This Research Dossier supports the Report Card on HIV Prevention for Girls and Young Women in India produced by the United Nations Global Coalition on Women and AIDS (GCWA). It documents the detailed research coordinated for the GCWA by the International Planned Parenthood Federation (IPPF), with the support of the United Nations Population Fund (UNFPA), United Nations Program on AIDS (UNAIDS) and Young Positives.

The Report Card provides an ‘at a glance’ summary of the current status of HIV prevention strategies and services for girls and young women in India. It focuses on five cross-cutting prevention components:

1. Legal provision
2. Policy context
3. Availability of services
4. Accessibility of services
5. Participation and rights

The Report Card also includes background information about the HIV epidemic and key policy and programmatic recommendations to improve and increase action on this issue in India.

This Research Report is divided into two sections:

**PART 1: DESK RESEARCH:** This documents the extensive desk research carried out for the Report Card by IPPF staff and consultants based in the United Kingdom.

**PART 2: IN-COUNTRY RESEARCH:** This document the participatory in-country research carried out for the Report Card by a local consultant in India. This involved:

- Two **focus group discussions** with a total of 19 girls and young women aged 15-24 years. The participants included girls and young women who are: living with HIV; in/out-of/school; involved in sex work; living in urban and suburban areas; and working as peer activists.
- Five **one-to-one interviews** with representatives of organisations providing services, advocacy and/or funding for HIV prevention for girls and young women. The stakeholders were: a country representative of an international NGO; a nurse at a national NGO focusing on sexual and reproductive health; a counsellor at an NGO/government voluntary counselling and testing centre; a programme officer of a United Nations agency; and a Technical Adviser of an international donor agency.
- Additional **fact-finding** to address gaps in the desk research.
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One-to-one interview: Counselor (male living with HIV/AIDS) Salvation Army (NGO in Mumbai)
One-to-one interview: President (female living with HIV/AIDS) Network of Maharashtra Positive People (positive people network in Mumbai-Sister concern of Indian Network of Positive People)
One-to-one interview: Manager HIV/AIDS (female) FPAIndia (Mumbai)
One-to-one interview: Dr. E Mohamed Rafique (male) Resource person and moderator, AIDS community UNAIDS (New Delhi) Mr. Gurumurthy Rangaiyan, (male) National Program Officer UNAIDS (New Delhi)
One-to-one interview: Assistant Representative-India Country Office, (UNFPA- New Delhi)

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstain-Be Faithful-Use Condoms</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CCM</td>
<td>The Convention on Consent on Marriage</td>
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<tr>
<td>CEDAW</td>
<td>The Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CIA</td>
<td>Central Intelligence Agency</td>
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<td>CRC</td>
<td>The Convention on the Rights of the Child</td>
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<td>CT</td>
<td>Counselling and Testing</td>
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<td>CTX</td>
<td>Cyclophosphamide</td>
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<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
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<td>ICW</td>
<td>The International Community of Women Living with HIV &amp; AIDS</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>MANASO</td>
<td>India Network of AIDS Service Organisations</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MDHS</td>
<td>India Demographic Health Survey</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PLWHA/PLWA</td>
<td>People Living With HIV and AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>RHAP</td>
<td>Regional HIV and AIDS Programme</td>
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<td>SP</td>
<td>Sulfadoxine-Pyrimethamine</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>The United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling &amp; Testing</td>
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For further information about this Research Report, or to receive a copy of the Report Card, please contact:
PART 1:
DESK RESEARCH
### COUNTRY PROFILE


- **Languages**: English enjoys associate status but is the most important language for national, political, and commercial communication; Hindi is the national language and primary tongue of 30% of the people; there are 14 other official languages: Bengali, Telugu, Marathi, Tamil, Urdu, Gujarati, Malayalam, Kannada, Oriya, Punjabi, Assamese, Kashmiri, Sindhi, and Sanskrit; Hindustani is a popular variant of Hindi/Urdu spoken widely throughout northern India but is not an official language , (CIA (2006) The World Factbook – India, [http://www.odci.gov/cia/publications/factbook/geos/in.html](http://www.odci.gov/cia/publications/factbook/geos/in.html) (Date accessed 11/07/06))

- **Number of deaths due to AIDS (adults and children) in 2005**: 270,000 – 680,000

- **Number of women (15-49) living with HIV in 2005**: est. 1,600,000

- **Number of children (0-15) living with HIV (ages 0-14 years, 2005)**: 100,000*
<table>
<thead>
<tr>
<th>Key questions</th>
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<tbody>
<tr>
<td><strong>1. What is the minimum legal age for marriage?</strong></td>
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“The child marriage restraint act 1939 prohibits marriage below 18 for girls and 21 for boys. But some 80% of Indians live in villages where family, caste and community pressures are more effectual than any remote legislature.” ... “is one amongst millions of girls worldwide who are married off before they attain the age of 18, the legal age of marriage in many countries, including India. Despite the existence, since 1929, of legislation banning it, child marriage continues to be a social reality in India today. A disproportionate number of girls in semi-urban and rural areas are married off in childhood, as compared to boys. The law has a number of lacunae and contradictions, and lacks gender sensitivity in dealing with the age of marriage, of consent, and the validity of marriage.”

(UNICEF Website (2006) - Early Marriage: A childhood interrupted

“Women in Rajasthan tend to marry at an early age. Forty-nine percent of women age 15-19 are already married, including 11 percent who are married but gauna has yet to be performed.”

(NACO 2005, Social Assessment of HIV/AIDS Among Tribal People in India A Report Submitted to NACP-III Planning Team, New Delhi,
http://www.nacoonline.org/socialassessmentNACP.pdf (date accessed 19/12/06))

| **2. What is the minimum legal age for having an HIV test without parental and partner consent?** |

**Informed consent for HIV testing of minors**

“The law gives paramount importance to the best interests of the child. In the context of HIV/AIDS, the best interests of the child are served by promoting access to information and services including VCT. Whenever possible, minors are encouraged to involve their parents/guardians in supervising their health care. However, unwillingness to inform parents/guardians should not interfere with the minor’s access to information and services.

Access to VCT services should be available to children and young people under the age of 18 years based on an assessment of their evolving capacities and their ability to comprehend the nature and implications of HIV/AIDS and an HIV test result. It is the role of the trained counselor to assess these abilities.

However, the informed consent of parents / guardians is required prior to testing of minors for HIV.”


“The age of consent for HIV testing should be decreased to 16 years.”
3. What is the minimum legal age for accessing SRH services without parental and partner consent?

"According to a literature review by Ramasubban (1995), as many as 25% of patients attending government STI clinics in India are younger than 18 years old."

Editorial Indian Pediatrics 2004 - Adolescent Sexual and Reproductive Health
http://www.indianpediatrics.net/jan2004/jan-7-13.htm (Date Accessed 04/01/07)

4. What is the minimum legal age for accessing abortions without parental and partner consent?

"Grounds on which abortion is permitted:

<table>
<thead>
<tr>
<th>Ground</th>
<th>Permitted</th>
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<tbody>
<tr>
<td>To save the life of the woman</td>
<td>Yes</td>
</tr>
<tr>
<td>To preserve physical health</td>
<td>Yes</td>
</tr>
<tr>
<td>To preserve mental health</td>
<td>Yes</td>
</tr>
<tr>
<td>Rape or incest</td>
<td>Yes</td>
</tr>
<tr>
<td>Foetal impairment</td>
<td>Yes</td>
</tr>
<tr>
<td>Economic or social reasons</td>
<td>Yes</td>
</tr>
<tr>
<td>Available on request</td>
<td>No</td>
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</table>

Additional requirements:

Contraceptive failure on the part of the wife or husband constitutes valid grounds for legal abortion. Unless a medical emergency exists, a legal abortion must be performed during the first 20 weeks of gestation by a registered physician in a hospital established or maintained by the Government or in a facility approved by specific legislation. A second opinion is required in cases where the duration of the pregnancy is between 12 and 20 weeks, except in urgent cases. In general, the consent of the pregnant woman is required before the performance of an abortion, while written consent of her guardian must be obtained for a minor (defined as under age 18) or a mentally retarded woman."


5. Is HIV testing mandatory for any specific groups (e.g. pregnant women, military, migrant workers, and sex workers)?

"5.8.3 HIV-positive women should have complete choice in making decisions regarding pregnancy and childbirth. There should be no forcible abortion or even sterilisation on the ground of HIV status of women. Proper counselling should be given to the pregnant women for enabling her to take an appropriate decision either to go ahead with or terminate the pregnancy. The prophylaxis for prevention of mother to child transmission will be introduced to cover all infected mothers as a part of the National programme. This facility will be entirely voluntary on the basis of informed consent."

National AIDS Prevention and Control Policy,
http://www.nacoonline.org/prog_policy.htm (date accessed 19/12/06)
“Although voluntary testing is officially supported in India, some states have tried to implement policies that would force people to be tested for HIV against their will. In Goa, the state government recently planned to make HIV tests compulsory before marriage, and in Punjab it has been proposed that all people wishing to obtain or retain a driver’s license should be tested for HIV.

Unfortunately, cases of people being tested without their consent or knowledge are common in Indian hospitals. In one 2002 study, it was suggested that over 95% of patients listed for surgical procedures are tested against their will, often resulting in their surgery being cancelled. Hospital staff and health professionals, much like the rest of the Indian population, are often unaware of the facts about HIV. This leads to unnecessary fears and, in some cases, causes them to stigmatise HIV positive people and discriminate against them, including testing them without consent.”

Avert website, http://www.avert.org/aidsindia.htm (Date accessed 19/12/06)

“There is an active debate in the country on the issue as to whether there should be mandatory testing of people suspected of carrying HIV infection. Considerable thought has been given to this issue. Testing for HIV is more than a mere biological test for it involves ethical, human and legal dimensions. The government feels that there is no public health rationale for mandatory testing of a person for HIV/AIDS. On the other hand, such an approach could be counter productive as it may scare a large number of suspected cases from getting detected and counselled to take appropriate measure to improve his quality of life and prevent spread of infection to other persons in the community. HIV testing carried out on a voluntary basis with appropriate pre-test and post test counselling is considered to be a better strategy and is in line with the national policy on HIV testing and also the WHO guidelines”


6. Is there any legislation that specifically addresses gender-based violence?

“The Government of India passed a Bill on 8th March, 2002 on Domestic Violence. The Government of India Bill defines “Domestic Violence” as follows: -

for the purpose of this Act, any conduct of the respondent stall constitute domestic violence if he,

a) habitually assault or makes the life of the aggrieved person miserable by cruelty of conduct even if such a conduct does not amount to physical ill-treatment,

b) faces the aggrieved person to bad an immoral life or

c) otherwise injuries or harms the aggrieved person.

