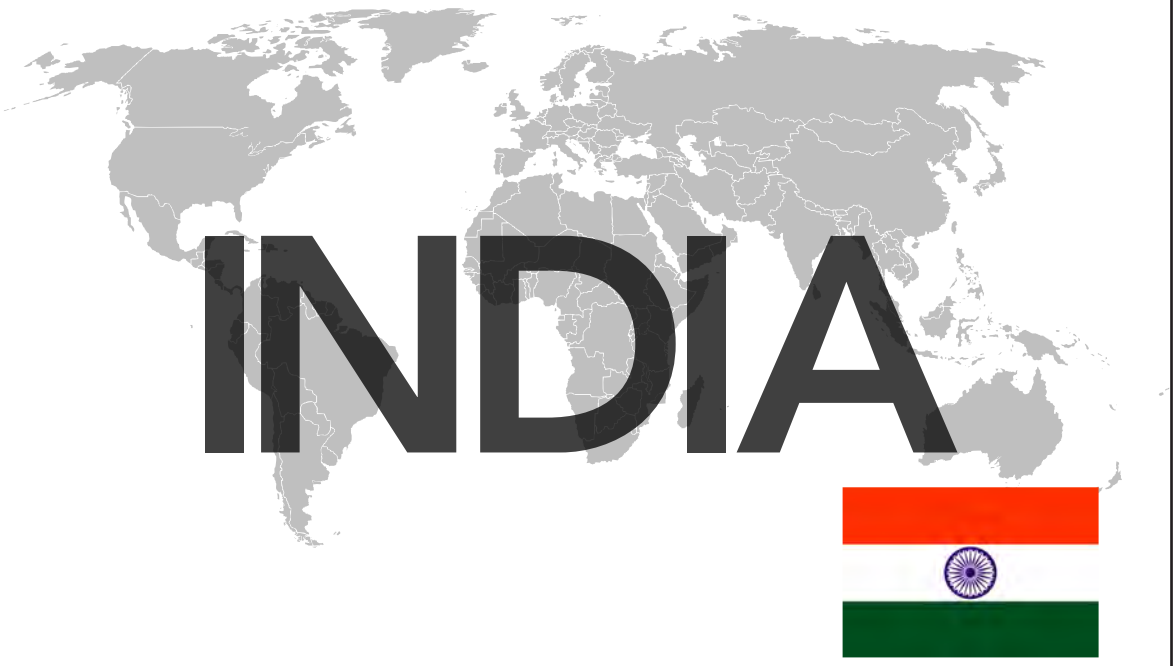
National Youth Shadow Report

Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS



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The Global Youth Coalition on HIV/AIDS (GYCA) is a youth-led, UNAIDS and UNFPA-supported alliance of 1,600 youth leaders and adult allies working on HIV/AIDS worldwide. The Coalition, based at a North Secretariat in New York City and a South Secretariat in Port Harcourt, Nigeria, prioritizes capacity building and technical assistance, networking and sharing of best practices, advocacy training, and preparation for international conferences.

GYCA aims to empower youth with the skills, knowledge, resources, opportunities, and credibility they need to scale up HIV/AIDS interventions for young people, who make up over 50% of the 5 million people infected with HIV each year. Our members are working at the local, national, regional, and international levels to ensure that young people are actively involved in policies and programmes to halt the spread of the deadly pandemic.

For more information about GYCA or to join, please visit www.youthaidscoalition.org or write to info@youthaidscoalition.org.

The views and findings in this report are those of the author alone.

About the Author

Himakshi Piplani, 18, is a youth activist from India. Himakshi's interest in HIV/AIDS and Health related Human Rights of young people and children developed early last year while she was researching for an article on Sexual Abuse and Violence against children and young people in the war-torn Darfur region. A couple of months later she also attended the first day of the three day long International Inter-Faith Conference on HIV/AIDS organized by National Aids Control Organization (NACO) of India which prompted her to do further research on the HIV/AIDS scenario in India and abroad. Through UNICEF's Voices of Youth forum, Himakshi got the opportunity to do an e-course with Global Youth Coalition on HIV/AIDS (GYCA) on Political Advocacy (with a focus on UNGASS and Millennium Development Goals). It led her to develop an advocacy campaign plan based on increasing young people's access to HIV/AIDS related Information, Education and Communication services in India. Himakshi hopes to further work towards ensuring greater access of young people to HIV/AIDS relates services and towards protecting health related human rights of children and young people in general. She will be attending the UNGASS AIDS 2006 Review in New York, May/June 2006, at the United Nations Secretariat.

Acknowledgements

I would like to thank the following people for their invaluable contribution to this report:

Mr. Arun Joshi for helping me out with the research on financial commitment;
Mr. Kenneth Mohanty and his team in Kolkata for their input on the ground level situation at VCTC, schools and colleges in Kolkata;
Mrs. Usha Rajput for an insight on Adolescent Education Program in govt. schools (Delhi.);
Ms. P. Anjali Mehta for her inputs on LSBE at Amity International School, a leading public school in Noida (U.P);
Ms. Revathi Rajaramn of ThoughtShop Foundation;
Ms. Shakuntala Biswas of NRS Medical College Sealdah, Kolkata (VCTC);
and lastly,
Mila Gorokhovich and Joya Banerjee of GYCA for their constant support and invaluable guidance!

