

# 2008 National Youth Shadow Report

Progress Made on the 2001 UNGASS  
Declaration of Commitment on HIV/AIDS



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## Preface<sup>1</sup>

In just two years, the world will evaluate ten years of work toward “Universal Access by 2010” to HIV and AIDS prevention, care and treatment. While progress has been made in several areas of the AIDS response, the targets laid out so ambitiously for youth in the 2001 Declaration of Commitment on HIV/AIDS (DoC) will be unmet by drastic margins; indeed, 7 years later, few governments even bother to collect data specifically on youth.

Globally, 1.7 billion young people aged 10–24 make up one quarter of the world’s population. Approximately 40% of all new HIV infections occur among young people between 15–24 years of age,<sup>2</sup> and there are 5.4 million young people living with HIV.<sup>3</sup> Young people are the face of HIV. We are at higher risk of HIV infection because we lack access to the crucial information, education, and services to protect ourselves. However, our needs are often ignored when data is collected and strategies on HIV and AIDS are drafted, policies developed, and budgets allocated. Successful programs often lose funding as interests shift toward other, less controversial topics, or young leaders “age out” and others with similar potential are not empowered. This is especially tragic, because we, as young people, are statistically more likely than adults to adopt and maintain safe behaviors.<sup>4</sup>

Ignoring us in policies, programs, and resource allocation is a main contributing reason to the further spread of the HIV epidemic. Our particular vulnerability to HIV infection draws attention to societal inequities that few want to speak of, let alone address, such as sexual violence, injecting drug use, same-sex relationships, and sex work. Evidence clearly displays that the longer governments, stakeholders and health care providers continue to ignore the unpleasant realities faced by many young people, the more our peers and siblings will be infected with HIV.

In June 2001, heads of State and government representatives convened for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). At the first UNGASS on HIV/AIDS, 189 countries signed the Declaration of Commitments (DoC) as a pledge to halt and begin to reverse the spread of the AIDS epidemic through international, regional and country–level partnerships and with the support of civil society. Progress is measured through intermittent reviews.

Despite DoC commitments to work in full partnership with youth, governments still treat us as beneficiaries of programmes and services rather than crucial stakeholders and key actors in achieving the DoC targets and goals.<sup>5</sup> The impact of this exclusionary attitude will manifest shortly in a lack of leadership and an even greater shortage of health care workers. As we come of age to adulthood, we must be trained and empowered today as a cadre of young leaders.

The DoC states that by 2005, at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 will have access to the information, education, skills and services to protect themselves from HIV infection. **However, as of 2007, only 40% of young men**

Notably, the DoC recognizes young people’s higher risk to HIV infection 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.
  - Expanding good-quality, youth-friendly information and sexual health education and counseling services;
  - Strengthening reproductive and sexual health programs; and
  - Involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programs.

<sup>1</sup> Adapted from GYCA and Global Youth Partners, “Our Voice, Our Future: Young People Report on Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS.” UNFPA, 2005. <http://www.youthaidscoalition.org/resources.html>

<sup>2</sup> UNAIDS (2007) AIDS epidemic update: Core slides: Global Summary of the HIV and AIDS epidemic. UNAIDS, Geneva. [http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi\\_slides.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_slides.asp)

<sup>3</sup> UNAIDS (2007) AIDS Epidemic Update

<sup>4</sup> UNICEF/UNAIDS/WHO (2004) Young People and HIV/AIDS, Opportunity in Crisis. UNICEF, UNAIDS & WHO, 2004.

**and 36% of young women had accurate HIV knowledge on transmission and prevention.<sup>6</sup>**

The needs of young people are not homogenous or universal. Young people are mothers, students and sex workers. They are injection drug users and prison inmates. Young people have varying sexualities, lifestyles and definitions of the family. Young people living with HIV are studying, working, having sex and planning families. Young advocates are best positioned to design policies and programs that are most relevant and effective at addressing our varying needs.

### **Methodology**

With only two years left to achieve the UNGASS goals and targets, young people are actively participating in the tracking and reporting of UNGASS commitments. In 2008, these young people have produced 10 UNGASS Youth Shadow Reports to present at the UNGASS, in its seven-year review. Young researchers from Egypt, Jamaica, Viet Nam, Nepal, India, Kenya, Zimbabwe, Senegal, Nigeria and the United States of America tracked and monitored progress on the UNGASS commitments to young people in their own countries and made recommendations for moving forward. Their research, findings and analysis will set the tone for needs and priorities that must be taken into account during the high level meetings. On 10-11 June 2008, 30 young leaders will advocate to decision-makers by sharing knowledge of their country's national response and identifying major gaps and barriers to success.