Nothing contained in clause (c) of the sub-section (1) shall amount to domestic violence if the pursuit of course of conduct by the respondent was reasonable of his own protection or for the protection of his or another’s property.

The United Nation framework for model legislation on domestic violence states: “All acts of gender-based physical and Psychological abuse by a family member against women in the family, ranging from simple assault to aggravated physical battery, kidnapping, threats, intimidation, coercion, stalking, humiliating verbal use, forcible on unlawful entry, arson, destruction of property, sexual violence, marital rape, dowry or related violence, female genital mutilation, violence, related to exploitation through prostitution, violence against household workers and attempts to commit such acts shall be termed “Domestic Violence.”

Though the Govt. of India Bill has been criticized by different organization in India.
They say that Govt. of India bill fails to define domestic violence and washes itself off the responsibility of defining it and leaves it to judges to decide. This leaves too much to the mercy of the judge and too little to the rights of the person aggrieved. The definition does not use the language of rights and uses instead the outdated concept of conduct, making “The life of an aggrieved person miserable.” It does not even define cruelty. There is in the Govt. of India Bill, a persistent denial to recognize that domestic violence exists and the need to articulate its various forms. This definition will defeat the very purpose of the law and will render its meaning less for women, if not make their position worse.”

(Delhi Commission for Women Website - Domestic Violence
http://dcw.delhigovt.nic.in/Domestic%20Violance.htm (Date Accessed 12/07/2006))

In 2001 India announced the National Policy for the Empowerment of Women that includes ‘Elimination of discrimination and all forms of violence against women and the girl child’

Sensitive Legislative Legislation and Policies in India
http://www.unescap.org/esid/GAD/Events/EGMiCT2001/edappagath.pdf (date accessed on 03/0407)

7. Is there an AIDS Law – or equivalent – that legislates on issues such as confidentiality for testing, diagnosis, treatment, care and support?

“CONFIDENTIALITY: Street confidentially about a person’s HIV status whether HIV positive or negative will be ensured. No information will be released without his or her written consent or only on subpoena by the Law Court. Breach of confidentiality by the staff will be taken as a disciplinary matter and will be dealt with under the disciplinary procedure.”

(NACO 2005, Social Assessment of HIV/AIDS Among Tribal People in India A Report Submitted to NACP-III Planning Team, New Delhi,
http://www.nacoonline.org/socialassessmentNACP.pdf (Date accessed 19/12/06)

8. Is there any legislation that protects people living with HIV/AIDS, particularly girls and young women, from stigma and discrimination at home and in the workplace?

India’s AIDS Bill To Stamp Out Discrimination

“Prevention of discrimination towards HIV-positive people is the focus of India’s HIV/AIDS Bill 2005 which awaits a go-ahead from the Health Ministry. The bill addresses problems like discrimination in employment and prevention of hate, victimisation and discriminatory propaganda. The legislation will allow HIV-positive people and AIDS patients the right not to be given medical treatment or be made the subject of research without their consent. Consent would also become mandatory for any HIV-related test or treatment. Consent from a representative is needed for minors and for those lacking the physical or mental capacity to give consent. Exemptions have been made in case of court orders.

The bill, which has been prepared by the Lawyers Collective HIV/AIDS Unit and was submitted to NACO two months ago, was drafted after three years of consultations and research in co-ordination with NACO and State AIDS Control Societies. The legislation outlaws discrimination by the state or any person. It also states that the HIV-positive and AIDS patients cannot be denied or thrown out of jobs except when certified to be unfit by a doctor or when their employment poses a risk to co-workers. Denial or discontinuation or unfair treatment in healthcare, education or with regard to access to goods, accommodation, benefits, public entertainment places and burial grounds have been made punishable offences.”
“SOCIAL SERVICE PROVISION: No one will be denied of service such as education, accommodation, housing, travel, hospital services and social service benefits to which he/she is entitled solely because of his/her HIV status. The State government will review the existing policies and practices in the Government department in order to ensure that the employees are adequately protected against HIV infection. The State Government is committed to the active involvement of people living with HIV/AIDS in their own care and in the implementation of the programme. (pg122)”

(NACO 2005, Social Assessment of HIV/AIDS Among Tribal People in India A Report Submitted to NACP-III Planning Team, New Delhi, http://www.nacoonline.org/socialassessmentNACP.pdf (Date accessed 19/12/06)

9. Are sex workers legally permitted to organise themselves, for example in unions or support groups?

Unions in Sonagachi Negotiate Safe Sex

“In the land of comrades if you put two of them together, they form a union. This has happened in Sonagachi, one of the largest red light areas of Kolkata, West Bengal. While fighting for their professional rights, the commercial sex workers union here has transformed itself into a unique, self-driven community project. It addresses the problems of sex workers’ health through peer education and carries out HIV/AIDS awareness campaigns among its members. They have been taught to negotiate the use of condoms with the clients. The use of the rubber sheath is now 80% and the exposure to HIV infection under control. The Sonagachi project covers 60,000 members and has attracted international funding.”


Vocal protests

“This is not the first attempt to solve the problems of sex workers in India. In the last few years sex workers in many parts of India have successfully campaigned to highlight their plight.

In March 2001, Calcutta sex workers’ union, the Durbar Mahila Sammanoy Samity, organised a meeting of several thousand sex workers from India and other countries of South Asia to discuss the increasing problem of trafficking of vulnerable women.

The meeting agreed to set up a network to prevent women being targeted by trafficking gangs.

In may 2001, Indian sex workers took out a huge May Day procession protesting against the Indian Census Commission decision to include them in the same category as beggars, vagabonds and street children in the national census.

The protest was organised by a non-governmental organisation, Bharatiya Patita Uddhar Sabha.”


10. Are harm reduction methods for injecting drug users (such as needle exchange) legal?

*The most important strategy to combat the problem of intravenous drug use and its serious consequences in transmission of HIV/AIDS would be the ‘Harm Minimisation’ approach which is now being accepted world wide as an effective preventive mechanism. Harm minimization aims to reduce the adverse social and economic consequences and health hazards by minimizing or reducing the intake of drugs leading to gradual elimination of their use. Harm minimization in the context of Intra Venous (IV) drug use would require not only appropriate health education, improvement in treatment services but in most practical terms, providing of bleach powder, syringes and needles for the safety of the individual. An appropriate Needle Exchange Programme with proper supervision by trained doctors/counsellors, etc. will be required. Government will encourage NGOs working in the drug de-addiction programmes to take up harm minimization as a part of the HIV/AIDS control strategy in areas, which have a large number of drug addicts. Greater convergence will be brought about between the NGOs based programmes for drug de-addiction and the hospital-based de-addiction programmes run by the Government*


Discussion questions:

- Which areas of SRH and HIV/AIDS responses are legislated for?

- What are the biggest strengths, weaknesses and gaps in legislation in relation to HIV prevention for girls and young women?

- Is action taken if laws are broken (e.g. if a girl is married below the legal age)?

- Is there any specific legislation for marginalised and vulnerable groups? If yes, is the legislation supportive or punitive? And what difference does it make to people’s behaviours and risk of HIV infection?

- To what extent are ‘qualitative’ issues – such as confidentiality around HIV testing – covered by legislation?

- How much do girls and young women know about relevant legislation and how it relates to them? Are there any initiatives to raise awareness about certain laws?

- Overall, how is relevant legislation applied in practice? What are the ‘real life’ experiences of girls and young women? What difference does it make to their vulnerability to HIV infection?
How do the effects of legislation vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

PREVENTION COMPONENT 2: POLICY PROVISION
(national policies, protocols, guidelines, etc)

Key questions:

11. Does the current National AIDS Plan address the full continuum of HIV/AIDS strategies, including prevention, care, support and treatment?

Objectives and goals

The general objective of the policy is to prevent the epidemic from spreading further and to reduce the impact of the epidemic not only upon the infected persons but upon the health and socio-economic status of the general population at all levels. The policy envisages effective containment of the infection levels of HIV/AIDS in the general population in order to achieve zero-level of new infections by 2007. The specific objectives of the policy are:

(i) to reiterate strongly the Government’s firm commitment to prevent the spread of HIV infection and reduce personal and social impact.

(ii) to generate a feeling of ownership among all the participants both at the Government and non-Government levels, like the Central Ministries and agencies of the Government of India, State Governments, city corporations, industrial undertakings in public and private sectors, panchayat institutions and local bodies to make it a truly national effort

(iii) To create an enabling socio-economic environment for prevention of HIV/AIDS, to provide care and support to people living with HIV/AIDS and to ensure protection/promotion of their human rights including right to access health care system, right to education, employment and privacy, to mobilise support of a large number of NGOs/ Community Based Organisations (CBOs) for an enlarged community initiative for prevention and alleviation of the HIV/AIDS problem.

(iv) To decentralise HIV/AIDS control programme to the field level with adequate financial and administrative delegation of responsibilities.

(v) To strengthen programme management capabilities at the State Governments, municipal corporations, panchayat institutions and leading NGOs participating in the programme.

(vi) To bring in horizontal integration at the implementation level with other national programmes like Reproductive and Child Health, TB Control, Integrated Child Development Scheme and with the primary health care system.

(vii) to prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects

(viii) To provide adequate and equitable provision of health care to the HIV-infected people and to draw attention to the compelling public health rationale for overcoming stigmatisation, discrimination and seclusion in society

(ix) To constantly interact with international and bilateral agencies for support and
cooperation in the field of research in vaccines, drugs, emerging systems of health care and other financial and managerial inputs.

(x) To ensure availability of adequate and safe blood and blood products for the general population through promotion of voluntary blood donation in the country.

(xi) To promote better understanding of HIV infection among people, especially students, youth and other sexually active sections to generate greater awareness about the nature of its transmission and to adopt safe behavioural practices for prevention.”