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List of Abbreviations used:

1. HIV/AIDS - Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome.
2. NACO – National AIDS Control Organization
3. STD/STI – Sexually Transmitted Disease/Infection
4. IDU – Injecting Drug User
5. MSM – Men who have Sex with Men
6. IEC – Information, Education and Communication
7. VCTC – Voluntary Counseling and Testing Centre
8. UNGASS – United Nations General Assembly Special Session on HIV/AIDS
9. SRH – Sexual and Reproductive Health
10. LSBE – Life Skills Based Education
11. MOHFW – Ministry of Health and Family Welfare
12. YPTA – Young People Talk Aids
13. UTA – Universities Talk Aids.
14. BCC – Behavior Change Communication
15. NACP – National AIDS Control Programme.
16. USD – US Dollars.
17. USAID – United States Agency for International Development.
18. UNAIDS – The Joint United Nations Program on HIV/AIDS
19. DFID – Department For International Development, UK.
20. CIDA – Canadian International Development Agency
21. AUSAID – Australian Agency for International Development
22. UNDP – United Nations Development Programme.
23. PLWHA – People Living With HIV and AIDS
24. WHO – World Health Organization

Preface[1]

On 25–27 June 2001, heads of State and government representatives met for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), which resulted in the issuance of the Declaration of Commitment on HIV/AIDS (DoC). The DoC outlines what governments have pledged to achieve– through international, regional and country-level partnerships and with the support of civil society– to halt and begin to reverse the spread of the HIV/AIDS pandemic. The DoC is not a legally binding document; however, it is a clear statement by governments concerning what should be done to fight the spread of HIV/AIDS and what countries have committed to doing, with specific time-bound targets[2].

The DoC is unique because it recognized the **specific vulnerability of young people** to HIV and AIDS and established time-bound targets for action:

- (Paragraph 37) By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that (…) involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people (…)

- (Paragraph 47) By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal: to reduce, by, 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent.
  - To reduce, by 2010, HIV prevalence among young men and women aged 15-24 globally.
  - To intensify efforts to achieve these targets as well as to challenge gender stereotypes, attitudes, and inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.

- (Paragraph 53) By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV/AIDS education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers.

- (Paragraph 63) By 2003, develop and/or strengthen strategies, policies and programmes:
  - Which recognize the importance of the family in reducing vulnerability, in educating and guiding children and take account of cultural, religious and ethical factors,
  - To reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents;
  - Ensuring safe and secure environments, especially for young girls;
  - Expanding good-quality, youth-friendly information and sexual health education and counseling services;
  - Strengthening reproductive and sexual health programmes; and
  - Involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible.

As part of the monitoring process of the DoC, progress made towards attaining the targets will be reviewed at the UN General Assembly in New York on May 31- June 2, 2006. The participation of young people in this review process is critical and this report strives to ensure their voices are heard.

[1] Global Youth Coalition on HIV/AIDS and Global Youth Partners, "Our Voice, Our Future: Young People Report on Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS."UNFPA, 2004.
[2] DoC on HIV/AIDS. Resolution adopted by the UN General Assembly, A/RES/S-26/2. August 2001

Methodology

To ensure that the voices and concerns of young people are included in the monitoring process of the UNGASS DoC in its five year review, young people from around the world reported on the progress made towards achieving the UNGASS targets related to young people in their countries.

To ensure that all of the country reports addressed the same issues, a guide was developed by young people with the technical assistance of adult allies to assist youth researchers in gathering information and reporting on their country's progress.[3] A number of questions, based on the indicators suggested by the UNAIDS *National AIDS Programmes - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*",[4] were suggested to guide their research. Members of the Global Youth Partners Initiative[5] actively contributed to the development of the research tool in 2004 through an interactive e-discussion. Data collection and analysis focused on four main indicators:

1) Political Commitment
2) Financial Commitment
3) Access to Information Services
4) Youth Participation

Young people used a range of methods to conduct their research and collect relevant information. They gathered inputs from young people, including young people living with HIV and AIDS (YLWHA) in their countries through focus group discussions, in-depth interviews and workshops. Young people were asked to make recommendations for strategies to ensure that their country would achieve the UNGASS targets for young people. This qualitative information was supplemented by reviews of national policies, laws and documents, as well as academic literature. Young people also consulted representatives from national and local governments and national AIDS programmes, as well as various stakeholders such as service providers, representatives from NGOs, international and bilateral organisations. The final reports were reviewed and edited by GYCA staff, preserving original content.

Why focus on young people?

Over half of all new infections worldwide each year are among young people between the ages of 15 and 24. Every day, more than 6,000 young people become infected with HIV – almost five every minute. Yet the needs of the world's over one billion young people are often ignored when strategies on HIV/AIDS are drafted, policies developed, and budgets allocated. This is especially tragic as young people are more likely than adults to adopt and maintain safe

[3] The research guide is available upon request.
[4] National AIDS Programmes - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people. UNAIDS, 2004.
[5] Global Youth Partners (GYP) is a UNFPA youth-adult partnership initiative, and aims to rally partners and stakeholders to increase investment and strengthen commitments for preventing HIV infections among young people, especially among under-served youth. GYP is building capacity of GYP team members, learning lessons from successful advocacy campaigns and building partnerships and collaborative networks with other youth initiatives, including youth-adult partnerships. In the foreground of the initiative stands the development, implementation and monitoring of national strategic advocacy action plans in seven countries.

behaviours.[6] Young people are vulnerable to HIV infection because they lack the crucial information, education, and services to protect themselves.