Since 2005 GYCA has facilitated the production of 34 UNGASS National Youth Shadow Reports.<sup>7</sup> GYCA members from 17 countries volunteered to research and produce shadow reports, and assembled national teams of young people from various networks to take part. For several of researchers, this report was the first of such an undertaking. Seven reports address findings at the community level, and will be available shortly on GYCA's website. Researchers 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 (YPLHIV) 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 meet 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 programs when available, as well as various stakeholders such as service providers, representatives from NGOs, international and bilateral organizations. The final reports were reviewed and edited by GYCA staff, preserving original content, tone, and perspectives as much as possible.

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.<sup>8</sup> A number of questions, based on the indicators suggested by the UNAIDS National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people,<sup>9</sup> were suggested to guide their research. Data collection and analysis focused on four main areas:

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

Country's progress on collecting youth-specific, disaggregated data was also evaluated. This report details the findings of the young researchers, and their recommendations and vision for the way to move forward.

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<sup>6</sup> UNGASS (2008). Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to Millenium Development Goal.

<sup>7</sup> The first twelve reports were compiled into GYCA & GYP's "Our Voice, Our Future", UNFPA 2005. In 2006, six independent reports were produced, and in 2008, this report is one of 17- 10 national reports and 7 community level reports.

<sup>8</sup> The research guide is available upon request, and is loosely based on UNDESA's 2004 "Making Commitments Matter: A toolkit for young people to evaluate national youth policy."

<sup>9</sup> UNAIDS (2004) National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people.

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## About the authors

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**Himakshi Piplani**, 20, is a youth activist, currently pursuing her law degree from Symbiosis Law School in Pune, India, and serves as the Regional Focal Point for South Asia with the Global Youth Coalition on HIV/AIDS. In 2007 she was the GYCA National Focal Point for India. Her interest in HIV and AIDS related issues developed in early 2005 while researching for an article on sexual violence against children in the war-torn Darfur region, as well as the International Inter-Faith Conference on HIV/AIDS organized by National AIDS Control Organization (NACO) of India. This experience prompted her to do further research on the HIV and AIDS situation in India and abroad.

In 2006, she led a team of youth volunteers to review the government's commitments to UNGASS on HIV/AIDS and subsequently wrote the UNGASS India Youth Shadow Report for UNGASS + 5 Review as a part of GYCA's National Research for UNGASS + 5 review process, and attended the Youth Summit UNGASS side event as a youth representative with full funding provided by UNICEF. She has been a volunteer on the Wake Up Pune HIV Awareness Campaign (WUP) since November 2006, and in February 2007 led a team of young volunteers to establish a Pune-based youth network on HIV and AIDS called YAHAAN (Youth Action HIV And AIDS Network). YAHAAN functions as the youth program of WUP and partners with local NGOs such as Deep Griha Society's HIV/AIDS program, Sahara Aalhad, Heroes Project, and foundations such as AIESEC and Retract Club. Himakshi hopes to further work towards ensuring greater access of young people to HIV/AIDS related services and towards protecting health related human rights of children and young people.

## About the Global Youth Coalition on HIV/AIDS (GYCA)

GYCA is a youth-led global network of over 4,000 young leaders and adult allies fighting the spread of HIV and AIDS in over 150 countries worldwide. GYCA, supported by UNFPA and UNAIDS, was established in 2004 and is based in New York and Accra, Ghana. GYCA empowers young leaders with the knowledge, skills, opportunities and resources they need to be effective agents of change in their communities. For more information please visit <http://www.youthaidscoalition.org>, or write to [info@youthaidscoalition.org](mailto:info@youthaidscoalition.org).

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### List of Abbreviations Used

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

#### *Discrepancies in new estimates:*

In 2007, UNAIDS and WHO released new estimates on the global AIDS pandemic that included a downward shift in the number of people living with HIV. Previously it was estimated that 39.5 million people were living with HIV as of 2006; the new estimates put the figure closer to 33.2 million people. Unfortunately the decrease in the number of people living with HIV does not necessarily represent progress. The changes can be linked to several factors such as improved methodology for collecting data, increased availability of data, and a growing understanding of the disease. Significantly more data was available from nationally representative, population-based, household surveillance efforts.