(National AIDS Control Organisation - National AIDS prevention and Control Policy 
http://www.nacoonline.org/prog_policy.htm (Date Accessed 12/07/2006))

(III) Continuum of Care

“HIV/AIDS is a disease with long incubation period. People suffering from this condition requires a long, continuous treatment. Hospital care in such condition is not feasible. So, home based care of care is absolutely necessary for care of such cases. The home based care has some specific objectives:

1. Formation of indispensable teams, which will train the family members who will provide social support and teach prevention. They will develop referral network linking health services with NGOs.

   - Follow up
   - Nursing Care
   - Medical Care
   - Infection Control practices
   - Educating family members
   - Counseling has to be done on HIV testing to reduce stress and anxiety and plan for the future. The home care will include training of the family members, provide moral support and also linkage to the social welfare.

The home based care has to be monitored and the monitoring has to be done by some community based NGOs. The patient with AIDS need psychological support, needs help by trained family members. The care providers will be members of the family and NGO volunteers. Ordinary symptoms like cough, diarrhoea will be treated by the family members. They will know the medicines to stop the loose motions, dehydration and adjust the nutrition requirements of the patients. They and NGO volunteers will be looking after the patient at home and they will be trained as to when to refer the patients to dispensary for community care. The dispensary staff doctor and primary health care doctors will know when to refer the patient to the referral hospitals about counseling, diagnosis medical treatment and nursing care. At home, family members will be trained how to deal with excreta, the swelling and the blood split, if there is, how to clean them and to provide moderate universal care will be taught to them in training. If this is done, the home care is possible.”

(National AIDS Control Organisation, Ministry of Health and Family Welfare Government of India, http://www.nacoonline.org/prog_sche_carePLWHA.htm (Date accessed 19/19/06)

12. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of girls and young women?

“Age group 15-59 years
The challenge is the massive increase in the number of people in this age group. They will:

need wider spectrum of services:
- maternal and child health services
- contraceptive care
- gynaecological problems
- RTI /STD management
- expect better quality of services
- expect fulfilment of their felt needs for
- MCH/family planning care.

Opportunity is that if their felt needs are met
- through effective implementation of RCH
- programme, it is possible to accelerate
- demographic transition and achieve rapid population stabilisation (pg172)"


“(vi) To bring in horizontal integration at the implementation level with other national programmes like Reproductive and Child Health, TB Control, Integrated Child Development Scheme and with the primary health care system.

(vii) to prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects

(xi) To promote better understanding of HIV infection among people, especially students, youth and other sexually active sections to generate greater awareness about the nature of its transmission and to adopt safe behavioural practices for prevention.”


13. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of marginalised and vulnerable groups, including people who are living with HIV/AIDS?

“3.(vii) to prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects ” ..

“4.1.(ii) controlling STDs among vulnerable sections together with promotion of condom use as a preventive measure” ..

“6. Government recognises that without the protection of human rights of people, who are vulnerable and afflicted with HIV/AIDS, the response to HIV/AIDS epidemic will remain incomplete.” ..

“7.5 As socially marginalized sections like commercial sex workers, injecting drug users, street children, men having sex with men, etc. are not normally accessible through the traditional Government machinery, involvement of non-Governmental organizations and CBOs should be secured to effectively reach these populations through a holistic approach of targeted intervention programmes. These programmes should aim at
prevention and control of sexually transmitted diseases, deliver relevant IEC messages which are in the local idiom and are interactive in nature, promote condom use for effective prevention of the spread of HIV/AIDS and create an enabling environment that reduces vulnerability of these groups. NGOs and charitable organizations should also be actively involved in organizing low cost care and support systems and outreach for people living with HIV/AIDS.”


14. Does the National AIDS Plan emphasise confidentiality within HIV/AIDS services?

“5.6.iv. In case a person likes to get the HIV status verified through testing, all necessary facilities should be given to that person and results should be kept strictly confidential.” ..

“5.8.2 The HIV-positive person should be guaranteed equal rights to education and employment as other members of the society. HIV status of a person should be kept confidential and should not in any way affect the rights of the person to employment, his or her position at the workplace, marital relationship and other fundamental rights.”

“6 (ii) Government will strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy, confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.”


15. Does the national policy on VCT address the needs of girls and young women?

“VCT services must become available and accessible to vulnerable groups including young people, women, mobile and migrant populations and people with high-risk behaviour.” “The VCTC counselor must: ... Be sensitive to the needs of the clients especially and people from marginalised groups.”


“The age of consent for HIV testing should be decreased to 16 years.”


16. Does the national protocol for antenatal care include an optional HIV test?

“All pregnant women attending clinics were encouraged to undergo an HIV/AIDS group education session through a structured talk. The talk emphasised the key HIV messages which normally are highlighted in a pre-test counselling. This didactic session was followed with a video film session. At the end of the session the women were offered HIV test option. Written informed consent was obtained from willing women. Those women, who refused to undertake HIV test were counselled on one-to-one basis to allay their anxieties and/or any fears they may have for undertaking the test. However, adequate efforts were made to ensure that the effort was not perceived as a coercive effort. The blood samples for HIV testing were collected from women who
gave written informed consent. Those women who took the HIV test were offered to choose a day for receiving their HIV test results. The post-test counselling was offered on one-to-one basis. Due emphasis on safer sexual behaviours and harm reduction was placed during counselling as a component of primary prevention of HIV infection. The women were informed about free HIV testing facility in the hospital where her husband could also undertake the free test. The issue of partner notification, confidentiality, AZT prophylaxis and intervention to reduce MTCT were discussed in detail with women testing HIV-seropositive. HIV-infected women were given at least few days time to decide whether she was willing to participate in the feasibility study. Women who provided consent for enrolment were included in the study. The following issues were emphasised:


17. Does the national protocol for antenatal care include a commitment that any girl or young woman testing HIV positive should automatically offered PMTCT services?

The national programme on Prevention of Parent-To-Child Transmission (PPTCT)

Transmission of HIV from parent-to-child can occur during pregnancy, at the time of delivery or through breast-feeding. There is a 25-30% chance that the child of an HIV positive mother will also be infected with HIV. In India. Parent-to-child transmission of HIV (perinatal transmission), accounts for more than 2 percent of the country’s HIV/AIDS cases.

HIV transmission from parent-to-child can be prevented with a combination of low-cost, short-term preventive drug treatment, safe delivery practices, counseling and support, and safe infant-feeding methods.

NACO is scaling up the Prevention of Parent-to-Child Transmission (PPTCT) Programme to cover all medical colleges and districts in high HIV prevalence states. Currently 256 PPTCT centers are providing services through trained counselors.

Elements of the national PPTCT program:

• Primary prevention of HIV infection, especially among women, through education of adolescent girls and women, voluntary counseling and testing, and education on infant feeding.

• Prevention of unintended pregnancies through reproductive health services, which include family planning, extended to all women, including women infected with HIV.

• Anti-retroviral (ART) prophylaxis, safer delivery practices and support for women whose HIV infection is identified only when they are already pregnant.

• Care and support services to HIV-infected women who are enrolled with the programme and to their children and families.”


18. Is there a national policy the protects the rights and needs - including HIV prevention, SRH services, employment opportunities and education - of young women or girls at risk or affected by early marriage?

“6. Government will adopt the following measures to implement an effective rights based response.

(i) Government will review and reform criminal laws and correctional system to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.
(ii) Government will strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy, confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

(iii) Government will ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and services.

(iv) Government will ensure support service that will educate people affected by HIV/AIDS about their rights, provide legal services to enforce these rights and develop expertise on HIV related legal issues.

(v) Government will promote wide distribution of creative, education, training and media programmes explicitly designed to change attitudes of community towards discrimination and stigmatization associated with HIV/AIDS.

(vi) Government in collaboration with and through the community will promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.”

(National AIDS Control Organisation - National AIDS prevention and Control Policy
http://www.nacoonline.org/prog_policy.htm (Date Accessed 12/07/2006))

19. Is HIV prevention within the official national curriculum for both girls and boys?

“5.2.3 In educational institutions AIDS education should be imparted through curricular and extracurricular approach. The programme of AIDS education in schools and the ‘Universities Talk AIDS’ (UTA) programme should have universal applicability throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators to the rest of the community. Non-student youth should also be addressed through the large network of youth organizations, sports clubs, National Service Scheme (NSS) and Nehru Yuvak Kendras spread across the country. AIDS prevention education should also be integrated into the programmes of workers education and schemes of social development.”

(National AIDS Control Organisation - National AIDS prevention and Control Policy
http://www.nacoonline.org/prog_policy.htm (Date Accessed 12/07/2006))

20. Is key national data about HIV/AIDS, such as HIV prevalence, routinely disaggregated by age and gender?

Yes.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 15 to 49</td>
<td>0.9 [0.5 – 1.5]%</td>
</tr>
<tr>
<td>Adults aged 15 and up living with HIV</td>
<td>5 600 000 [3 400 000 – 9 300 000]</td>
</tr>
<tr>
<td>Women aged 15 and up living with HIV</td>
<td>1 600 000 [820 000 – 2 800 000]</td>
</tr>
</tbody>
</table>

(UNAIDS Country Situation Analysis, India http://www.unaids.org/en/Regions_Countries/Countries/india.asp (date accessed on 29/03/07))


Discussion questions:

- To what extent are relevant bodies – such as the Ministry of Education, NGO networks, religious organisations, etc – engaged in policy-making around HIV prevention for girls and young women?

- To what extent do those bodies work in partnership or in isolation? What areas of HIV prevention responses (e.g. behaviour change, counselling, treatment, home-based care) have national protocols or guidelines?

- To what extent do those protocols address the needs of girls and young women, including those that are marginalised and vulnerable?

- What does school-based sex education cover? Does it help to build young people’s confidence and skills, as well as knowledge?

- To what extent do policies help to reduce stigma and discrimination? For example, do they encourage people to stop using derogatory language or ‘blaming’ specific groups for HIV/AIDS?

- To what extent are different areas of policy provision – such as for HIV/AIDS and antenatal care – integrated or isolated?

- What policy measures exist in relation to consent, approval and confidentiality? For example, can girls and young women access services such as VCT without having to notify their parents and/or partner? And are they informed of their right to confidentiality?

- Overall, how are relevant policies applied in practice? What are the ‘real life’ experiences of girls and young women? How much do they know about them and how they relate to them? What difference do these policies make to their vulnerability to HIV infection?