The 2001 United Nations General Assembly Special Session on HIV/AIDS noted, "poverty, under-development and illiteracy are among the principal contributing factors to the spread of HIV/AIDS". These factors are particularly poignant for young people who are so often voiceless and powerless in society. Young people are in a transitional phase between childhood and adulthood, and are rarely taken into account in official statistics, policies, and programmes.

This year, 2006, marks five years since the DoC was put into effect. The author and 60 young leaders in HIV/AIDS will participate in the Five Year AIDS 2006 Review at the United Nations Secretariat to advocate to decision-makers to scale-up comprehensive, evidence-based interventions on HIV/AIDS for and with young people.

[6] Young People and HIV/AIDS, Opportunity in Crisis. UNICEF, UNAIDS & WHO, 2004.

I. Introduction

The face of HIV/AIDS in India today is sadly that of a young person. Poverty, low literacy levels, inadequacy of youth-oriented information and services along with gender inequality are making young people increasingly vulnerable to this disease. Over 35 % of new infections every year occur in the age group of 15-24 in India.[7] In 2003 alone, 184,100 young Indians in this age group were infected with HIV.[8] Moreover, the disease is now moving from high-risk populations to general population underscoring the urgent need for scaling up of preventive measures. India's history with HIV is two decades old with first case having been reported in 1986 in Chennai. Although the overall HIV prevalence in the country remains less than 1 % as opposed to the double digit figures in parts of Africa, India now accounts for up to 10 % of the 40 million people living with HIV/AIDS globally, with the second highest prevalence rate in the world.[9]

Heterosexual Transmission accounts for up to 85% of the HIV infections. Spread of HIV in intravenous drug use settings is localized mostly to the north-eastern region of the country and some metropolitan cities. Parent to Child Transmission of HIV is also on the rise.
The National AIDS Control Organization, Ministry of Health & Family Welfare updates the HIV estimates for the country every year since 1998 for monitoring the trends and pattern of HIV/AIDS epidemic in the country. The HIV burden is estimated on the basis of the HIV prevalence observed at designated sentinel surveillance sites for different risk groups. The Data thus compiled is used for epidemiological analysis and estimation purpose. The sentinel sites, which have gone up from 184 in 1998 to 659 in 2004[10], cover both high-risk populations such as attendees of Sexually Transmitted Diseases (STD) clinics, injecting drug users (IDUs), sex workers and men who have sex with men (MSM) as well as highly vulnerable populations such as women attending antenatal clinics.

The annual sentinel surveillance surveys from 1998 to 2002 have divided States and Union territories in India into three broad categories:

- **High prevalence:** Maharashtra, Tamil Nadu, Manipur, Andhra Pradesh, Karnataka and Nagaland are states which have HIV prevalence rates exceeding 5% among groups with high-risk behavior and 1% among women attending antenatal clinics in public hospitals.

- **Concentrated epidemics:** Gujarat, Pondicherry and Goa where the HIV prevalence rate among populations with high-risk behavior has been found to be 5% or more, but HIV prevalence rates remains below 1% among women attending ante-natal clinics.

- **Low prevalence:** All other States and Union Territories fall into the low prevalence category because HIV prevalence rates among high risk population is below 5 per cent and less than 1% among women attending ante-natal clinics.

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[7] 'Trends and Estimates of HIV Infections', UNAIDS, http://www.unaids.org.in/displaymore.asp?itemid=56&chkey=76&subchkey=0&chname=HIV%20Epidemic%20i

[8] 'HIV Estimates 2004', NACO, http://www.nacoonline.org/facts_hivestimates04.htm (The figure has been arrived at through deductive analysis of the data.)

[9] 'AIDS Epidemic Update', December 2004, UNAIDS

[10] 'HIV Estimates 2004', NACO, http://www.nacoonline.org/facts_hivestimates04.htm

Of late NACO has reclassified **Low Prevalence** States as **High Vulnerable** States – an acknowledgement of the need to address vulnerabilities in these States with as much priority as in other more affected states.
Tracking the epidemic and implementing effective programs is compounded by the fact that there is no one epidemic in India. Rather, there are several localized sub-epidemics reflecting the diversity in socio-cultural patterns and multiple vulnerabilities present in the country.

II. Methodology for Gathering Information

- *LITERATURE REVIEW*: A comprehensive and thorough review, of the existing documentation and literature on political commitment, financial commitment, participation of youth and access to information, education and communication (IEC) and other relevant services as well as on evaluation of programs and policies was undertaken. The information obtained was analyzed to identify relevant achievements and gaps.
- *INTERCATIVE RESEARCH:* As a part of the interactive research, several young volunteers evaluated the ground-level situation in their respective cities through interviews with Youth Counselors at schools and VCTCs, chemists, consultations with local NGOs, surveys etc.

III. Key Findings and Recommendations

FINDINGS: Over the last few years the HIV/AIDS scenario pertaining to young people has undergone a paradigm shift.