According to the Kaiser Family Foundation, **70% of the reduction in the number of people living with HIV can be attributed to better data in India** and several African countries. Because of the disproportionately large populations in these countries, any small change represents a large number of people. The new estimates do not necessarily mean that the number of people living with HIV has fallen; instead they mean that previous estimates may have been too high. People living with HIV are also living longer, there continue to be thousands of new infections everyday, and, moreover, the overall population of the world has grown.<sup>10</sup>

<sup>10</sup> Kaiser Family Foundation (2008) "Understanding the New UNAIDS Estimates." <http://www.kff.org/hiv/aids/upload/7742.pdf>

<b>Portrait of India in Numbers</b>	
Total population	<b>1,131,900,00<sup>11</sup></b>
Percentage of population 10-24	<b>25%<sup>12</sup></b>
Illiteracy rate among young people 15-24	<b>30% f, 18% m<sup>13</sup></b>
Estimated number of people living with HIV	2-3.1 million persons, approximately 0.36% of the adult population. <sup>14</sup>
HIV prevalence among young people ages 15-24	<b>0.57%<sup>15</sup></b>
Median age of first intercourse	
Median age of first marriage	<b>18.7%f, 23.4% m<sup>16</sup></b>
<i>UNGASS Core Indicator:</i> Young people ages 15-19 who have had sex before age 15	<b>3%<sup>17</sup></b>
<i>UNGASS Core Indicator:</i> Young people ages 15-24 reporting sex with a non-marital non-cohabiting partner in the last year	<b>28%<sup>18</sup></b>
<i>UNGASS Core Indicator:</i> Young people ages 15-24 reporting using a condom the last time they had sexual intercourse with a non-regular partner	<b>65%<sup>19</sup></b>
<i>UNGASS Core Indicator:</i> Young people ages 15-24 who can identify two prevention methods and reject three misconceptions about HIV/AIDS	<b>43%<sup>20</sup></b>
Schools with teachers trained in life-skills-based HIV/AIDS education who taught it during the last academic year	<b>79%</b>
Number of physicians per 100,000 people	<b>60%<sup>21</sup></b>

## I. Introduction

Young Indians ages 10-24 years make up almost 25 percent of the country's population<sup>22</sup> and account for over 50% of the population living with HIV (YPLHIV).<sup>23</sup> However, the 2008 UNGASS Country progress report did not collect new data on YPLHIV. In the face of skyrocketing rates of transmission among this population, regular surveillance of trends of new infections is critical to effectively prevent the spread of the epidemic among young people.

The HIV epidemic in India is characterized by heterogeneity; it shifts from the most marginalized populations— such as injecting drug users, female sex workers, and men who have sex with men— to “bridge” populations, such as clients of sex workers, STI patients, and partners or drug users, and then to the general population. More than 85% of infections in India are passed on through heterosexual sex.<sup>24</sup> Globally, India is second only to South Africa in terms of the total number of people living with HIV/AIDS.<sup>25</sup>

The Behavioural Surveillance Survey (BSS) 2006, conducted by ORG Centre for Social Research and NACO among almost 80,000 people aged 15-24, shows that while 83.7% of sexually active youth aware of the importance of condoms, only 47% use them consistently during casual sex with non-regular partners, mostly sex workers. This higher risk behaviour is common among urban as well as rural youth.<sup>26</sup>

<sup>11</sup> 2008 UNGASS Country Progress Report. [http://data.unaids.org/pub/Report/2008/india\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/india_2008_country_progress_report_en.pdf)

<sup>12</sup> SEARO/WHO. (2007)

<sup>13</sup> UNFPA. (2005) India Country Profile. <http://www.unfpa.org/worldwide/indicator.do?filter=getIndicatorValues>

<sup>14</sup> 2008 UNGASS Country Progress Report.

<sup>15</sup> HIV Sentinel Surveillance Survey 2006.

<sup>16</sup> UNFPA (2005) India Country Profile.

<sup>17</sup> National Behavioral Surveillance Survey Report. 2006

<sup>18</sup> Behavioral Surveillance Survey 2006

<sup>19</sup> National Behavioral Surveillance Survey Report. 2006

<sup>20</sup> 2008 UNGASS Country Progress Report. [http://data.unaids.org/pub/Report/2008/india\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/india_2008_country_progress_report_en.pdf)

<sup>21</sup> Human Development Report 2007/2008 <http://hdrstats.undp.org/indicators/58.html>

<sup>22</sup> Boston Globe. (9 December 2007) “Slowly, AIDS Education Gets on Track in India.

[http://www.boston.com/news/world/asia/articles/2007/12/09/slowly\\_aids\\_education\\_gets\\_on\\_track\\_in\\_india/](http://www.boston.com/news/world/asia/articles/2007/12/09/slowly_aids_education_gets_on_track_in_india/)

<sup>23</sup> SEARO/WHO. (2007) ‘Young People and HIV/AIDS: Responding to Unmet Need.’ [http://www.searo.who.int/LinkFiles/Initiatives\\_II-6yafaha.pdf](http://www.searo.who.int/LinkFiles/Initiatives_II-6yafaha.pdf)

<sup>24</sup> WHO (2005) Summary Country Profile for HIV/AIDS Treatment Scale-up, India. [http://www.who.int/hiv/HIVCP\\_IND.pdf](http://www.who.int/hiv/HIVCP_IND.pdf)

<sup>25</sup> SEARO/WHO. (2006) “Young People and HIV: India.”