- How do the effects of policies vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
### Prevention Component 3: Availability of Services

(number of programmes, scale, range, etc)

<table>
<thead>
<tr>
<th>State/Region</th>
<th>Number of SRH Clinics or Outlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>61</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>7</td>
</tr>
<tr>
<td>Assam</td>
<td>15</td>
</tr>
<tr>
<td>Andaman and Nicobar islands</td>
<td>4</td>
</tr>
<tr>
<td>Bihar</td>
<td>25</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>6</td>
</tr>
<tr>
<td>Chandigarh</td>
<td>3</td>
</tr>
<tr>
<td>Dadra and Nagar Haveli</td>
<td>1</td>
</tr>
<tr>
<td>Delhi</td>
<td>12</td>
</tr>
<tr>
<td>Goa</td>
<td>4</td>
</tr>
<tr>
<td>Ahmedabad</td>
<td>4</td>
</tr>
<tr>
<td>Gujrat</td>
<td>29</td>
</tr>
<tr>
<td>Haryana</td>
<td>16</td>
</tr>
<tr>
<td>Himachal</td>
<td>20</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>11</td>
</tr>
<tr>
<td>Karnataka</td>
<td>34</td>
</tr>
<tr>
<td>Kerala</td>
<td>20</td>
</tr>
<tr>
<td>Lakshadweep</td>
<td>1</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>45</td>
</tr>
<tr>
<td>Chattisgarh</td>
<td>9</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>34</td>
</tr>
<tr>
<td>Mumbai</td>
<td>14</td>
</tr>
<tr>
<td>Manipur</td>
<td>10</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>6</td>
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<td>Mizoram</td>
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<tr>
<td>Nagaland</td>
<td>8</td>
</tr>
<tr>
<td>Orissa</td>
<td>34</td>
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<tr>
<td>Pondicherry</td>
<td>4</td>
</tr>
<tr>
<td>Punjab</td>
<td>11</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>33</td>
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<tr>
<td>Sikkim</td>
<td>3</td>
</tr>
<tr>
<td>Tripura</td>
<td>3</td>
</tr>
<tr>
<td>Tamilnadu</td>
<td>57</td>
</tr>
<tr>
<td>Chennai</td>
<td>13</td>
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<tr>
<td>Uttar pradesh</td>
<td>68</td>
</tr>
<tr>
<td>Uttarakhand</td>
<td>9</td>
</tr>
<tr>
<td>West Bengal</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>682</td>
</tr>
</tbody>
</table>

1. National AIDS Control Organisation Website - Directory of Services - State wise

www.nacoonline.org/directory.htm (Date Accessed 13/07/2006)
23. At how many service points is VCT available, including for young women and girls?

"HIV testing and counselling sites: number of sites Dec 2005 - 833 National AIDS Control Organisation"

(WHO 2006 Summary Country Profile for Treatment Scale Up http://www.who.int/hiv/HIVCP_IND.pdf (Date Accessed 13/07/2006))

"By the end of 2005 there were 873 VCT centres in India”

(Avert website 2006, http://www.avert.org/aidsindia.htm (date accessed 19/12/06))

24. Are male and female condoms available in the country?

"Reported condom use at last higher risk sex
(15-24 years)% - female 2001 51% Behavioural Surveillance Study

Reported condom use at last higher risk sex
(15-24 years)% - male 2001 59% Behavioural Surveillance Study”

25. Is a free HIV test available to all pregnant girls and young women who wish to have one?

"5.6 VCT
Access to VCT (Voluntary Counseling and Testing) will be available in all Medical Colleges and the Districts in the HIV high prevalence States. Women, their partners and families should have access to follow – up counseling and care. Counselors will need to be supported and quality of counseling guaranteed. A community referral net work for on going counseling and psychological support will be developed.”


“Information for VCT clients. VCT is for anyone who may be at risk of HIV infection and anyone who wants to know their HIV status, including women who are pregnant and their partners.

If you decide to go for the test, you are asked to pay Rupees 10, 2 ml of your blood will be drawn and you are requested to return to the VCTC at the time specified by the counselor for picking up the test result and posttest counseling.”


26. At how many service points are PMTCT services (such as nevirapine) available for pregnant girls or young women who are HIV positive?
27. At how many service points are harm reduction services for injecting drug users available?

"In 2004, the total number of sentinel sites stands at 659 and this includes 171 STD sites, 269 ANC sites, 24 IDU sites, 15 MSM sites, 42 FSW sites, 132 ANC (rural) and 6 TB sites."


"In the majority of Indian states, tough regulations make it hard to reach IDUs. However, there has been some progress recently; particularly in urban areas but also in Manipur where local government has adopted their own harm reduction policies."

AVERT, Who is affected by HIV and AIDS in India http://www.avert.org/hiv-india.htm (date accessed on 02/04/07)

28. Are there any specific national projects (such as camps, conferences, and training courses) for boys/girls and young people living with HIV/AIDS?

"(5) Holding camps in each village during campaign
It is proposed to hold camps separately for male and female target groups in each village. Each camp will be attended by male and female health workers separately and assisted by community volunteers. The health workers will discuss the problems of RTI/STI with the target group in reference to cases, symptoms and complications. They will also make them aware about HIV/AIDS transmission and its prevention and control. Attendees of the camps will also be informed about the facilities available for treatment and referral"
slips will be issued to those who need treatment. Health care workers would also keep a record for those who are referred for treatment so that they can make follow-up visits to ensure complete cure of the patients.”

(National AIDS Control Organisation, Feasibility Study of Administering Short-Term Azt Intervention Among Hiv-Infected Mothers To Prevent Mother–To-Child Transmission Of Hiv In India, Ministry of Health and Family Welfare Goverment of India, http://www.nacoonline.org/prog_sche_carePLWHA.htm Date accessed 19/19/06)

29. At how many service points are ARVs available to people living with HIV/AIDS?

“Government hospitals identified for the initial launch of antiretroviral treatment in consultation with the State AIDS Control Societies were:

a) Sir JJ hospital, Mumbai, Maharashtra
b) Institute of Thoracic Medicine and Chest diseases, Tambaram, Chennai
c) Regional Institute of Medical Sciences (RIMS), Imphal, Manipur
d) Bangalore Medical College Hospital, Bangalore, Karnataka
e) Osmania Medical College Hospital, Hyderabad, Andhra Pradesh
f) Ram Manohar Lohia (RML) Hospital, New Delhi
g) LNJP Hospital, New Delhi
h) District Naga Hospital, Kohima, Nagaland

NACO reviews very frequently, the roll out of ART and we closely monitor emerging teething problems and the progress achieved in the accurate disbursement of antiretroviral treatment across 8 hospitals that have commenced implementing this initiative. Counselling including family counselling and networking with NGOs and positive peoples networks have been ensured. These 8 ART centers have achieved an adherence rate of 96.1% among people who have been placed on treatment.

Union Health Minister has reviewed in July and in August, 2004 the current status in implementation of the ART initiative. He has directed that during 2004-05, government will increase the numbers of ART centres from 8 centres to 25 centres* at identified government hospitals across HIV high prevalence and HIV low prevalence states.”

(National AIDS Control Organisation Website - Directory of Services - Statewise List Of VCT, ARVs and PPTCT Centres http://www.nacoonline.org/directory_ptct.htm (Date Accessed 13/07/2006)

30. Are there specific positive prevention services, including support groups, for young women and girls living with HIV/AIDS?

“5.8.4 The Government would actively encourage and support formation of self-help groups among the HIV-infected persons for group counselling, home care and support of their members and their families. Social action through participation of NGOs would be encouraged and supported for this purpose.”

(National AIDS Prevention and Control Policy, http://www.nacoonline.org/prog_policy.htm (Date accessed 19/12/06)

*Contact Details for PLWHA Support Groups - Listings for India

Name: Infected and Affected Women Group in Churachandpur
“Set against those statistics is an army of people trying to fight the virus. Backing some of them are hundreds of millions of dollars from the world’s deepest philanthropical pockets — The Bill and Melinda Gates Foundation. The foundation’s AIDS prevention effort in India, known as “Ahavan” — a Sanskrit word meaning “call to action” — has a $200 million five-year grant to operate an HIV prevention program on a scale never done before.”

“Ahavan’s strategy has been to adopt a business-style structure. The product is prevention, and the foundation formed a pyramid structure to get it to consumers. It contracted 15 other organizations that, in turn, work with about 150 grass-roots groups. They employ some 5,000 prostitutes, many of them HIV-positive, to get the message out.

“I talk to women about condoms and how they must insist even their regular clients wear condoms,” said Vijaymala, a fruit seller who supplements her income by working as a prostitute without her family’s knowledge.

She has a third job working as a “peer counselor” at Saathi, a tiny Gates-funded clinic nestled among the shantytown brothels in Turbhe, an industrial area on Bombay’s outskirts.

Employing prostitutes means feedback comes quickly when there are problems.

“In talking with sex workers, our team found that the women felt the condoms available in the market did not suit them,” said Sanjeev Gaikwad of Family Health International, which runs the Saathi clinic.

So they went to a condom manufacturer to produce the stronger, better-lubricated ones they now distribute.”

Discussion Questions

- What scale and range of HIV prevention services is available for girls and young women? For example, do programmes go beyond ‘ABC’ strategies? Do programmes cover social issues (e.g. early marriage)?

- To what extent are SRH, HIV/AIDS and broader community services integrated and
able/willing to provide referrals to each other? For example, could most SRH clinics refer a girl testing HIV positive to a support group for people living with HIV/AIDS?

- To what extent are HIV prevention services available through ‘non-traditional’ outlets (e.g. religious organisations, youth clubs)?

- Are there community programmes on gender awareness/dialogue for girls/boys and young women/men? Do they explore power differences and social ‘norms’ for sexual behaviour? Is there mentoring, peer support and economic development that targets females?

- How available is prevention information and support for girls and young women living with HIV/AIDS?

- How available are HIV prevention ‘commodities’ (e.g. condoms)? How are they distributed?

- How much do girls and young women know about the availability of services, such as where to get condoms or ARVs?

- Overall, what does the availability of HIV prevention services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference do these services make to their vulnerability to HIV infection?

