sustainable Development Goals 3.3 of ending the HIV/AIDS epidemic as a public health threat by 2030. Esic is a leading healthcare provider in India to Insured Persons (IP's) and every effort should be made to deepen links to develop integration with NACP so that the benefit of quality preventive, diagnostic and treatment services can be passed on to our IP's.

In this regard, the committee recommends training for all cadres of healthcare staff involved in diagnostic, treatment and preventive services. in accordance with the National AIDS Control Organization (NACO) guidelines, the recommendations are as follows:

I. ESTABLISHMENT OF TESTING INTEGRATED COUNSELLING AND TESTING CENTRE (ICTC CENTRE) IN ESIC MEDICAL INSTITUTIONS/ HOSPITALS:

HIV COUNSELLING & TESTING

HIV testing determines whether a person is infected with HIV or not. It's a simple blood test to determine anti-HIV antibodies. Diagnosis of HIV/AIDS is not like other infectious diseases. A number of moral, ethical, legal and psychosocial issues are associated with a positive HIV status. Disease is lifelong, disease is variable, no cure and vaccine is available so far, and in

majority, the transmission is through sexual contact. Hence, HIV positive individuals are likely to be stigmatized and fear being discriminated or socially outcasted.

Therefore, following care need to be taken (5Cs) while performing test for HIV (National HIV Counselling and Testing Services (HCTS) Guidelines December 2016):

1.COUNSELLING (PRETEST & POST TEST)
2. CONSENT
3.CONFIDENTIALITY
4.CORRECT TEST
5.CONNECTION TO CARE, SUPPORT AND TREATMENT

WHERE TO CONDUCT COUNSELLING & TESTING

As per NACO guidelines, HIV testing & counselling can be conducted at a health care facility(hospital) through their existing staff with due sensitization, orientation, guidance, monitoring and training by the respective State AIDS Control Society (SACS).

Proper signages should direct and guide people to reach the site and functionary for HIV screening. To ensure audio-visual privacy and confidentiality during HIV screening and counselling, the health facility should earmark a suitable room with good cross-ventilation to prevent air-borne infection.

WHICH POPULATION TO BE TESTED FOR HIV (*National HIV Counselling and Testing Services (HCTS) Guidelines 2016):*

Healthcare Provider to offer HIV testing to the following priority populations:

a) All pregnant women

b) Babies born to HIV-positive women

c) Untested children of women living with HIV (WLHIV)

d) Children presenting with suboptimal growth or severe acute malnutrition, delay in developmental milestones, oral thrush, severe pneumonia and sepsis

e) Patients who present with signs and symptoms suggestive of HIV/AIDS in any health-care setting including emergency

f) Individuals who have faced sexual assault

g) Before initiating PEP and as a follow-up testing

h) Patients with TB or presumptive TB, Kala-azar, hepatitis B or C, or STI/RTI

i) STI/RTI clinic attendees

j) Sexual partners/spouses of PLHIV

k) Any other situation where the health-care provider feels HIV testing is essential

1.COUNSELLING:

PRETEST COUNSELLING

Provide pre-test counselling to the individual and document the details in the counselling register. Counsel using posters, flip charts, brochures and short video clips so as to prepare him/her for the HIV test and to address myths and misconceptions.

2. CONSENT (INFORMED CONSENT):

Take informed consent of individual for HIV testing with signature/ thumb impression in the counselling register. Each individual should give informed consent **for testing with an opt-out option.** In case of individuals below 18 years of age, informed consent has to be obtained from their parents.

If individual opts for HIV testing, provide information related to testing procedure. If individual opts out, provide further counselling to the individual on the benefits of knowing his/ her HIV status.

Conduct HIV screening testing as per applicable procedures.