[http://www.whoindia.org/LinkFiles/Adolescent\\_Health\\_and\\_Development\\_\(AHD\)\\_Fact\\_Sheet\\_HIV\\_AIDS\\_Doc.pdf](http://www.whoindia.org/LinkFiles/Adolescent_Health_and_Development_(AHD)_Fact_Sheet_HIV_AIDS_Doc.pdf)

<sup>26</sup> 2008 UNGASS Country Progress Report

In terms of geographical diversity regarding HIV trends, 118 districts are categorized as a generalized epidemic with HIV prevalence more than 1% among mothers attending antenatal clinics. The 2006 estimates indicate that the epidemic has stabilized or declined in Tamil Nadu and other southern states with high HIV prevalence. Yet, new areas have seen a rise in HIV prevalence, particularly in the northern and eastern regions. Twenty-six districts have been identified with high prevalence, largely in the states of Madhya Pradesh, Uttar Pradesh, West Bengal, Orissa, Rajasthan and Bihar.<sup>27</sup>

Strong cultural and religious taboos and myths around issues of sexuality stemming from India's colonial period are a major barrier to providing adequate prevention, treatment and care services—especially protecting children, youth and adults living with HIV from pervasive stigma, discrimination, and violence. Despite the very high rates of unprotected heterosexual sex (as evidenced by India's having the second largest population in the world), policy makers regularly impede progress on HIV and AIDS, citing puritanical religious values and mores. According to Ashok Alexander of the Gates Foundation initiative Avahan, "We pretend to be more moral than others, even though studies show the high prevalence of concurrent sexual relationships... We act as if our morality is an invisible condom."<sup>28</sup>

Despite the growing number of infections among youth and the extreme lack of awareness of HIV transmission and sexual health, 11 states' governments have banned sex education in schools, removing biological depictions of human anatomy from text books that are part of the Adolescence Education Programme. Young people going through puberty are being denied their right to information about their bodies and reproductive health, and given the common practice of early marriage among Indians, this can often be fatal or extremely detrimental to their health and development.

#### Young Women

One in every four newly reported HIV infections is in a woman in India. Almost 38% of all Indians living with HIV currently are women; 1.6 million women ages 15 and above.<sup>29</sup> Gender inequalities perpetuate the feminization of HIV in India, a highly patriarchal society that holds strong religious and socio-cultural taboos around female sexuality.

Women often do not have the autonomy, skills, or knowledge to prevent unprotected sex.<sup>30</sup> Early marriage is still highly common among Indians, with 40% of girls in rural India ages 15 to 19 already married compared to only 8% of boys the same age.<sup>31</sup> Early marriage often leads to social isolation, which can perpetuate cycles of domestic violence, early pregnancy, obstetric complications, and, in turn, susceptibility to transmission of STIs and HIV. And yet, only 25.8 % of rural women between the ages 15-24 have comprehensive and correct knowledge on HIV/AIDS according to a recent govt. study.<sup>32</sup> 30 % of young women (15-24) are illiterate and few receive formal schooling opportunities compared to men and even then many have to drop out due to early marriages and economic constraints of the household.<sup>33</sup> Therefore, these young women are less likely to receive information on HIV and reproductive health and are usually, thus they are dependent on male wage-earners.

Moreover, women with unequal gender relationships are often unable to negotiate the use of condoms, demand faithfulness from their partner, abstain from sexual intercourse, and to access confidential health services without their husband's permission. Women who have been infected with HIV by their husbands are often blamed, thrown out of their homes, and face brutal violence and stigma. While practices differ widely across region, economic and educational status, and ethnic group, overall women's choices about when and with whom they have sex, and whether that sex is protected or not, can be severely constrained by their lack of economic independence.

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<sup>27</sup> National AIDS Control Organization. (2007) 'Breaking Down the Numbers.' [http://www.nacoonline.org/Quick\\_Links/To\\_Read\\_More/](http://www.nacoonline.org/Quick_Links/To_Read_More/)

<sup>28</sup> Ashok Alexander, Avahan. Boston Globe, 9 December, 2007. "Getting AIDS Education on Track in India." [http://www.boston.com/news/world/asia/articles/2007/12/09/slowly\\_aids\\_education\\_gets\\_on\\_track\\_in\\_india/](http://www.boston.com/news/world/asia/articles/2007/12/09/slowly_aids_education_gets_on_track_in_india/)

<sup>29</sup> UNAIDS figures for India, at [http://www.unaids.org/en/Regions\\_Countries/Countries/india.asp](http://www.unaids.org/en/Regions_Countries/Countries/india.asp)

<sup>30</sup> K.G. Santhya et al, (2007) "Consent and Coercion: Examining unwanted sex among young married women in India." International Family Planning Perspectives. <http://www.guttmacher.org/media/nr/2007/10/08/index.html>