- How do the effects of availability vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

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**PREVENTION COMPONENT 4: ACCESSIBILITY OF SERVICES**
(location, user-friendliness, affordability, etc)

**Key questions:**

31. Are all government HIV prevention and SRH services equally open to married and unmarried girls and young women?
The Tenth Plan goals for HIV/AIDS programme are:

- 80 per cent coverage of high risk group through targeted interventions;
- 90 per cent coverage of schools and colleges through education programmes;
- 80 per cent awareness among the general population in rural areas;
- reducing transmission through blood to less than 1 per cent;
- establishing of at least one voluntary testing and counselling centre in every district;
- scaling up of prevention of mother-to-child transmission activities up to the district level;
- achieving zero level increase of HIV/AIDS prevalence by 2007."

(Tenth Five Year Plan 2002-2007,  
(Date accessed 16/11/06)

"(d) HIV/AIDS, Sexually Transmitted Diseases and Substance Abuse

8.3.11 The Policy recognizes that the percentage of young people falling prey to substance abuse, STDs and HIV/AIDS being relatively higher, these issues need be tackled as, primarily, confronting the younger generation, particularly the adolescents who are most affected. Being highly impressionable, and, therefore, prone to high risk behaviour, they require proper education and awareness about reproductive health issues, including safe sexual behaviour. The Policy, therefore, advocates a two-pronged approach of education and awareness for prevention and proper treatment and counselling for cure and rehabilitation. It further enjoins that information in respect of the reproductive health system should form part of the educational curriculum. The Policy also stresses the need for establishment of adolescent clinics in large hospitals and similar projects in rural areas to address the health needs of the young adults.

NATIONAL YOUTH POLICY 2003 - India  
http://yuva.nic.in/Publications.aspx

32. Are all government HIV prevention and SRH services equally open to girls and young women who are HIV positive, negative or untested?

"(d) HIV/AIDS, Sexually Transmitted Diseases and Substance Abuse

8.3.11 The Policy recognizes that the percentage of young people falling prey to substance abuse, STDs and HIV/AIDS being relatively higher, these issues need be tackled as, primarily, confronting the younger generation, particularly the adolescents who are most affected. Being highly impressionable, and, therefore, prone to high risk behaviour, they require proper education and awareness about reproductive health issues, including safe sexual behaviour. The Policy, therefore, advocates a two-pronged approach of education and awareness for prevention and proper treatment and counselling for cure and rehabilitation. It further enjoins that information in respect of the reproductive health system should form part of the educational curriculum. The Policy also stresses the need for establishment of adolescent clinics in large hospitals and similar projects in rural areas to address the health needs of the young adults.

NATIONAL YOUTH POLICY 2003 - India  
http://yuva.nic.in/Publications.aspx

33. Are VCT services free for girls and young women?

"Information for VCT clients. VCT is for anyone who may be at risk of HIV infection and anyone who wants to know their HIV status, including women who are pregnant and their partners."
If you decide to go for the test, you are asked to pay **Rupees 10**, 2 ml of your blood will be drawn and you are requested to return to the VCTC at the time specified by the counselor for picking up the test result and posttest counseling.”


34. Are approximately equal numbers of females and males accessing VCT services?

35. Are STI treatment and counseling services free for all girls and young women?

36. Are condoms free for girls and young women within government SRH services?

**India-Based Company To Begin Selling Female Condoms; Government Considering Subsidizing Them for Sex Workers**

India-based... Hindustan Latex on Friday said it will begin selling female condoms in the country next month to help curb the spread of HIV, the Associated Press reports. M. Ayyappan, managing director of Hindustan Latex, said the company initially will import the female condoms from the London factory of Chicago-based Female Health Company and later will begin producing its own condoms. The condoms will sell for about $2.30 each, but the government’s National AIDS Control Organization is supporting the product and considering a subsidy to bring the cost to 12 cents per condom for commercial sex workers.

Medical News Today Website 02 Aug 2005

“Condoms are free from the Indian government, but have less than 10% use.”

Rotarian Action Group For Population and Development Website : WCS in India

“Millions of the condoms distributed free in India to combat Aids and population growth are being used for other purposes such as waterproofing roofs, reinforcing roads and even polishing saris, say health workers.”

Telegraph website- News12th Aug 2004

37. Are ARVs free for all girls and young women living with HIV/AIDS?

**Court Asks Government To Explain Why Treatment Target Not Met**

“In related news, India’s Supreme Court on Thursday asked the government by the end of September to explain how it set a [target of providing 100,000 HIV-positive people treatment at no cost by 2005](http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2004/08/13/windia13.xml) and why it has delayed the target twice, Reuters AlertNet
The government in April 2004 launched the program by distributing antiretroviral drugs at no cost at seven centers nationwide (Kaiser Daily HIV/AIDS Report, 4/2/04). According to a status report released by the government after the court’s ruling, 36,110 HIV-positive people as of July 31 were receiving antiretrovirals at no cost at 54 NACO clinics, IANS/DailyIndia.com reports (IANS/DailyIndia.com, 8/31). The not-for-profit groups Common Cause, Sahara, Sankalp Rehabilitation Trust and the Voluntary Health Association of Punjab told the three-member high court on Thursday that the government’s treatment target is insufficient and has not been achieved. Chief Justice of India Y.K. Sabharwal said, “What’s the difficulty? Why was the target year shifted?” NACO has said that it is difficult to provide regular access to antiretrovirals to HIV-positive people in rural areas (Reuters AlertNet, 8/31). According to Ramadoss, the number of centers around the country dispensing antiretrovirals at no cost will increase by the end of September from 60 to 100. In addition, the government by 2007 hopes to reach the 100,000 target, as well as increase the number of centers providing HIV/AIDS treatment, testing, counseling and prenatal checkups from 2,875 to 5,000 in the next two years, Ramadoss said (Bloomberg News, 9/1).”

Kaiser Network News September 05 2006
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=39599 (Date Accessed 05/01/2007)

38. Are issues relating to HIV/AIDS stigma and discrimination included in the training curriculum of key health care workers at SRH clinics?

“2. Training of medical and paramedical staff in the medical colleges and tertiary hospitals

Most of the 28 states/UTs have initiated the training of other medical and paramedical in the medical colleges and tertiary hospitals. With more number of doctors being covered in the training courses would lead to fewer of referral of cases and less discrimination and stigmatization of HIV/AIDS.”

http://www.nacoonline.org/prog_sche_train.htm (Date Accessed 04/01/2007)

39. Are issues relating to young people included in the training curriculum of key health care workers at SRH clinics?

40. Are there any government media campaigns (e.g. television commercials and newspaper advertisements) about HIV/AIDS that specifically address prevention among girls and young women?

Components of IEC Strategy

“The IEC strategic plan for AIDS prevention and control program in India includes, a variety of communication strategies for raising awareness, behavioural change and social mobilization. The IEC strategic plan has the following components:

Use of Mass Media

• Advocacy at various levels
• Inter-Sectoral collaboration
• Training
• Involvement of NGOs
Research

**National level IEC Activities**

NACO has empanelled two professional agencies to design and develop mass media campaigns on HIV/AIDS prevention and control in the country. These two agencies were selected through a transparent and competitive process and recommended by a committee of experts. In addition, NACO is utilizing the various media units of the Ministry of Information and Broadcasting such as Directorate of Field Publicity, Song and Drama Division and the Press Information Bureau for outreach in the rural areas and the regional press.


• "Media Campaign"

The Mass Media Campaign seeks to create widespread awareness on HIV/AIDS, promote positive attitudes towards people living with HIV/AIDS, and influence groups to change high risk behavior that make them vulnerable to the infection. It will use a series of public service announcements (PSA), online and print content, television and radio programming as well as several educational events to do this. In order to best address HIV/AIDS through the various mass media, Heroes Project has developed a strategic communications approach to address diverse groups such as sexually active men, married women and youth across all levels of society.

Heroes Project Website - Media Campaign [http://www.heroesprojectindia.org/media_campaign/media_campaign.htm](http://www.heroesprojectindia.org/media_campaign/media_campaign.htm) (Date Accessed 14/07/2006)

• "4. Work with development partners and public and private sector enterprises to improve HIV/AIDS prevention and control in tribal people Operational sing capacity of communication programmes varies considerably with states and hence, the need for IPC to strengthen efforts through IEC and BCC, could be made possible through hand holding with development partners who have strong hold at grassroot level as well as segment specific targeted communication. Public privat partnerships could be a link to strengthen operationalising capacity within tribal communities, involving positive people’s networks. A vital step would be develop synergies between NACO and SACS, between partner ministries and departments and between different media channels like mass media, mid media to strengthen advocacy activities and ensure effective dissemination of IEC material. The in-flow of funds needs to be monitored and outflow channelised so as to make significant, effective and complete utilization of available resources.(pg13)"

(NACO (2005)- Social Assessment of HIV/AIDS Among Tribal People in India A Report Submitted to NACP-III Planning Team, New Delhi, [http://www.nacoonline.org/socialassessmentNACP.pdf](http://www.nacoonline.org/socialassessmentNACP.pdf) (Date accessed 19/12/06)

Discussion questions:

• Are HIV prevention services truly accessible to girls and young women, including those that are marginalised and vulnerable? For example, are they: safe? Affordable? Reachable by public transport? in appropriate languages? Non-stigmatising? open at convenient times?
• What are the cultural norms around prioritizing females and males for health care?

• To what extent are informed and supportive SRH services accessible for girls or young women living with HIV/AIDS?

• What are the client/service provider ratios in different types of HIV prevention services? What is the gender ratio for staff in those services?

• Do services make proactive efforts to attract girls and young women? For example, do SRH clinics have separate rooms for young women so that they do not risk seeing family members or familiar adults?

• What are the attitudes of service providers to girls and young women, including those who are marginalised and vulnerable? Are they kind, non-judgemental and realistic (for example about young people’s sexual pressures and desires)? Can they encourage girls/boys to assess their risks of HIV infection and change their behaviour? Are attitudes generally getting better or worse?

• Do HIV prevention information campaigns, etc, target girls and young women? For example, are they culturally and linguistically appropriate? Are materials distributed through appropriate media and outlets?

  o Is there a national monitoring and evaluation framework? Does it encourage data to be disaggregated (according to gender and age) – to help assess the extent to which girls and young women are accessing programmes and services?

  o Are referrals and follow-up provided during HIV/AIDS, SRH and antenatal care services for young women and girls?

  o Overall, what difference does accessibility to services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?

  o How do the effects of accessibility vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
**Key questions:**

41. **Has the country signed the Convention on the Rights of the Child (CRC)?**

   Yes, on 11th Jan 1993


42. **Has the country signed the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages (CCM)?**

   CEDAW : Yes on 8th August 1993


   CCM : No


43. **In the National AIDS Council (or equivalent), is there an individual or organisation that represents the interests of girls and young women?**

   “Our National AIDS Policy also advocates a multi-sectoral approach to combat the epidemic. It emphasizes that by mainstreaming youth related issues in HIV and reproductive health into a number of sectors, a more holistic, sustained and cost-effective approach is possible. Operationally this would require persons from different sectors to plan together. This approach is uncommon because most departments have worked in isolation although the young person is the same target audience............