Below is a summary of key findings.

a.) The Govt. is now **recognizing the place of adolescents** in India's response to the HIV/AIDS epidemic and has shown **commitment towards greater youth participation**.[11]

b.) **India has achieved success in reducing the rate of new HIV infections in the South India especially among young people since 2000 due to intensive IEC initiatives.** HIV prevalence among women aged 15 to 24 years in the states of Tamil Nadu, Maharashtra, Karnataka and Andhra Pradesh (High Prevalence states) has fallen from 1.7 percent to 1.1 percent in a four-year period (2000-2004).[12]

c.) **A large percentage of young people have heard about HIV/AIDS but do not have comprehensive knowledge on it especially regarding prevention methods.** According to UNAIDS, only 17% of male and 21% of female respondents were able to identify two prevention methods and reject three misconceptions.[13] Hence comprehensive IEC initiatives with nation-wide coverage are lacking.

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[11] Refer to section on political commitment and youth participation for more information.
[12] 'HIV infection rate down in South India', Nirmala George (AP), http://www.washingtonpost.com/wp-dyn/content/article/2006/03/30/AR2006033001817.html
[13] ' India – Comprehensive Indicator Report' , HIV Insite (UCSF Centre for HIV Information) University of California

d.) **Political and Financial Commitment to fight HIV/AIDS has been strengthened over the last five years**. However, young people's vulnerability to the epidemic persists since there is no separate budgetary allocation to address young people as a comprehensive group.

RECOMMENDATIONS: The efforts of the Government of India to meet UNGASS targets so far have been commendable. Based on our research we would like to suggest the following:

a.) Extend existing youth based services such as 1097 Helpline and Young People Talk AIDS program to all cities.

b.) Scale up IEC initiatives further throughout the country including low prevalence states and rural areas as well through comprehensive media campaigns.

c.) Introduce Adolescent Education/ Life Skills Based Education as a mandatory part of the curriculum in all government and public schools with immediate effect.

d.) Introduce family based orientation initiatives/programs to combat stigma and discrimination and encourage open discussions on Sexual and Reproductive Health.

e.) Greater involvement of young people for policies and programs related to young people, at the policy-making levels through regular interaction and adequate representation in international, national and state level bodies.

IV. Results

POLITICAL COMMITMENT

Recent years have seen a steadily rising level of awareness and action among elected representatives on the issue of HIV/AIDS. The formation of the Parliamentary Forum is a proof of this.

- Shri Atal Behari Vajpayee, ex-Prime Minister of India, National Convention for Elected Representatives on HIV/AIDS, July 26, 2003

Political Commitment towards HIV/AIDS has increased in recent years. Formation of the Inter Parliamentary Forum on HIV/AIDS that further organized the first ever National Convention of Elected Representatives on HIV/AIDS (July 2003) and National Student and Youth Parliament Special Session on HIV/AIDS (November 2003; attended

TENTH FIVE-YEAR PLAN (2002 2007) TARGETS TO STOP THE SPREAD OF HIV/AIDS IN THE COUNTRY

- *80% coverage of high risk groups through targeted interventions*
- *90% coverage of schools and colleges through education programs,*
- *80% awareness among the general population in rural areas*
- *Reducing transmission through blood to less than 1%;*
- *Establishing of at least one voluntary testing and counseling centre in every district*
- *Scaling up of prevention of mother-to child transmission activities up to the district level*

by over 3000 youth representatives) made this growing commitment abundantly visible. The govt. has undertaken a multi-sectoral approach where by the Ministry of Health and Family Welfare, Ministry of Youth Affairs and Sports, Ministry of Railways and Ministry of Education along with other international and bilateral agencies are working together towards achieving the UNGASS targets. The National AIDS Control Organization (NACO), a semi-autonomous organization under the Ministry Of Health and Family Welfare, leads the national response to the HIV/AIDS epidemic in India.

In its second phase, the National AIDS Control Program (**NACP-II, 1999-2004, extended till 2006**) has taken several steps to strengthen its focus on vulnerable people. Policy initiatives have also begun to focus on care, support and treatment issues alongside prevention, in response to the growing number of HIV infections in the country. Given below is a critical analysis of key national policies addressing Youth and HIV/AIDS:[14]

National AIDS Control Policy (2000) is a crucial component of the national health strategy. While the policy talks about *programmes for adolescents like Universities Talk AIDS and Villagers Talk AIDS* implemented by Nehru Yuva Kendra Sangathan (NYKS), it does not specifically mention adolescents. The policy *does not identify adolescents as vulnerable group*, particularly 15-24 years age group that accounts for 35% percent of HIV cases[15]. Also missing is the fact *that screening/testing before marriage needs to be promoted as a preventive measure* as it has crucial implications for the adolescent group.

The National Health Policy expresses *concern for the health of special groups such as adolescent girls, albeit only with regard to their nutritional needs*. Elsewhere, *adolescent* girls are *grouped with pregnant women and children* within maternal and child health services instead of being treated as a distinct group with specific needs and problems.

A *life cycle approach* to the health needs of women is needed .Moreover a *comprehensive approach for reproductive health of adolescent* and young people and while working towards including out of school youth in larger numbers.

National Population Policy (2000) has recognized the earlier invisibility of adolescents and views them as a section of population identifying them *as 'under-served' population* groups. The policy *calls for interventions in* specific areas such as *protection from* unwanted pregnancies and *STDs and encouragement of delayed marriages* and child bearing. The policy also *targets the education of adolescent girls and boys on reproductive health services especially in rural India*. This issue is important because adolescents and youth are becoming sexually active at an early age resulting in higher risk of HIV infection.