<sup>31</sup> International Centre for Research on Women (ICRW) website, [Adolescent Reproductive Health in India](http://www.icrw.org/adolescent-reproductive-health-in-india)

<sup>32</sup> Youth BSS 2006

<sup>33</sup> UNFPA (2005) Country Profile <http://www.unfpa.org/worldwide/indicator.do?filter=getIndicatorValues>

Young Sex Workers

Young sex workers constitute one of the most vulnerable groups for HIV infection and transmission. Of the estimated two million women involved in sex work in India, 25-30% are under the age of 18.<sup>34</sup> Surveys in different parts of the country showed that 30% of street based sex workers were not aware that condoms prevent HIV infection. Nationally 42% of female sex workers felt that they could identify a HIV positive client on the basis of his physical appearance.<sup>35</sup> As many as 25,000 women are trafficked into India each year from Bangladesh alone,<sup>36</sup> and condom use is still low among many sex workers and their clients. Sex workers report that they are often paid significantly less for sex without a condom.<sup>37</sup>

MSM

Pervasive sexual taboos shield male homosexual behavior from the public. While sexual contact between men is common, a significant percentage of men who have sex with men do not use condoms during paid or non-paid intercourse.<sup>38</sup>

Condom use amongst MSM under 24 years <sup>39</sup>		
Age	≤19 years	20-24
Consistently used condoms with all nonpaying partners over last month's recall	30.6	30.1
Consistently used condoms in anal sex with paid male partners in a month's recall	21.0	21.5

IDU

It should be noted that the authors were unable to find reliable data on young people who are injecting drug users. The North-East region of India, particularly Manipur and Assam, have extremely high rates of injecting drug use, mostly among young people. Sharing needles results in high HIV and Hepatitis infection rates, and treatment access is limited. This region is located along the drug-trafficking route known as the "Golden Triangle." Many sex workers trafficked into India also come from this region, and many sex workers are also injecting drug users (and vice versa). Conditions are prolific for an HIV explosion.

Years of civil and political conflict as well as geographical isolation from much of India has resulted in high unemployment, poor infrastructure, and unreliability of health services due to frequent violence and unrest in the region by rebel groups. Several successful harm reduction organizations exist; however, they have difficulty obtaining funds and must compete for scarce resources with other public health initiatives.

**About this Report**

A comprehensive and thorough review was undertaken by a team of youth researchers on the existing documentation and literature on HIV and AIDS policies, national plans and strategies, financial allocations, programs and schemes regarding youth access to information, education and communication (IEC) and services as well as the avenues for youth participation in the HIV/AIDS response. The information obtained was then analyzed to identify relevant achievements and gaps. Then, recommendations were made accordingly to bring in the youth perspective on the identified issues.

<sup>34</sup> WHO/SEARO. "Young People and HIV: India." 2006.

<sup>35</sup> UNAIDS/WHO. (2005) AIDS epidemic update: special report on HIV prevention. Geneva. [http://www.unaids.org/epi/2005/doc/EPIupdate2005\\_pdf\\_en/epi-update2005\\_en.pdf](http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf)

<sup>36</sup> The New Nation, Bangladesh's Independent News Source, <http://nation.ittefaq.com/issues/2007/10/28/news0552.htm>

<sup>37</sup> In person interviews conducted by Joya Banerjee atGYCA with Bombay adolescent sex workers through the Aruna Project in Kamathipura, 2006.

<sup>38</sup> WHO/SEARO 2006.

<sup>39</sup> See Knowledge, Attitudes and Practices of Young Adults (15-24 years) Disaggregated Data from the National Behavioral Surveillance Survey 2001. Supported by National AIDS Control Organization and UNICEF (India).

## Key Findings

1. In National AIDS Control Plan-III (NACP III), the Government of India has finally recognized the heterogeneity of youth in India and categorized young people into three groups based on the level of their risk and vulnerability to HIV infection for effective HIV prevention programming.
2. Increasing access to condoms as well as encouraging communities to provide free testing facilities and early treatment of STIs has been identified as explicit goals by the Ministry of Youth Affairs under NACP III.
3. While the commitment of the central govt towards youth sexual and reproductive health and rights has been strengthened, several state governments still treat youth issues regarding sex and sexuality as 'foreign' and 'against Indian culture.'
4. Substantial amount of funds are being allocated to youth-oriented programs however their proper implementation and service delivery is highly dependent on regional political will as well as social perceptions, with monitoring and evaluation vague at best.
5. Several good programs targeting young people's access to HIV and AIDS services are being implemented by the government in partnership with agencies such as USAID, UNICEF etc. Nonetheless, these programs remain highly localized.
6. The role of youth participation in the country's HIV response has been significantly recognized under the NACP III. The youth potential as agents of change has been acknowledged through schemes such as Red Ribbon Clubs and training of young people as peer-educators, especially for rural districts.
7. The government has finally begun collecting age and gender specific disaggregated data for better HIV programming among youth.