POST TEST COUNSELLING:

a) For individuals screened reactive, provide post-test counselling .

b) Explain the test results and diagnosis results and help him/her cope with emotions arising from the diagnosis of HIV infection

c) Provide clear information on free ART (where it is offered, when ART will start, for how long it has to be taken, how many times it has to be taken, who will provide ART, what tests

are required for starting ART, side-effects and benefits of ART, available social benefit schemes, importance of adherence to ART etc

d) About opportunistic infections, etc.) and reducing the risk of HIV transmission

e) Ensure linkage with an ART Centre while addressing any specific barrier

f) Discuss possible disclosure of the result and the risks and benefits of disclosure, particularly among couples

g) Encourage and offer HIV testing for untested sexual partner(s)/spouse and children (age upto14 years) of HIV-positive women.

3. CONFIDENTIALITY:

The results of HIV test will only be known to the patient and treating medical team. The test results are confidential and it is against policy to share patient's report with others without his permission.

4. CORRECT TESTING:

HIV testing in the National AIDS Control Programme (NACP) is performed by:

- The Integrated Counselling and Testing Centres (ICTCs) for individual testing in healthcare facilities
- Blood Banks (for safety of blood products).

HIV infection in any individual beyond 18 months of age can be detected by laboratory test/s that demonstrate(s) either the virus or viral products, or antibodies to the virus in blood/serum/plasma. In children below 18 months of age, due to persistence of maternal antibodies, diagnosis of HIV is made by PCR tests that detect HIV nucleic acid.

Quality Checked Diagnostic Kits' supply from NACO: Need-based quantities of these test kits should be supplied on a regular basis by respective SACS to the ESIC Health care Facility. These test kits need to be stored between 2°C to 8 °C in the refrigerator available at the health facility.

Under the NACP, the most commonly employed rapid tests are based on the principle of enzyme immunoassay, immuno-chromatography (lateral flow), immuno-concentration/dot-

blot assays (vertical flow) and particle agglutination. All these different rapid tests should have a sensitivity of ≥99.5% and specificity of ≥98%.

HIV testing strategies for Adults and Children (above the age of 18 months)

National HIV testing strategies enable the Programme to screen for HIV or confirm the diagnosis of HIV among priority populations at the nearest facility. In view of the low prevalence of HIV in India, it is necessary to use three different principles or antigen-based rapid tests to confirm the diagnosis. Every individual with an HIV-non-reactive result should be educated about the possibility of a window period, and that a non-reactive result does not always rule out the possibility of HIV infection, if the individual has been recently infected.

Strategy I :

Single test (enzyme-linked immune sorbent assay [ELISA] or rapid) is mandatory for screening of donated blood in blood banks. If found reactive for HIV, the donated blood should not be used for transfusion or transplantation, and after informed consent, the donor should be promptly referred to the linked SA-ICTC for confirmation of the HIV diagnosis and further necessary action.

Strategy II (A):