   There are already on the ground, which are collaborative efforts of various government departments such as School AIDS Education Programme; Universities talk AIDS (UTA); ARSH and life skills interventions are being supported through NYKS, NSS and RGNVYD; National Youth Parliament; reaching youth through TIs, mainstreaming young people in vulnerable communities through VTA and NGO outreach; initiation of district-wide strategy to reach young people in vulnerable communities in the high prevalence/high priority districts (NACO/SACS/UNICEF); nation, state and district wide mass media campaigns; Red Ribbon Express; Adolescent Reproductive and Sexual Health (ARSH) in the RCH - II Programme; etc. There are many other programmes at the planning stage.24 In the last half a decade, there has been a phenomenal growth in the numbers of NGOs mainstreaming HIV/AIDS into their programmes with varying focus. NGOs’ work has touched every segment of the youth population, with varied scale of reach. NGOs – international, national and ocal – have not only implemented programmes individually but now they are building programmes in collaboration and partnerships for reaching out to larger and more unreached segments of youth population. NGOs have focussed largely on reaching out to the ‘difficult to reach’ subsets of population of women, affected and vulnerable children and young people in vulnerable settings. Multiple types of interventions and approaches are being implemented in India. A number of international, national, and local organizations
including USAID/IMPACT and India HIV/AIDS Alliance have supported efforts focusing on care and support for children affected by HIV/AIDS and prevention among children who are especially vulnerable to becoming infected by HIV/AIDS. There has been a significant involvement of private sector also in raising awareness and self esteem of people affected by HIV/AIDS. (pg31)"

(NACO (2005), Social Assessment of HIV/AIDS Among Tribal People in India A Report Submitted to NACP-III Planning Team, New Delhi, http://www.nacoonline.org/socialassessmentNACP.pdf (date accessed 19/12/06))

**National AIDS Committee**

**Members**
1. Dr. Anbumani Ramadoss, Union Minister of Health & Family Welfare - Chairman
2. Smt. Panabaka Lakshmi, Union Minister of State for Health and Family Welfare - Vice Chairperson ...
20 Secretary, Min. of Women & Child development – Member ...
22 Secretary, National Commission for Women - Member


44. In the National AIDS Council, is there an individual or organisation that represents the interests of people living with HIV/AIDS?

"Since a key priority is to foster an enabling environment, NACO has smoothly incorporated the greater involvement of people with AIDS (GIPA), and those directly affected by it. GIPA is more a process than a goal, an all-inclusive principle based on the fundamental premises that we need to start looking beyond the notion of beneficiaries towards the notion of synergistic community action.

In an attempt to consolidate efforts around GIPA, NACO commenced a partnership during 2003, with the Indian network of people living with HIV (INP+) and UNDP, to organize the “Leadership for Results” programme. Three workshops were held: Delhi, Cochin and Kolkata, and we had several positive outcomes. The idea is if we are to apply GIPA across the board, then we need to invest in capacities of the people living with the virus and those affected by it.

In June 2003, every AIDS Control Society was directed to be mindful, of GIPA as a tool to better implement its activities, and to apply GIPA where possible. Many states have responded favourably to this call and have reported the application of this principle in several areas. Many other states are catching up. People living with HIV/AIDS (PLHAs) have become an integral part of the behaviors change communication (Bcc) programme, development of materials and designing of messaging, to eschew stigma.

In NACO’s Vision document, GIPA has a clear strategic place without which it would be an incomplete vision.

- The Operational Guidelines for Voluntary Counseling and Testing, 2004, has an entire chapter dedicated to co-opting people living with HIV/AIDS as peer counselors.
- With the roll out of the anti-retroviral treatment, for people living with AIDS, we have ensured that PLHAs have an expanded role, both as stakeholders as well as facilitators.
- Support from NACO and UNDP has enabled the INP+ to establish and strengthen up to 15 state level networks of people living with HIV/AIDS. Positive women’s groups have been updated with current knowledge on human rights, treatment literacy and positive living.
- NACO has supported the INP+ to finalize the first national strategy for GIPA, after wise
ranging stakeholder consultation.

- Over the past two years, we have moved from being driven by awareness generation to being driven by service delivery. And this quantum leap has been recognized in the draft national GIPA strategy."

National AIDS Control Organisation Website - GIPA (Greater Involvement of People Living with and directly affected by HIV/AIDS)
http://www.nacoonline.org/netwrkpstve_gipa.htm (Date Accessed 04/01/2007)

45. Was the current National AIDS Plan developed through a participatory process, including input from girls and young women?

"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" Page 19

"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.

**KEY RECOMMENDATIONS:**

a.) Formation of special focus group ‘GIYP – Greater Involvement of Young People’ for continued participation of young people in policy-making." Page 12

46. Is there any type of group/coalition actively promoting the HIV prevention and SRH needs and rights of girls and young women?

**U.N. Agencies, Indian Government Launch Campaign To Increase HIV/AIDS Awareness Among Young Women, Girls**

"The Coordinated HIV/AIDS Response Through Capacity Building and Awareness -- along with the United Nations Development Fund for Women, UNAIDS and Indian government agencies -- on Tuesday is scheduled to begin a campaign to increase HIV/AIDS awareness among young women and girls in India ages 15 to 29. IANS/newindpress.com reports (IANS/newindpress.com, 3/3). CHARCA is a joint U.N. program aimed at young women and girls in India for prevention of and education about HIV and other sexually transmitted infections."

The Women’s UN Report Program & Network News Tuesday, March 07, 2006
http://www.wunrn.com/news/04_16_06/042406_india_feminization.htm (Date Accessed 04/01/2007)

**CHARCA Strategies**

CHARCA is based on five key strategies interlinked with one another; these pillars form CHARCA’s vision to empower young girls and women with voice and visibility to overcome vulnerabilities and gender disparities.

**Coordinated HIV/AIDS Response Through Capacity Building and Awareness (CHARCA) Website**
47. Is there any type of national group/coalition advocating for HIV prevention (including positive prevention) for girls and young women?

**U.N. Agencies, Indian Government Launch Campaign To Increase HIV/AIDS Awareness Among Young Women, Girls**

"The Coordinated HIV/AIDS Response Through Capacity Building and Awareness -- along with the United Nations Development Fund for Women, UNAIDS and Indian government agencies -- on Tuesday is scheduled to begin a campaign to increase HIV/AIDS awareness among young women and girls in India ages 15 to 29, IANS/newindpress.com reports (IANS/newindpress.com, 3/3). CHARCA is a joint U.N. program aimed at young women and girls in India for prevention of and education about HIV and other sexually transmitted infections."

The Women's UN Report Program & Network News Tuesday, March 07, 2006

48. Is the membership of the main network(s) for people living with HIV/AIDS open to young people, including girls and young women?

The essence of Network of People Living with HIV/AIDS (INP+) is to provide a voice for PLHA at the local, regional and national levels in order to facilitate systemic change in critical areas such as care and support, access to treatments and addressing issues of discrimination facing PLHA in Indian society.

(Network of People Living with HIV/AIDS, http://www.nacoonline.org/netwrkpstve.htm (Date accessed 16/11/06)

"INP+ is a non-profitable community based organization of people living with HIV and its secretariat is based in Chennai. "... "The membership of INP+ is open to all Indians living with HIV, irrespective of gender, caste, religion etc. The confidentiality of members is ensured by INP+.

Indian NGOs Website - Indian Network for People Living with HIV / AIDS (INP+)

"Membership is open to all women living with HIV in India. If you are willing to become a member of PWN+, you should pay annual membership fee of Rs. 120/ as per the byelaws."

Positive Womens Network(PWN+) Website
http://www.pwnplus.org/mem.htm (Date Accessed 04/01/2007)

49. Are there any programmes to build the capacity of people living with HIV/AIDS (e.g. in networking, advocacy, etc)?

"Since a key priority is to foster an enabling environment, NACO has smoothly incorporated the greater involvement of people with AIDS (GIPA), and those directly affected by it. GIPA is more a process than a goal, an all-inclusive principle based on the fundamental premises that we need to start looking beyond the notion of beneficiaries towards the notion of synergistic community action."
• “With the roll out of the anti-retroviral treatment, for people living with AIDS, we have ensured that PLHAs have an expanded role, both as stakeholders as well as facilitators.

Support from NACO and UNDP has enabled the INP+ to establish and strengthen up to 15 state level networks of people living with HIV/AIDS. Positive women’s groups have been updated with current knowledge on human rights, treatment literacy and positive living.”

(National AIDS Control Organisation - GIPA (Greater Involvement of People Living with and directly affected by HIV/AIDS)
http://www.nacoonline.org/netwrkpstve_gipa.htm (Date Accessed 03/01/2007))

50. Are there any girls or young women living with HIV/AIDS who speak openly about their HIV status (e.g. on television or at conferences)?

“An Indian activist who has worked with prostitutes and others at risk of contracting Aids has received the highest award of a leading international human rights body. Meena Seshu, who has been honoured by Human Rights Watch, has worked with sex workers in the Indian state of Maharashtra, helping them to spread awareness about Aids among themselves and the wider community.”

BBC News Website - 14 November, 2002, 18:11 GMT - Top award for Indian Aids activist
http://news.bbc.co.uk/2/hi/south_asia/2478163.stm (Date Accessed 03/01/2007)

“GUWAHATI, India, March 5, 2006 (AFP) - A social outcast five years ago, Jahnabi Goswami -- who is HIV positive -- is now campaigning to persuade Indian couples planning to wed to dump traditional horoscope-matching in favour of AIDS tests.

Goswami's campaign to persuade people to get AIDS tests at first drew hostility from locals in her home state of Assam in northeastern India where HIV-AIDS is rife, mainly due to rampant drug abuse.

But now the campaign is being taken seriously and the 29-year-old woman has been asked by the ruling Congress party to contest state elections to be held next month in Assam.