## Key recommendations

8. Along with the on-going review of Adolescence Education Program materials, sensitization of all politicians, including those at state level and in Panchayats (village councils) on youth SRH issues, including the need of sexuality education should be urgently taken up by Parliamentary Forum on HIV/AIDS in collaboration with all State AIDS Control Societies.
9. Campaigns such as 'Jawan hoon, nadan nahin' (I am young, but not reckless/naive) being implemented by govt. of India in only a few of the high prevalence districts should be thoroughly evaluated and scaled up accordingly.
10. Funding on youth-oriented programs needs to be tracked and implementation seen through the project cycle including a thorough evaluation in terms of impact and service delivery. For example the government of Maharashtra was provided funds to the tune of over 5 crore INR (USD \$ 1,183,711) during the year 2005 for strategic meetings and teacher trainings for the Adolescence education program and yet the state government banned it in 2007 on grounds of explicit content in teacher training manuals<sup>40</sup>.
11. The HIV/AIDS bill (pending since 2005) which seeks to recognize and protect the rights of PLHIV, including rights of a young person such as the right to HIV testing without guardian consent for youth aged 12 and above (currently 18 and above), anti-discrimination provisions in schools, inheritance and property rights among several other provisions, needs to be tabled and passed by the Parliament this year.
12. The NACO helpline 1097, currently functional only across 4 states and in 10 cities needs to be made functional across the entire country.
13. Youth awareness about HIV services other than IEC, i.e, testing and treatment, the barriers to access and also the quality/ youth-friendliness of service provided all need greater attention during HIV/AIDS programming.
14. The government also needs to look into interventions for children and youth orphaned by AIDS or abandoned/thrown out due to HIV / AIDS related stigma.

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<sup>40</sup> Adolescence Education: National Framework and State Action plans (2005-06)

## II. Political Commitment

The Government of India is committed to preventing HIV among youth under the National AIDS Control Programme 2007–2012 (NACP III). Recognizing the heterogeneity of the youth particularly different sub-populations, NACP III has categorized young people into three groups based on the level of their risk and vulnerability to HIV infection:

- a) Young people in the general population (in schools, colleges, universities, uniformed services and out of school/non-student youth in community),
- b) Especially vulnerable young people in high and low vulnerable districts (with large concentration of CSWs, IDUs, MSM, significant out-migration, high HIV prevalence etc.)
- c) Young people most at risk of infection (adolescents in sex work, young IDUs, street children, working children etc.).



While the high risk young people under ‘c’ category will be addressed by targeted interventions and community-based efforts through dedicated workers and community based organisations (CBOs), the ‘a’ category will be covered through curricular and the mainstreaming efforts initiated by respective ministries, including the Adolescence Education Program. The ‘b’ category of especially vulnerable young people will be addressed through behaviour change education efforts of dedicated workers (link workers and volunteers).

The overall outcomes envisaged under NACP-III for young people are a reduction of higher risk behaviour. NACO also has devised a plan with various ministries as detailed below to promote sexual health and HIV awareness.<sup>41</sup>

### Major gaps and recommendations

- All states should have Legislative Forums on HIV/AIDS to develop clear action plans in line with the agenda and action plan of the Parliamentary Forum on HIV/AIDS, to strengthen the coordination between the legislative branches and avoid unnecessary controversies and resistance from state governments.
- Sensitization of all parliamentarians, right down to the members of Panchayats (village councils), on sexual and reproductive health rights of youth needs to be undertaken by NACO with active role of the State AIDS Control Societies.
- The HIV/AIDS bill seeks to establish legal framework on anti-discrimination among several other key provisions towards recognizing and protecting PLHIV rights and needs to be passed with immediate effect.

## III. Financial Commitment

According to the Ministry of Health and Family Welfare, Domestic AIDS spending is clearly increasing. India spent US\$171 million on HIV prevention, care and treatment in 2006-2007; a 28% increase since 2005-2006. However, there is little or no accountability and transparency with regards to how and where these funds are spent, especially the youth-specific funding. And even where funds are being allocated to youth-oriented programs there are many gaps at implementation level where these funds are being misused.