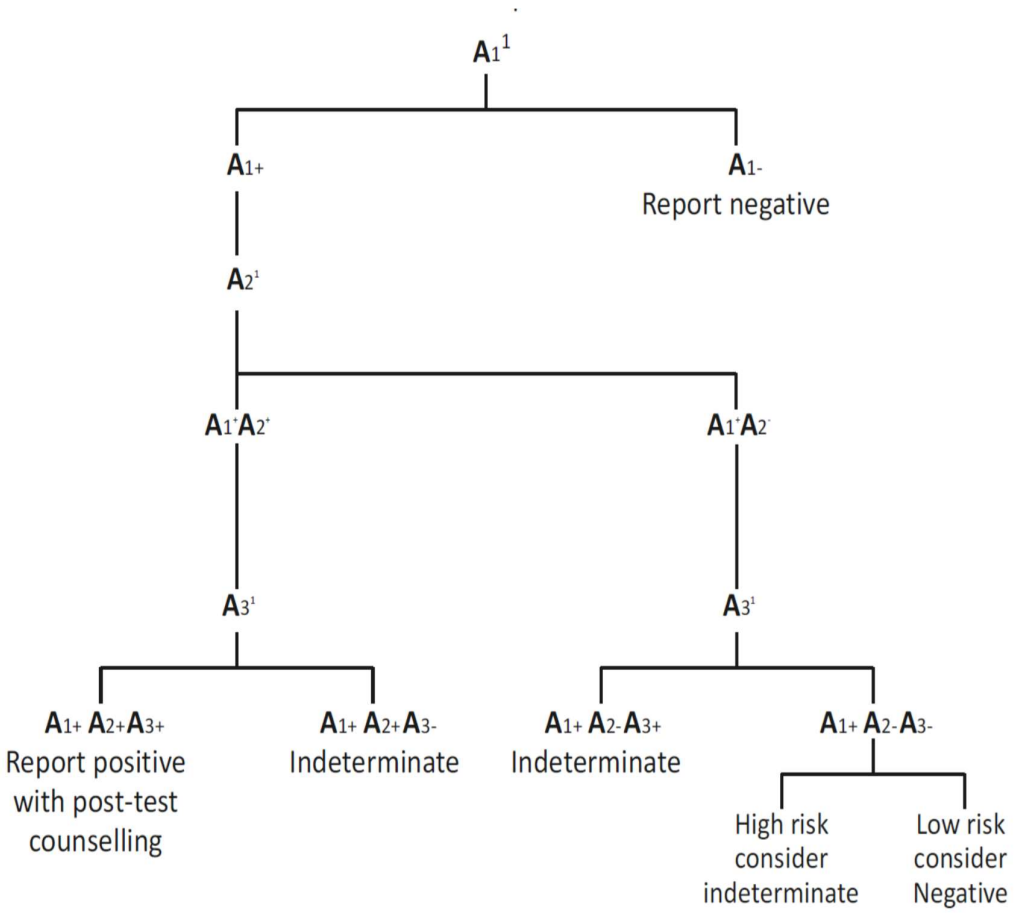
Two rapid tests are mainly used in case of HIV sentinel surveillance where two testing kits are being used.

Strategy II (B):

A patient who is clinically symptomatic and suspected to have an AIDS indicator condition/ disease is referred to the SA-ICTC for confirmation of the diagnosis. In this case, the same blood sample is tested twice using kits with either different antigens or principles. The patient is declared HIV-negative if the first test is non-reactive and as HIV-positive when both tests show reactive results. When there is discordance between the first two tests (first reactive and the second non-reactive), a third test is done. When the third test is also negative it is reported as negative. When the third test is reactive, it is reported as indeterminate and the individual is retested after 14–28 days.

Strategy III: For healthcare facilities such as ESIC hospital, this strategy is most commonly used for individual screening for HIV by employing a single rapid test kit. If the test is found non-reactive, the individual is considered HIV-negative and needs to be followed, as per the guidelines. If the test result is found reactive, the sample should be retested with two different kits based on a different antigen or principle. The individual is considered HIV positive when all three tests show reactive results.

Diagnostic Strategy III



(*National AIDS Control Organization (2021). National Guidelines for HIV Care and Treatment, 2021. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India*)

MANPOWER REQUIRED FOR COUNSELLING & TESTING:

S. No.	Staff	Job responsibility	Roles
1.	**Counsellor: Qualification:** Counsellor should be a graduate degree holder in Psychology/Social Work/Sociology/ Anthropology/Human Development OR diploma in Nursing with minimum 3 years of experience in HIV/AIDS.	**1 counsellor for less than 500 individuals/ month need to be counseled 1 additional for > 500 counselling/ month**	• Ensure that each individual tested for HIV is given pre-test counselling, posttest counselling & follow-up counselling, ensuring audio-visual privacy and confidentiality • Provide psychosocial support to individuals for accepting HIV test results • With the consent of PLHIV, counsel and prepare the family for acceptance and support the PLHIV • Home visit to PLHIV with prior consent, is one of the outreach activities. The visit is to be planned based on need, such as loss of linkage, or non-compliance to the prescribed services • Maintain counselling records and registers, and prepare monthly report. • Update details of HIV-positive individuals on a weekly basis in PLHIV ART Linkage System (PALS) • Prepare a monthly/quarterly /annual data analysis and display the updates • Facilitate and monitor linkages and referrals to and from the ICTC
2.	**Lab technician** The LT should hold at minimum a Diploma in Medical Laboratory Technology (DMLT) from state government-approved institution. LT needs to undergo the 5-days induction and 3-days refresher training as per the NACO guidelines	One LT for less than 10,000 annual test load. For every additional 5,000 annual tests, one additional LT, subject to the maximum of three LTs, may be appointed	• Perform HIV tests as per national guidelines Participating in proficiency testing and quality control activities Participate in training activities conducted by SRLs • Ensure that the laboratory premises and workstation are maintained as per the infection control protocols. • Ensure maintenance of all laboratory equipment including cold chain of test kits • Conduct testing for HIV as per NACO testing protocols following SOPs • Follow internal and external quality assurance procedures • Follow universal safety precautions and strictly adhere to biomedical waste management guidelines