The National Youth Policy 2003 provides a comprehensive overview of youth issues and concerns. For the first time in India, this *policy recognizes adolescents by dividing them into target groups*, (i) rural and tribal youth (ii) Out of school youth and (iii) adolescent, particularly female adolescents. By *distinguishing the age of adolescence*, the policy facilitates advocacy efforts for focus on adolescents in government programmes. It gives a *special focus to adolescent health*, as "they are the most important segment of the population". *HIV/AIDS, STIs,*

[14] Based upon similar analysis by Arindam Roy in 'UNGASS Youth Report – The Indian Perspective (2005)' with added inputs.

[15] 'Trends and Estimates of HIV Infections', UNAIDS, http://www.unaids.org.in/displaymore.asp?itemid=56&chkey=76&subchkey=0&chname=HIV%20Epidemic%20i

substance abuse and population education finds place in the health component with emphasis on Youth Participation for implementation. A note worthy feature has been the distinction between target-groups of 13-35 years which has been sub classified into (13-19 years, 20-35 years). The elements of participation, access and leadership building have been clearly delineated as objectives of the policy.

In addition to these, The Declaration on Political Leadership in Combating HIV/AIDS clearly states that the activists of political parties shall take steps to ensure that the response (to HIV/AIDS) includes a focus on youth.[16]

KEY RECOMMENDATIONS**:**

a.) Formation of special focus group 'GIYP – Greater Involvement of Young People' for continued participation of young people in policy-making.
b.) Policy is needed to ensure that comprehensive Life Skills Based Education is made part of the curriculum in all govt. and public schools.
c.) Policy is needed to protect reproductive and sexual rights of young women especially those infected with HIV.
d.) Policy needed to combat stigma and discrimination attached with the disease especially at the workplace.

FINANCIAL COMMITMENT

The Government of India is working jointly, with NGOs, international organizations and other bilateral agencies to fight the scourge of HIV/AIDS in the country. The financial commitment towards fighting HIV/AIDS has been strengthened considerably over the last five years. The table given below highlights the annual budgetary allocation by the Union Govt. to National AIDS Control Program over the last few years[17].

Year	Amount allocated to National AIDS Control Program (in Crores of Rupees)	Percentage of Ministry of Health Budget it covers
2003 - 2004	205 + 20.00	9.11%
2004 - 2005	232 + 27.00	9.63%
2005 – 2006	476.50 + 57.00	13.93%

In addition to the above allocations, India has taken a loan of USD 191 million from World Bank.[18]

[16] 'Annex 3: Declaration on Political Leadership in Combating HIV/AIDS, Role of Political Leaders in Combating HIV- AIDS', UNAIDS, http://www.unaids.org.in
[17] Union Budget, Ministry of Finance, http://indiabudget.nic.in
[18] 'Portfolio of Grants in India', The Global Fund to fight AIDS, Tuberculosis and Malaria, http://www.theglobalfund.org/search/portfolio.aspx?countryID=IDA&lang=en

No allocation could be found in the budget for any youth specific HIV prevention efforts. India follows a multi-sectoral approach to respond to the challenges of the HIV/AIDS epidemic. Funds to various NGOs and youth specific HIV prevention programs initiated by internal ministries are routed through the govt. Hence it is difficult to obtain figures of expenditure on youth specific programs for HIV/AIDS prevention and care.
External support totaling US$140 million was made available by the UK's DFID (for prevention interventions in West Bengal, Andhra Pradesh, Orissa, Kerala and Gujarat); USAID (prevention in Tamil Nadu and Maharashtra); CIDA (capacity building for targeted interventions in Rajasthan and Karnataka); UNICEF (for prevention of mother to child transmission); UNDP and UNAIDS (for research, policy development and institutional strengthening). AUSAID has provided assistance for prevention, care and support programs in the northeastern States (Manipur, Mizoram, and Meghalaya) and Delhi. The Bill and Melinda Gates Foundation had pledged US$ 200 million for a five-year period for the 6 high prevalence states for prevention interventions, and a national prevention program for truck drivers. States contribute to this effort both with their infrastructure and human resources.

ACHIEVEMENTS AND GAPS

With the second phase of the National AIDS Control Program (1999- 2004), NACO has expanded its program. NACO provides funds to state AIDS control societies for targeted interventions, blood safety, youth campaigns, VCT, care and support and social mobilization.[19] The increase in several IEC initiatives targeted at young people such as toll free helpline, media campaigns etc. indicate an increase in allocation to efforts for prevention of HIV in youth. The govt. has promised to increase its budgetary allocation for NACP from $ 50 million to $ 100 million by 2006.

Below is the resource outlay plan of the govt. to fight HIV/AIDS:

RESOURCE OUTLAY PLAN BY GOVERNMENT OF INDIA TO FIGHT HIV/AIDS

In USD (Millions)	2004	2005	2006	2007	2008
Total resources available	$74	$ 87	$100	$107	$111
Total need	$805	$805	$805	$805	$805
Unmet need	$731	$718	$705	$698	$694

The figures for "total need" were estimated by combining the costs of expanding prevention interventions, VCTCs and introducing ART services at a realistic pace over the next five years. For costing the expansion of VCTCs, a median annual cost of operating the current centers of US$ 500 was used and 100 newly-established VCTCs per year. For costing of a new ART service, the University of Cape Town ART Costing Model (February 2004) was used, with modifications for the Indian situation and a target of 15,000 people on ART by the end of 2005 and 137,000 by the end of 2009. Source: National AIDS Control Organization, 2004

The shortage of resources to fight HIV/AIDS in India is clearly visible from the figures above.