<sup>41</sup> [http://www.nacoonline.org/Partnerships/Ministries\\_and\\_Departments/](http://www.nacoonline.org/Partnerships/Ministries_and_Departments/)

**Case Study: Misuse of funds in Maharashtra**

Maharashtra has received NACO's biggest budgetary allocation, a total of Rs 200 crore from 1999 to 2004. When the State Assembly set up an Estimates Committee to look up the fund allocation it came up with several disturbing findings.<sup>42</sup>

The committee found that almost 50 per cent of the state's 157 AIDS Control NGOs were falsified and non-existent. Worse, these phantom agencies received grants from the Maharashtra State AIDS Control Society (MSACS) for approximately Rs 12 crore (USD \$ 2,840,906) from 1992 to 1998 during the first phase of the National AIDS Control Programme.<sup>43</sup>

There are charges that officials in the MSACS and the Mumbai District AIDS Control Society (MDACS), both autonomous government bodies under the state Health Department, take commissions of up to 20 per cent to sanction grants. State Health Minister Digvijay Khanvilkar says he was unaware of the findings, but admits that there are discrepancies, which will be investigated.<sup>44</sup>

**Major gaps and recommendations**

- Establish a comprehensive framework to track HIV and AIDS spending, particularly spending on youth-oriented programs and projects.
- Ensure accountability and transparency in HIV/AIDS spending through stricter laws and regulations for all stakeholders involved as well as stringent and frequent monitoring and evaluation exercises.

**IV. Access to information and services**

NACO reaches out to youth through a specially developed Adolescent Education Programme (AEP) focused primarily on prevention through awareness building. The AEP is one of the key policy initiatives of NACP II. AEP is implemented by the Department of Education in collaboration with the State AIDS Prevention and Control Societies. The Karnataka State AIDS Control Society implemented the program during 2003-2004 with almost 87% coverage of the targeted 20 lakh (two million) students.<sup>45</sup>

A large number of out-of-school youth aged 10-25 years, belonging to diverse groups of several sub-sets in terms of marital status and social background, are highly vulnerable to HIV/AIDS owing to their limited understanding of the infection. Thus a number of district-wide innovative programmes have been initiated and the SACS are also implementing peer education programs to ensure coverage of 80 percent out-of-school youth in 59 high prevalence districts of India.

"Universities Talk AIDS" (UTA) is a low-cost program initiated by the Government in 1991 where each college campus receiving almost US\$90/year<sup>46</sup> to inform students about HIV and AIDS. However, the effective implementation of UTA has largely been left up to the university's initiative and thus needs a stronger monitoring and evaluation framework in place.

**Major gaps and recommendations**

1. A Lack of much-needed sensitization of state level ministers on youth sexual and reproductive health rights and issues leads to a conflict of political will between the federal and state government. Protests and intense lobbying from conservative factions of the community have hampered young people's access correct and comprehensive information on sex, sexuality and HIV/AIDS. Furthermore, India's complex political system allows states to retain autonomy over decision making regarding

<sup>42</sup> <http://www.india-today.com/webexclusive/dispatch/20010328/farah.html>

<sup>43</sup> ibid

<sup>44</sup> ibid

<sup>45</sup> Adolescence Education: National framework and State Action Plans (2005-2006)

<sup>46</sup> WHO/SEARO. 'Responding to unmet needs through innovative approaches. [http://www.searo.who.int/LinkFiles/Initiatives\\_ii-1yaaa-fucc.pdf](http://www.searo.who.int/LinkFiles/Initiatives_ii-1yaaa-fucc.pdf)

young people's access to these services, particularly sexuality education, despite what the federal government opines. Several powerful fundamentalist religious groups fighting for a Hindu nation are particularly opposed to providing young people with information regarding their bodies, sex and HIV, mistakenly associating Hinduism with puritanical and repressive sexual values. These groups and other repressive conservatives dominate states in which information has been curtailed and denied to youth, such as Maharashtra and Gujarat.

#### V. The Adolescent Education Program Controversy

During 2007, 11 of India's 29 states suspended the federal initiative, 'Adolescence Education Program', designed for 15- to 17-year-olds in all state-run schools and devised jointly by the Ministry of Human Resource Development (HRD) and NACO after extensive regional workshops and consultations with state education departments and state AIDS control Societies during 2005-2006 on grounds that the flip charts used for training teachers contained explicit images of male and female reproductive systems, conception, and contraception. They said the training program was irresponsible, encouraging sex in the guise of spreading AIDS awareness."<sup>47</sup>

Announcing the decision to suspend the course in Karnataka, chief minister H.D. Kumaraswamy said at a news conference, **"Sex education may be necessary in western countries, but not in India... It will have adverse effect on young minds, if implemented."**<sup>48</sup>

This controversy highlights the crucial need to educate and sensitize policymakers, public officials, teachers and parents. Numerous international studies show that sex education does not increase sexual activity among youth; in fact, sex education has been proven to delay sexual debut and increase the likelihood of condom use.<sup>49</sup> The lack of access to sex education, ignorance about HIV, the low cultural acceptance of condom use, gender inequality, and pervasive early marriage put Indian young people at high risk for HIV infection. The denial of sex education in schools by state governments violates the right of Indian young people to HIV education, information and services, as stipulated in the UNGASS Declaration of Commitment on HIV/AIDS.