5. CONNECTION TO CARE, SUPPORT AND TREATMENT

Connections/Linkages is defined as a process of actions and activities that support people testing for HIV and people diagnosed with HIV to engage with prevention, treatment and care services as appropriate for their HIV status. For people with HIV, it refers to the period beginning with HIV diagnosis and ending with enrolment in care or treatment.

II. ROLE OF NACO IN CAPACITY BUILDING WHICH CAN BE UTILISED FOR ESIC MEDICAL COLLEGES/ HOSPITALS

1. ESIC medical colleges/ hospitals should get in touch with the respective SACS for conducting the training courses for medical officers, LTS, counsellors in ESIC medical colleges/ hospitals.
2. Services of State AIDS Control Society (SACS) can be utilised for efficient planning, implementation, coordination, monitoring, reporting and ensuring timely corrective measure in respect of training programs in the respective ESIC medical colleges/ hospitals.
3. SACS may ensure an appropriate involvement of the State Reference Laboratory, DAPCUs, identified training centres and suitable master trainers as per subject needs for training courses.
4. In situ trainings for hospital staff can also be conducted as per requirement of the institute.
5. The training courses currently offered by NACO which can be utilised by ESIC are as follows:

TRAININGS CONDUCTED BY NACO FOR CAPACITY BUILDING :I

S. No	Training Program	Eligible HCTS staff	Level of conducting training	Training Module	Trainer	Duration
1	Counsellors' Integrated Induction Training	New and untrained Counsellors of FICTC,PPP-ICTC,CBS,PITC, SA-ICTC, ARTC and DSRC/STI	State /UT at Identified Institutions	Integrated Induction Training Module	Master Trainers	Eight days
2	Counsellors' Integrated Refresher Training (Refresher I – after two years of induction training and Refresher II- after two years of Refresher I training)	Counsellors of FICTC, PPP-ICTC, CBS,PITC, SA-ICTC, ARTC and DSRC/STI, those who have already Undergone Induction Training	State /UT at Identified Institutions	Integrated Refresher Training Module	Master Trainers	Refresher I – Three days; Refresher II – Two days
3	HIV/TB Collaborative Training	SA-ICTC Medical Officer* ART Medical Officer * SA-ICTC Counsellor** District ICTC Supervisor** RNTCP – STS / STLS** DR - TB HIV Supervisors**	State/UT/ District	Integrated HIV / TB Training Module	Master Trainers	*Two days for Medical Officers **One day for others
4	Lab Technicians' Induction Training	New and untrained Lab technician at SA - ICTC, F-ICTC & PPP- ICTC	State/UT	Induction Training Module	State Reference Laboratory (SRL)- In charge and Technical Officer	Five days