[19] 'HIV and AIDS in India', AVERT. ORG, http://www.avert.org/aidsindia.htm

KEY RECOMMENDATION:

Greater Involvement of Business entities as stakeholders in the response to HIV/AIDS to further augment resources.

ACCESS TO INFORMATION AND SERVICES

Experience of AIDS control in other countries has shown that education is crucial to the success of the struggle against this epidemic. Only education can empower young people with the knowledge they need to protect themselves and their communities. Only education can combat the problem of stigma and discrimination..

- Shri Atal Behari Vajpayee, ex-Prime Minister of India, National Convention for Elected Representatives on HIV/AIDS, July 26, 2003.

- **Avenues of Information**: The avenues of information for young people have increased tremendously over the past few years and so has youth access to these avenues. Electronic media is being aggressively used to bring home the message on HIV prevention.

Radio slots, television programs such as 'Jasoos Vijay' and 'Hath se Hath Mila' (targeted at 200 million potential young viewers)[20] along with concerts and press activities are a part of NACO's IEC strategy.[21] NACO has also started a toll free National AIDS Tele-counseling Helpline in with the support of NGOs at state level to disseminate basic information on HIV/AIDS, the diverse and most common routes of transmission, to areas of services available for any personal anxieties.[22] Yet, only 17 % males in the age group of 15 to 24 had comprehensive knowledge about HIV/AIDS.[23]

- **Health Services**: India has a total of 631 VCTCs spread over 28 states and 7 Union Territories offering integrated health services but most young people have never heard about VCTC.[24] Another trend that was observed by counselors at VCTC was that although young people come more readily to VCTC nowadays while women are still hesitant in visiting VCTC alone.
- **Condom Use**: Condom Use among young people is reportedly rising especially in South India leading to lower rate of new infections. Yet, only 59 % of males in India reported condom use at last high-risk sex.[25] Moreover, use of contraception among young married women is reported to be as low as 5% among 15-19 yrs. old and 21% among 20-

[20] 'India : Hath Se Hath Mila', BBC World Service Trust, http://www.bbc.co.uk/worldservice/trust/developmentcommunications/story/2005/11/051125_india-haath.shtml
[21] 'Information, Education, Communication and Social Mobilization', NACO, http://www.nacoonline.org/prog_iec.htm
[22] 'Partnerships with NGOs : An Overview', NACO, http://www.nacoonline.org/partnership_ngolist.htm
[23] 'India : Statistics', UNICEF, http://www.unicef.org/infobycountry/india_india_statistics.html
[24] Our team in Kolkata carried out a short survey (due to time constraints) among students in various colleges.
[25] 'India : Statistics', UNICEF, http://www.unicef.org/infobycountry/india_india_statistics.html

24 yrs old.[26] This can be attributed to difficulty in negotiating condom use with partner, low awareness about contraceptive methods etc. Very few condom vending machines exist in the country mostly in red-light areas only. VCTC provide free condoms but people are not aware of the services provided by VCTC. Local chemists and drugstores provide condoms at competitive prices but most young people are hesitant in asking for condoms over the counter. Hence condom use remains low and inconsistent especially among young people.

- **SRH Education**: Reproductive and Sexual Health Education varies from state to state in India. While New Delhi has over 450 govt. schools implementing Adolescent education while the State Minister of education for Uttar Pradesh termed Sex Education in schools as useless and against Indian culture.[27] We as a part of interactive research interviewed youth counselors from a govt. school in Delhi and a posh public school in Noida (township on the border of Delhi and U.P) about the SRH Education in their respective schools[28]. Upon comparative analysis, it was observed that although a comprehensive LSBE program empowers students better to make healthy choices, for students of lower economic strata attending govt. schools, adolescent education program is more apt.

COMPARISON CHART OF SRH EDUCATION[29]

Institution – Name and Postal Address.	Govt. Co-Education Senior Secondary School, Chilla Village, New Delhi.- 110091	Amity International School, Sector 44, Noida, U.P - 201301
Format	Adolescent Education	LSBE
Description of training undertaken by the counselor.	Attended 6 day Seminar by Population Education Cell (Delhi govt.)	Attended Workshop by Dr. Patanjali Nayyar and team from WHO.
Level being taught at:	From 6th std. till 12th std.[30]	From std. 4th onwards till std. 11th [31]
Teaching Methodology	- Classroom lectures - Poster making - Question Box Activity etc.	- Class Discussion - Role Plays - Quiz and Questionnaires etc.
Grade based class.	No.	Yes.
Gender specific class.	Yes – boys and girls are taught separately	No – Mixed group.
HIV/AIDS Discussed	Yes	Yes
Sexual mode of transmission discussed	No.	Yes.
Abstinence discussed.	Yes.	No.

[26] 'World Youth Datasheet 2006', Population Reference Bureau
[27] 'No Sex Education please, we are Indians – Minister' , ExpressIndia, http://cities.expressindia.com/fullstory.php?newsid=135011
[28] See table on page 10; annex.
[29] Based on interviews with youth counselors of the concerned institutions
[30] 12 - 18 yrs. old.
[31] 10 – 17 yrs old. Std. 10th is excluded from this since they have higher secondary qualifying examinations.