Officials in low prevalence states have been reluctant to encourage AIDS education, claiming that the problem is not significant enough in these areas to warrant a widespread educational response.<sup>50</sup> For similar reasons, AIDS education is taught purely as a biological topic to avoid the cultural and religious barriers that make it difficult for teachers to talk about sex in the classroom. However, most experts agree that by addressing the social side of HIV and AIDS, the issues become more accessible and tangible for student.<sup>51</sup> Knowing the biological nature of HIV is quite different from having the knowledge and negotiating skills to practice safe sex, reduce the number of partners, and to use condoms.

3. Services are not very accessible for young women, particularly those from marginalized groups such as young sex workers and positive women due to gender insensitivity of service providers. Young rural women find it difficult to access services as most testing and treatment centres are located near urban settlements and the high levels of stigma necessitate travelling alone at times thereby hampering access. There is also dearth of free condoms and female condoms are not available for free. Women are shy to ask for condoms and they also lack the power to negotiate their use. Male service providers and pharmacists often stigmatize women who purchase condoms or wish to have an HIV test, asking them if they are married.

<sup>47</sup> Boston Globe, "Slowly, AIDS Education Gets on Track in India." 9 December, 2007.

[http://www.boston.com/news/world/asia/articles/2007/12/09/slowly\\_aids\\_education\\_gets\\_on\\_track\\_in\\_india/](http://www.boston.com/news/world/asia/articles/2007/12/09/slowly_aids_education_gets_on_track_in_india/)

<sup>48</sup> <http://www.livemint.com/2007/05/26002639/Conservatives-obstruct-sex-edu.html>

<sup>49</sup> UNAIDS, 1997. "Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review." Only three out of 53 studies that evaluated specific interventions found increases in sexual behaviour associated with sexual health education. Twenty-two reported that HIV and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STD rates.

<sup>50</sup> Global Campaign for Education. 2005. Deadly inertia: A cross-country study of educational responses to HIV/AIDS

[http://hivaidsclearinghouse.unesco.org/ev\\_en.php?ID=5673\\_201&ID2=DO\\_TOPIC](http://hivaidsclearinghouse.unesco.org/ev_en.php?ID=5673_201&ID2=DO_TOPIC)

<sup>51</sup> AVERT, "HIV, AIDS & Schools." <http://www.avert.org/aids-schools.htm>

4. Most Government programs addressing access to services for youth are localized to few high prevalence districts. There is an urgent need to scale up these effective programs.

5. Also, current VCTC provisions require parental consent for HIV testing of those aged below 18, which acts as another major barrier to young people's access. Given the extreme secrecy around sex and sexuality, few young Indians want their parents to know if they are having sex. The HIV/ AIDS bill containing a provision lowering the age for testing without parental consent to 12 years, should be passed with immediate effect.

## **VI. Youth Participation**

With initiatives like the youth parliament in 2006, there has been greater political commitment in initiating the programs. The NYKS is the largest grassroots level organization of its kind in the world with the mandate of bringing rural youth into the mainstream of national development as active participants. Youth participation is formalized within the structure at state level and district level for implementation of the above program. NYKS involvement and participation is in social/community mobilization & execution of campaign with its network of youth clubs & 500 district offices to reach to the rural areas. There has been excellent collaboration among the ministries with the exception of controversies on introducing sex education in schools.

The Red Ribbon Club (RCC) is a voluntary on-campus intervention programme for students in educational institutions. It is initiated and supported by the SACS and implemented through multi-sectoral collaboration, particularly using the services of cadre officers of the State's NSS. The club has been proposed to expand to every school and college to provide youth with access to information on HIV and voluntary blood donation. The club also works towards promotion of life skills to bring about behavioural change among the youth. RRCs have already been established in more than 16,000 schools and colleges.

In addition, the largest national campaign to date is a seven-coach train called the Red Ribbon Express launched by NACO on 1<sup>st</sup> December 2007. The train, which will visit 23 states, stopping at over 180 stations, offers education, counseling, an exhibition and symptomatic treatment.

### **Major Gaps and recommendations for action**

- Current campaigns that focus more on youth participation for prevention must integrate issues of treatment, care and support.
- Incorporate the principle of GIYA – Greater Involvement of Youth living with and affected by HIV/ AIDS.
- India has several national level youth movements of Faith Based Organizations (FBOs). These organizations can mobilize and reach youth with more ease and less resource as they have an infrastructure already established nationwide. It is necessary that all such organizations come together on a common platform, network with each other on the issue of HIV and AIDS prevention and care and support.