S. No	Training Program	Eligible HCTS staff	Level of conducting training	Training Module	Trainer	Duration
5	Lab Technicians' Refresher Training After two years of Induction Training	In-service Lab Technicians at SA - ICTC, F-ICTC, & PPP-ICTC	State/UT	Refresher Training Module	SRL - In charge and Technical Officer	Three days
6	F - ICTC Staff' Hands on Sensitization and Orientation	Nurses / LHV / ANM / MPW Male / LT / Pharmacist RNTCP – LT / STS / STLS TI NGO Staff	District / SA - ICTC	Hands on Sensitization and Orientation Module	DAPCU / SA - ICTC Medical Officer, Counsellor and LT	One day
7	District ICTC Supervisors' Training	District ICTC Supervisors	State/District	DAPCU Training Module	Master Trainers	Three days
8	SA – ICTC Staff' Team Training	Medical Officer, Counsellor, Lab Technician from SA -ICTC and Labour Room Staff Nurse of the Health Facility where SA-ICTC is located	State	Team Training Module	Master Trainers	Three days
9	Full Site Sensitization on NACP	Medical, Nursing and Paramedical Staff of the Health Facility where SA-ICTC is located	At respective Health Facility where SA – ICTC is located	Sensitization Module	DAPCU/ District HIV Nodal Officer/ SA-ICTC MO, Counsellor & LT	One day
10	Training on PLHIV - ART Linkage System (PALS)	SA - ICTC Counsellor, ART Data Managerand DAPCU and SACS M&E and Data Managers	State/District/ Facility	Password Protected Software and Web -based User Manual	Master Trainers	One day
11	Training on SIMS	SA-ICTC – Counsellor and Lab Technician F-ICTC/PPP-ICTC/ TI functionary conducting HIV screening tests, DAPCU, District supervisor and SACS officials	State/District/ Facility	SIMS Training module Web -based User Manual	Master Trainers	One day

III. PROVISION FOR AVAILABILITY OF ART IN ESIC INSTITUTIONS/ HOSPITALS FOR USE IN SPECIAL CIRCUMSTANCES

1. As per NACO guidelines 2021, treatment for HIV with anti retroviral therapy (ART) has to be initiated irrespective of CD- 4 count.

Current NACO guidelines on when to start ART

All persons diagnosed with HIV infection should be initiated on ART regardless of the CD4 count or WHO Clinical Stage or age group or population sub-groups

2. The various Anti-Retroviral drugs approved for HIV treatment are as follows:

Nucleoside reverse transcriptase inhibitors (NsRTI)	Non-nucleoside reverse transcriptase inhibitors (NNRTI)	Protease inhibitors (PI)
Zidovudine (AZT)*	**Nevirapine (NVP)***	Saquinavir (SQV)
Stavudine (d4T)	**Efavirenz (EFV)***	**Ritonavir (RTV)***
Lamivudine (3TC)*	Delavirdine (DLV)	Nelfinavir (NFV)
Abacavir (ABC)*	Rilpivirine (RPV)	Amprenavir (APV)
Didanosine (ddI)	Etravirine (ETV)	Indinavir (INV)
Zalcitabine (ddC)	Doravirine (DOR)	**Lopinavir (LPV)***
Emtricitabine (FTC)	**Integrase Inhibitors**	Fosamprenavir (FPV)
Nucleotide reverse transcriptase inhibitors (NtRTI)	**Dolutegravir (DTG)***	**Atazanavir (ATV)***
	Raltegravir (RGV)*	Tipranavir (TPV)
	Elvitegravir (EVG)	**Darunavir (DRV)***
Tenofovir Disoproxil Fumarate (TDF)*	Bictegravir (BIC)	
Tenofovir Alafenamide (TAF)	Cabotegravir (CAB)	
Fusion inhibitors (FI)	**CCR5 entry inhibitor**	**Post attachment maturation inhibitor**
Enfuvirtide (T-20)	Maraviroc (MVC)	Ibalizumab (IBA)
***Available in the national programme**		

3. The usual first line ART approved by NACO is:

Tenofovir (TDF 300 mg) + Lamivudine (3TC 300 mg) + DOLUTEGRAVIR (DTG 50 mg) regimen (TLD) as FDC in a single pill once a day (at a fixed time every day as per patient's convenience)

4. A linkage with nearest NACO registered ART centre may be established by respective ESIC hospitals/ medical colleges for initiation and continuation of ART including monitoring tests such as CD4 count and viral load for patients newly diagnosed for HIV. For this purpose, patient will be referred for ART to these centres. The ART centre will also provide the following monitoring facilities as per NACO guidelines :