Congress is billing her as the first HIV-positive person to contest an election in the state.

Goswami is running on a platform that highlights the need for regular AIDS tests, especially among young couples intending to marry.”

Aegis News - Use AIDS tests not astrology, Indian HIV activist tells would-be couples
http://www.aegis.com/NEWS/AFP/2006/AF060310.html (Date Accessed 04/01/2007)

"Delegate Asha Ramaiah, a young woman from India who along with her husband and infant son is HIV-positive, has been embroiled in an uphill battle for access to affordable anti-retroviral medicine for many years now."

Action Aid Report - The peoples caravan (2005)

"My mother-in-law has kept everything separate for me-my glass, my plate, they never discriminated like this with their son. They used to eat together with him. For me, it's don't do this or don't touch that and even if I use a bucket to bathe, they yell - 'wash it, wash it'. They really harass me. I wish nobody comes to be in my situation and I wish nobody
does this to anybody. But what can I do? My parents and brother also do not want me back."
- HIV-positive woman, aged 23, India -

(Avert website (November 2, 2006), http://www.avert.org/aidsstigma.htm (Date accessed 19/12/06))

**Discussion questions:**

- How are international commitments (e.g. CRC, CEDAW, and CCM) applied within the country?

- Is the national response to HIV/AIDS rights-based? For example, does it recognise the SRH rights of women living with HIV/AIDS?

- Do key decision-making bodies (e.g. the Country Coordinating Mechanism of the Global Fund to Fight AIDS, TB and Malaria) have a set number of seats for civil society? Are any of them specifically for representatives of girls and young women or people living with HIV/AIDS?

- Are HIV prevention programmes generally developed ‘for’ or ‘with’ girls and young women, including those who are marginalised and vulnerable? Are girls and young women seen as ‘implementers’ as well as ‘receivers’ of services?

- To what extent are girls and young women aware of decision-making processes? Are they encouraged to have a voice? Are they seen as an important constituency within committees, management groups, etc?

- How high are issues relating to HIV prevention for girls and young women (e.g. early marriage and stigma) on the agendas of local leaders and decision-making groups (e.g. district AIDS committees)? To what extent do girls and young women participate in those type of bodies?

- To what extent are people living with HIV/AIDS organised, for example in networks? Are girls and young women involved in those bodies?

- How are issues of participation affected by stigma? For example, is it safe for people living with HIV to speak openly about their HIV status?

- Overall, how are participation and rights applied in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?
How do the effects of participation and rights vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
Focus group discussion: 15-24 year olds

Age group: 15-24 years
Number of participants: 11
Profile of participants: Girls and young women who are: in-school; out-of-school; peer activists; from urban areas; from suburban areas; living with HIV; married with children; newly married, living with HIV and unmarried.
Place: Chennai

Prevention component 1: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? and HIV test?

Many NGOs and State AIDS Control Societies conduct awareness programs in the community several times in a year. They conduct Camp for youth and women. All Government Health Centre provide information. They also conduct group meetings particularly with women to disseminate information on route of transmission and prevention methods. There are also community clinics to provide information on reproductive and sexual health issues that includes HIV/AIDS information. Government hospital in Egmore provides information through leaflets and pamphlets. There are also posters on HIV related issues within the government hospitals. Schools and colleges are conducting awareness programs within the premise for the students beyond VII standards.

There are VCTCs in all the government run clinics like KMC Government hospital and TB Sanatorium in Poonamallee and few clinics run by the NGOs. Government hospitals have a separate wing for HIV patients. The health Posts and the Primary Health Care Units are providing STI treatment. Counselling services for young girls and women are provided here. Free condoms are available with the government and NGOs. They provide information on the role of using condom and demonstrate how to use it. Few NGOs are also into social marketed condoms. But no such services are availed by unmarried girls due to stigma and discrimination. STI services are available within the government health set up. None of the STI clinics are youth friendly and are completely focused to cater the needs of men.

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

They have very limited knowledge as they don’t come for the meetings. Even if awareness level is there they are not translating awareness into practice. They are also afraid of coming for HIV test. They think that they know everything. The problem is more with the illiterates. To address this issue there should be a separate meeting for boys and young men specially those who are not married. They should be told to consistently use condoms. If a girl asks them to use condoms they refuse as they think that it reduces pleasure. If a girl carries condoms then they doubt the girl’s character. Married men are also not sensitive. For married men, there should be separate meeting.

“The influence of liquor is also responsible for the irresponsible behaviour of the boys.”

“My husband refuses to use condoms as he thinks that condoms are for unmarried people”.

They have a major role to play in HIV prevention program for girls. They should not go to prostitutes. “One man should live for one woman” (“ORUVANUKKU ORUTHI!”). They should have self control to delay sex and not come under peer pressure leading to substance abuse. More than using condoms, they should have self control. They should also be aware of women’s issues and give due respect to their views and needs.

“If men exercise self control, then only this problem will solve”.


What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

More meetings and camps at the community level to generate awareness on not only prevention methods but also on related issues like gender equality and women’s empowerment. Health care providers should be sensitized on women’s issues. Community based Organization should talk on myths and misconceptions related to HIV/AIDS. Sensitization programs for men particularly for middle aged men is required as there are incidences of sexual harassment everywhere in the society. Organize targeted programs to increase condom usage among men. Pre marital counselling can be done to both bride and groom. It will be very helpful as most of the young men and women are not aware of sexual health issues. Women will know about delivery, STIs and how to prevent it from her own husband. Men will listen once to others and will be aware of the issues that women are facing. More meetings with the men will reduce risk behaviours among them as “husbands are spending more time with other women than their wife”.

Prevention component 2: Accessibility of services

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

Government services are available and accessible and women are quite happy with the existing services but they feel there are scopes for improvement. Health care providers are not always trained and sensitized related to women’s reproductive health issues. They are also stigmatising people living with HIV/AIDS.

Private hospitals are very insensitive towards people living with HIV/AIDS. They do not have counselling facilities and confidentiality is not ensured in such institutions.

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?

Services are not expensive within the government health set up. It is not very far for urban people. It is little difficult for women coming from rural areas. The barrier that we face in government Hospitals is STI ward has a big board therefore people don’t like to enter the ward when some one is watching. They feel embarrassed; they should either change the name of the board or should do something else.

Posters like a man standing with a towel wrapped around his waist should be changed.. the wordings like “DO YOU HAVE PROBLEMS IN THAT PLACE?” should be revised. My relatives feel the word STIs and these pictures make them not to enter the ward because they are afraid of seen by others while entering.

When treatment involves surgery or operation, the government hospital do not provide proper care for people living with HIV.

“My friend who is HIV positive had done a surgery last month in government hospital; but post surgery they had isolated he was kept in the corner. Somebody should do something about it”.

In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

Any service is easier for married women to access. Even if the woman is a commercial sex worker it is easier for married sex workers to access services. If the woman is illiterate then it is difficult for her to understand the services provided and the mechanism to access it. Therefore it is easiest for literate married women.
Prevention component 3: Participation and rights

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

There are street dramas, student rally and mass events bring boys and girls together. These campaigns are good as it encourages young men to come forward to access information and services. In such programs people are quite involved. Self Help Groups are excellent medium to bring boys and girls together. This helps boys to participate in women’s program and also help them to understand women’s issues better. Create more awareness for people to come for services.

What would encourage you to get more involved in HIV prevention in your community?

Establishing self help groups, organizing sessions on yoga and art of living, conducting regular meetings at the workplace, salon and in the liquor shop would involve more men, informal discussions in the neighbourhood, involving mothers of young girls to get their participation would encourage and involve people more efficiently and effectively. If groups are formed and place is provided with identity cards women are willing to get more involved as volunteers for the cause.

Prevention component 4: Legal provision

What do you know about laws in India that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?

Marriage ACT delays young people’s sexual orientation but it is not strictly implemented. Parents are hesitant to delay marriage as they feel daughters are burden to the family. Even if girls are married after 18 they are harassed at in-laws place and have little knowledge and less empowered to exercise their rights. Community women are not aware of divorce laws and domestic violence bills. Legal literacy is very low among women particularly illiterate women. Above 18 years girls do not need parent consent for abortions. This law helps to abort baby if mother is living with HIV. This in turn prevents children to be orphan.

“MTP ACT allows young people to indulge in unprotected sex”.

“Give the Rights of conceiving and choice of abortion to women and not to men”.

The following legislations are required to improve the status of young girls and women:
- HIV/AIDS bill to protect women’s Rights.
- Priority to cases related to HIV and women
- Legislations to protect orphans and widow living with or without HIV
- Violation of Human Rights should be punished

Prevention component 5: Policy provision:

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

Sex education in school was not implemented before 2000. The curricula revolve around the changes in body that takes place during adolescence, positive sexual health practices, route of HIV transmission and methods of prevention. It did not talk of sexual health Rights. Only girl’s schools are much more comfortable with sexual health education classes but co-education school goers are told to learn these chapters at home. Due to absence of
parental support on this generally adolescents discuss such issues with peers who have equally distorted knowledge on the subject.

**What could the government of India do to fight fear about AIDS in your community?**

Government should make provision of mandatory HIV testing before registering marriages. More mass campaigns to reach out people with prevention messages. TV channels should focus on this issue in their programs. Government should come up with a rehabilitation policy for the commercial sex workers.

**Summary**

**What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in India to protect themselves from HIV?**

Government should create policy for people registering clubs and groups to work on HIV. Introduce insurance policy for people living with HIV/AIDS. Support from the community leaders to reach out to young girls and women with HIV prevention programs. Government should work hand in hand with NGOs to create awareness in the community particularly for the young boys and men.
Focus group discussion: 13-24 years old

**Age group:** 13-24 years  
**Number of participants:** 12  
**Profile of participants:** Girls and young women who are: in-school; out-of-school; peer activists; from urban areas; from suburban areas; commercial sex workers; married with children; newly married and unmarried.  
**Place:** Mumbai

### Prevention component 1: Availability of service

What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? condoms? treatment for a sexually transmitted infection (STIs)? and HIV test?

NGOs are providing services in the community. No government service providers are providing information or HIV related services in the community. Only one NGO is working on HIV/AIDS with the young people of the community. Others are working on education and children issues. The NGO is providing HIV related information through awareness activities and by establishing referral linkages for reproductive and sexual health services particularly STIs.