Condom Use discussed.	No	Yes.
Skills for negotiating Condom Use imparted.	No.	No.
Student Response.	Average to Good.	Excellent.
Other topics discussed.	Personal hygiene.	Peer – pressure, Drug Abuse etc.
Behavior Trend observed by counselor.	Students have a curious mind about SRH due to media exposure coupled with lack of adequate avenues of information elsewhere.	Students pretend to be ignorant but have incomplete knowledge in actuality.

KEY RECOMMENDATIONS:

a. We recommend that class XI girls and boys be imparted information on condom use and skills for negotiating condom use under the adolescent education program format since these students are vulnerable to HIV and lack of crucial information, necessitated especially by early marriages.

b. Also we urge that SRH education programs preferably in LSBE format for public schools and improvised Adolescent education format for govt. schools be introduced all over the country.

c. More aggressive and innovative media campaign focused on BCC especially in young people should be undertaken.

CASE STUDY – BALBIR PASHA MEDIA CAMPAIGN

Design and Execution: Population Services International.(PSI)

Funding: USAID (AIDSMark Funding Mechanism)

Target population: Young men aged between 18 to 40 belonging to lower socio-economic groups in Mumbai.

Campaign Objectives:

a. To increase perception of HIV/AIDS risk from unprotected sex with non-regular partners by personalizing the message and creating empathy through identifiable real-life situations. (ATTITUDINAL CHANGE)

b. To generate discussion about HIV/AIDS among the target populations and opinion leaders in order to facilitate understanding and knowledge acquisition. (CHANGING SOCIAL NORMS)

c. To motivate people to access HIV/AIDS helpline and VCT services. (BEHAVIORAL CHANGE)

Campaign Duration:
Phase 1- November 2002 till Feb 2003.
Phase 2-November 2004 till Feb 2005.

Impact: 250% increase in number of calls to PSI's Saadhan HIV/AIDS hotline, and shift in types of queries from superficial to more invasive & informed.

Lesson: Innovative and integrated media campaigns designed after in-depth study of target consumer and his/her lifestyle can bring about Behavioral Change in a short span of time.

YOUTH PARTICIPATION

FORMAL AVENUES OF PARTICIPATION:

Two major events in India highlighted the commitment of the political leadership and civil society organizations to involve young people in the fight against HIV/AIDS.

a. Various agencies (Government, NGOs, multilateral and bilateral agencies) working on youth issues organized a series of State Level Consultations with young people in all regions of the country seeking their inputs into national programs and policies on their health and development. This series of State Level Consultations converged into a National Level Consultation with young people. Recommendations from these consultations were shared with various ministries and departments in Central and State Governments of India for action.

b. Another event that was a cornerstone of young people's involvement was the National Youth Parliament. This youth parliament was convened with special focus to seek inputs from young people on the draft legislation on HIV/AIDS.
Over 4000 young people from all districts of the country participated in this two-day event. Inter Parliamentary Forum on HIV/AIDS, NACO and UN Agencies organized the event.

c. The Nehru Yuvak Kendra Sangathan (Nehru Youth Center Association) is a system of local youth clubs offering vocational training, peer-to-peer awareness campaigns, and health fairs to 8 million out-of-school youth.

INFORMAL AVENUES OF PARTICIPATION:

Largely young people's involvement is in peer education program for prevention of HIV/AIDS in India. The participation is largely in campaigns on issues rather than active planning process.

The International HIV/AIDS Alliance and Alliance India have pioneered an integrated community and home based care and support program in the states of Tamil Nadu, Andhra Pradesh and Delhi with support from the European Union, the Step Forward Initiative and the Allan and Nesta Ferguson Trust. Projects in the three states **encourage and advocate for the participation of children affected by HIV/AIDS at all levels of program development, planning and implementation.** Mainstreaming the response to children and families at the community level helps to overcome stigma and discrimination.

KEY RECOMMENDATIONS:

Formation of Greater Involvement of Young People (GIYP) to strengthen youth participation. Young people including those living with HIV need to be involved in the planning and implementation process of HIV interventions and policies, and their efforts need to be recognized. This will eradicate fear, stigma and discrimination and give confidence for positive living. Young people should not merely be regarded as a 'target group' – policies and interventions should not only be for them, but framed by young people.

V. Summary of Major Achievements and Gaps

- **A First Time**
  Formulation of the National Youth Policy in 2003 that addressed adolescents as a sub-group. In addition, it called for programs addressing adolescents' growth and development needs, especially sexuality education, HIV/AIDS and better reproductive health. The ICPD guidelines translated into provisions in The National Youth Policy (2003). Provision made in The National Youth Policy for population education, HIV/AIDS, STD's, substance abuse to be included in health component.
- **Five Years' Vision**
  The Tenth Five Year Plan for youth has been emphasized the need for Sexuality Education and the need for involvement of young people in the fight against HIV/AIDS. It called for multi-sectoral response for HIV/AIDS Prevention and Management among young people.

- **Increased Political Commitment**

  Role of political leadership stressed at the first National Convention of Elected Representatives on HIV/AIDS in July 2003.