Monitoring Tool	When to Monitor
Body weight Height / length in children	Every visit
Treatment adherence	Every visit
Clinical monitoring and T-staging	Every visit
4-symptom TB screening	Every visit
Screening for common NCD; Hypertension, Diabetes mellitus	Every 6 months or symptom directed
Laboratory evaluation based on ART regimen	Every 6 months or symptom directed
CD4 Count	CD4 must be done every 6 months*
Viral load	At 6 months, 12 months and then every 12 months**

5. In case of those ESIC medical colleges/ hospitals with a substantial HIV patient LOAD can approach their respective SACS to establish ART centre in their premises.
6. However, for management of rest of the comorbidities/ infections and investigations as required from time to time, patients to be managed at their respective ESIC hospitals.
7. Provision for indent of certain quantity of ART drugs at ESIC hospitals from ART centres can be arranged for potential use in special circumstances like for Post Exposure Prophylaxis (PEP) for healthcare workers and for any contingency situations. These medicines can be stocked in casualty department of ESIC hospitals for potential use in special contingent circumstances.

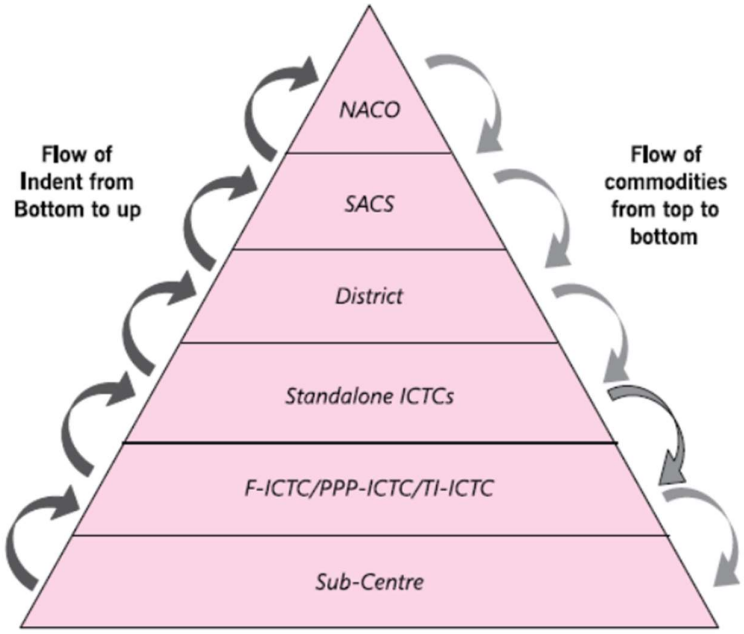
Exposed Person	Preferred Regimen for PEP Drugs and Dosages	Remarks
Adults (>30 kg weight)	Tenofovir (300 mg) + Lamivudine (300 mg) + Dolutegravir (50 mg) (FDC: One tablet OD)	PEP for HIV should ideally begin within 2 hours of exposure as it is essential to act immediately. There is little benefit if more than 72 hours have elapsed. The prophylaxis needs to be continued for 28 days.

The PEP drugs should be kept at the casualty where they are available round the clock. A casualty medical officer may be designated nodal officer to assess the need for PEP in cases of accidental needle stick injury or exposure to blood/ body fluids.

IV. INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES FOR AWARENESS REGARDING PREVENTIVE PRACTICES

1. The available display and IEC materials to be used at testing centres, OPD's, waiting areas such as information panels, posters, flip charts, booklets, pamphlets, etc. can be procured SACS.
2. Signs and signages should be ensured within the facility premises for easy access to services.
3. Provision of people-friendly services should be prominently displayed in the hospital / service centre.
4. Local branding of services may be considered to build confidence in the facility (appropriate ambience, good posters, etc.).
5. Awareness activities for prevention of the disease may be undertaken such as lectures and nukkad nataks in OPDs for general public.

V. ESTABLISHING LINKAGES BETWEEN ESIC INSTITUTES AND RESPECTIVE SACS



A BRIEF OVERVIEW OF FLOW OF SERVICES FROM NACO TO PERIPHERAL HEALTH CENTRES.

Many of the ESIC hospitals come in the category of SA-ICTC and need to develop linkages with their designated SACS for delivery of HIV related services.