  Over 3000 youth leaders participated at the National Youth Parliament: Special Session on HIV/AIDS in New Delhi in November 2004.

  It aimed at training the young people as Youth Ambassadors in generating awareness among their peers in their society about the epidemic.

  Proposal for 'The Red Ribbon Express' for awareness on HIV/AIDS across the country.

- **Increasing involvement of Youth Organizations**

  Nehru Yuvak Kendra Sangathan (NYKS) caters to the information needs of millions of rural youth through non-formal education and the Rajiv Gandhi National Institute of Youth Development (RGNIYD)-designated to serve as the apex information and research center on youth development issues - two of the autonomous organizations under the Department of Sports and Youth Affairs

- **Integration of Youth Friendly Services to millions of rural youth through non-formal education and the Rajiv Gandhi**

  Innovative programs like integration of adolescent friendly health services to Phase – II of the Reproductive and Child Health program will clear path for more programs to address the marginalized young people.

  1097- A toll free AIDS help- line in more than 80 cities in the country is a good medium to know about HIV/AIDS.

- **Mainstreaming of GIPA Remains on Paper.**

  Commitment to the Greater Involvement of (Young) People Living with HIV/AIDS (GIPA) has remained merely a concept that is reflected in the National AIDS Control Policy document but has hardly been in practice in services provided though.

- **Absence of policy to make SRH education mandatory part of school curriculum.**

  There is no policy in particular at present that supports and promotes young people's access to information and services.

  Limited channels to reach the less educated and illiterate young people exist.

  'Life skills based HIV/AIDS education' in school curriculum is being integrated only with a limited numbers of schools.

- **Policies for Stigma and Discrimination**

  There is no policy at present to combat stigma and discrimination attached to the epidemic. Policies relating to women like gender discrimination to access information and services, addressed women's need in a limited manner and with a limited scope.

VI. Major Recommendations for Action

1. **Adopt an approach – through formulation of a policy and amendments to existing laws –** that respects and promotes the human rights of (young) PLWHA's, legal protection against stigma and discrimination and wrongful termination either from an educational institution or a workplace.
2. **Introduce mandatory SRH education country wide in all schools even in low prevalence states.**

Reproductive and Sexual Health Education should be introduced immediately in all schools country-wide including low prevalence areas as only education can empower the young people to make healthy choices and prevent further spread of HIV/AIDS into the general population.

3. **More state governments should be encouraged to set up legislative forum on adolescents and youth related health issues** focusing on HIV/AIDS. There is a heightened need for taking international and national level efforts to fight HIV epidemic to state levels. The commitment shown by leaders of the world, whether they are high prevalent or low prevalent countries, should now be synergized to local level actions at state and district levels. Except Kerala, no other State has done work in terms of specific policies for adolescents.
4. **Policy essential for young people's access to information and services.** Young people needed to be recognized as the most significant element in the fight against HIV/AIDS and that the existing policies and programs on HIV/AIDS should address the needs of young people for age appropriate information and services. There is a need for a policy that could combat stigma and discrimination that prevails in our society and allow young people to access youth friendly services including their access to condom acquisition, address abstinence for adolescents and age of consent.
5. **Like GIPA, have GIYP.** Involvement of young people in policies and programs related to young people, at the policy-making levels through regular interaction and adequate representation in international, national and state level bodies. Young people including those living with HIV need to be involved in the planning and implementation process of HIV interventions and policies, and their efforts need to be recognized. This will eradicate fear, stigma and discrimination and give confidence for positive living. Young people should not merely be regarded as a 'target group' – policies and interventions should not only be *for* them, but framed by young people.
6. **Strengthen Community Response.** Greater efforts to undertake training and capacity building programs for the NGO, Civil society organization and young people's organizations to empower them to take up innovative projects like provision of medical facilities including home-based care, opening of community care centers, etc apart from the conventional areas of awareness, counseling and targeted interventions among risk groups.
7. **Mainstream Gender in all walks of life not merely in HIV/AIDS programs.** Gender stereotypes should be avoided; policies should focus on gender equity, which should include males also. Policies should view young people as a homogeneous group. Role of young males in family planning and protecting the rights of women free from trafficking and violence need to be addressed with a greater commitment. 'Feminization' of the epidemic needs to be addressed more specifically.
8. **Sensitize Service Providers first.** Doctors and health personnel working in hospitals should be sensitized not to discriminate between a patient not suffering from HIV and a PLWHA when it comes to treatment especially when conducting an operation. Every health worker who interacts with adolescents should develop the skills to be able to encourage young people to communicate their feelings and fears, and to guide them towards making decisions
9. **Involve the Gatekeepers to Young People**. Provide training to parents and teachers in school about the various myths and misconceptions about sexuality and HIV/AIDS so that they are comfortable when it comes to disseminating correct facts based information to their child.
10. **Encourage Condom Use among Young People.**

Life skills programs should teach negotiation skills in condom use, especially as adolescents are reluctant to confess to inexperience due to stigma and shyness. Married women of 15-19 and 20-24 years of age should be encouraged towards usage of condoms. Condom Vending Machines should be set up in all hospitals and medical institutes.

11. **RH/HIV interventions with out-of-school youth should include**
    1. Encourage youth to stay in school or return to school
    2. Providing out-of-school youth with accurate information on RH/HIV issues and services and with communication and negotiation skill.

VII. References

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