Condom is provided through the NGO. They are giving free as well as socially marketed condoms. STI services are available within the Government service network. The VCTC is also linked with the government health set up. There is no “anganwadi” (Integrated Child development scheme) in our community.

How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

They are well aware of this issue. They know HIV prevention methods. But they are not practicing safe sex as they are very casual in their approach. NGOs should start working exclusively with the boys of the community as they are the future generation and the girls lives are dependant on them. Girls do not have much decision making power. Gender discrimination is visible in every decision making process within the family. Boys need to have responsible behaviour and should understand girl’s feelings. "Adami bahut kuch kar sakata hai, jisase ham surakshit rahe" (he can play a major role which will keep us safe). Relationship should be based on mutual respect. Men can only make this difference by understanding women and by considering women as equal partners.

"Galat Sambandh nahi rakhana chahiye" ("They should not have multiple sexual relationships")

"Sambandh Vishwas ke upar hona chahiye" ("Relationship should be based on trust")

Men should not depend only on condoms if they have multiple partners as condoms are not 100% safe. "Surakshit sambandh hamesha puri tarah surakshit nahi hote; kyonki condom phat bhi sakta hai". (Protected sex is not always protected as condoms can break)

What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

NGOs should be more proactive in providing correct and consistent messages to the community. They should develop new techniques and methods to reach out different groups of people. Men should be targeted more than the women. NGOs always target women as they are soft targets and avoid men as they are trouble shooter. This mindset needs to be changed. Boys should be involved not only for the activities for the boys but also in other community activities. This would help them to understand the problems of the females. Free condoms should be made available at the community levels. There should also be
provision of free female condoms. This will help women to a large extent to protect themselves from sexually transmitted infections. The parents and in-laws should be involved more as they control and take decisions for girls and young women in the community. Prevention services should be made available at the door step as young girls are not allowed to travel alone to avail services. There should be a counselling centre for men and women. This will help both the sexes to share problems and understand situations better.

**Prevention component 2: Accessibility of services**

What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

The women are referred or used to go to G.T. hospital or Colaba Municipal Hospital. OPD is open for patients in morning only. It should be open in the afternoon because it is not possible for women to come out of home in the morning. Inconvenient timing forces women to go to unqualified medical practitioners in the community. Hospitals do not provide any medicines. Therefore people have to buy from outside. They are costly and very few people can afford them. There is no community based clinic that provides health services. Half of the women’s problem can be solved by providing comprehensive reproductive and sexual health services at the community level.

What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? unfriendly?

The main barrier for women in the hospital is the absence of a female doctor. There is no privacy and confidentiality in the government hospitals. Male & female are treated from the same chamber. Women feel that both the government hospitals are far from the community. The attitudes of doctors are fine but the staffs of the hospital particularly nurse and ward boys are very rough in dealing with women. Even with men they are rude.

"Aspatalwale garibon ke sath kutte jaise pesh ate hai." ("Hospital staffs treat us like dogs.")

Services are not expensive within the government health set up. It is not very far for urban people. But timings are inconvenient for women.

In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

The fact is all women (married or unmarried) or a girl (literate/illiterate) is facing similar problems in Government hospitals. The situation is worse for female commercial sex workers. Even doctors do not treat them properly and keep on saying, "you are only interested in money. When your physical condition becomes unbearable then only you think of doctors." People living with HIV/AIDS face stigma and discrimination even within the government health set up. In private hospitals they are not entertained if their status is revealed to them.

**Prevention component 3: Participation and rights**

Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

Only one NGO attempted to bring girls and boys in the same platform through peer education program. The community feels “Ladake aur ladkiyon ko eksath lekar programme hone chahiye”. (There should be programs jointly for boys and girls in the community”). If this kind of meetings are done it will be easier to know that what is their
thinking about the issues and how can we overcome our problems. The issue is quite sensitive and therefore

What would encourage you to get more involved in HIV prevention in your community?

Regular contacts and recognition by others will motivate them to join as volunteers and take the cause further.

**Prevention component 4: Legal provision**

What do you know about laws in India that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? prevent girls from using services unless they have the consent of their parents?

They are not at all aware of any law related to HIV/AIDS. They are aware of Marriage Act but they feel that in spite of the law child marriages are taking place and they are not even punished as the law enforcers are also from the same community and they have similar orthodox outlook. We need to orient them first before creating new law. MTP Act is also not implemented. Therefore there are many unqualified practitioners and quacks who are conducting abortion on young women particularly those who are unmarried.

**Prevention component 5: Policy provision:**

What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

Sex education in schools is a recent phenomenon. The curricula provides information on menstrual health, HIV prevention methods and route of transmission, delaying sexual debut and changes that take place in our body during adolescence. Few schools are teaching without any teaching aids and some schools are showing films. But there is absolutely no discussion around the issue. The students get no chance to clarify doubts and myths and misconceptions dominate their knowledge.

What could the government of India do to fight fear about AIDS in your community?

Government should have centres at the community level for the easy access of women. They should also take improve the service delivery mechanism and make it more poor and women friendly. Mass campaigns will also help people to come out of their fear. They should also provide free medicine to people living with HIV/AIDS. Counselling services should be incorporated within every health clinics.

**Summary**

What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in India to protect themselves from HIV?

Create alternative occupation for the commercial sex workers. Establish youth clinic with every Government health set up with inbuilt counselling facilities. Develop health infrastructure near to the community that is women friendly.
General

What is your impression about the general situation of HIV prevention for girls and young women in India? Are things getting better or worse ... and why?

The situation is apparently getting better for young girls and women, as far as availability of information is concerned. There are many responses within the country to reach out these groups with information. But the gap still lies in translating the information into practice. The risk behavior is not coming down in this age group. Targeted intervention at the country level has got much attention with the risk groups like truckers, sex workers and others since the inception of the HIV program but not due importance was given to young girls and women.

“Young girls and women have a unique identity but we lack guidelines, policies and practices to design intervention programs for them in the country. HIV planning is only focusing on immediate issues and is not futuristic.”

Prevention component 1: Legal provision

In your opinion, what laws in India are making HIV prevention for girls and young women better or worse?

There are legislations protecting the young girls and women in our country like marriage, prostitution, abortion and domestic violence bill. But it is not effective due to lack of law enforcement mechanism and patriarchal society. The new domestic violence bill look promising but the challenge lies in effective enforcement. Gender based violence particularly within marriage is being addressed in this new bill. The laws are unclear and silent on many issues.

How does legislation affect different types of girls and young women and their vulnerability to HIV?

The legislations affect the young girls and women as they are not youth friendly. The law makers and enforcers are not sensitive enough to young population. For example the youth in “special Homes” are treated as criminals and thereby exposing them to risk situation like drug abuse and sexual experimentation. Brothels are rampant, young girls are trafficked at minor ages, in spite of legislations on anti trafficking and soliciting/living on prostitute’s income being illegal. The “Domestic violence” bill will hopefully protect the married women from rape within marriage and in turn will reduce their vulnerability to HIV/AIDS.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Government need to introduce “Free Legal Aid Center” for young girls and women. There is no legislation on HIV/AIDS. HIV/AIDS bill will help to protect the rights of the infected and affected community to a great extent.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in India better or worse?
India has ICDS (Integrated Child Development Scheme) program to reach out the poorest of the poor community in urban and rural areas. HIV/AIDS should be linked with this scheme. It should not run as a parallel program. Counseling for young people should be introduced with special attention given to privacy, timing, attitudes of staff and user friendly services. Government has a strong condom policy but availability of suitable condoms specific to young people need to be ensured.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

School health program has “sex Education” in the curricula but it does not talk of reproductive and sexual health and Rights of young people. There is a strong need to work with the teachers to implement the curricula.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

We need a policy of a separate department for adolescents and young people within the government health care facilities. Involve youth at every level of policy making and planning. Focus on empowering youth and building strong cadre of peer educators and include more women representatives at the policy making and planning level.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in India?

There is no adequate program for general population girls and young women on HIV/AIDS. Female condoms are not easily available, affordable and accessible. STI services for female are not visible and primary health care centers are not well equipped in providing STI services. Voluntary counseling and testing centers are less in numbers and are not youth friendly. VCTC should be linked with non threatening services like pathology lab and others. ARVs are not widely available, absence of second line treatment and nutrition program are making the situation worse for young girls and women.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

We have the following services for girls and young women:
1. school health program for school going girls
2. Targeted intervention for women in prostitution, migrants, injecting drug users
3. Care and support program
4. Parent to child transmission program
5. International donors programs with the orphan and vulnerable children

No programs specifically for the out of school youth and young people in crisis.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

There is no specific program only for boys and young men. All the programs are targeted to both boys and girls. Gender discrimination within the society many a time restricts the girls and young women to avail the services.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?
As part of the prevention program the services that are required are: specific programs for 12-18 years girl, foster care programs, youth friendly clinics and comprehensive health program that includes prevention, care, treatment and nutrition.

**Prevention component 4: Accessibility of services**

**What are the main barriers to girls and young women using HIV prevention services in India?**

Cultural barriers prevent young girls and women to access services. There is a culture of silence in reproductive health. Parents and service providers never talk of reproductive health issues to young girls. Media is very indifferent and insensitive towards reproductive health issue of young women. Sex education is not related to life situations and it is only class room biology class. Gender insensitive service providers make the situation worse for girls and women.

“Most of the barriers are due to lack of participation. Power of women is not utilized. Policy makers are men groomed in a patriarchal society”

**Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?**

It is easier for married young women from the general population but unmarried women and women in prostitution are doubly stigmatized. It is equally difficult for out of school young people to avail services. It is difficult for illiterate girls as procedures are complicated. Service providers lack patience and listening skills and they are biased. Attitude and gender insensitivity of service providers towards women in prostitution and women living with HIV makes it difficult for them to access services. Availing services at the work place for young girls and women is a huge gap existing today.

“Community needs to realize the economic gains of a healthy girl child”

**What role do boys and young men have in making HIV prevention services easier and better for girls and young women?**

Presently they don’t play any role. Promotion of life skills education should involve them in programs for young girls and women.

“Both sexes start understanding each others vulnerability should be the goal of empowerment programs”

**Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?**

Introduce youth friendly clinics within the primary health care center. Life skills program to understand risk and vulnerability. Standardized school education program and involvement of health care service providers in care and support initiative for young girls and women. Introduce special course n medicine, nursing and social work colleges to create compassionate care givers and program people.

**Prevention component 5: Participation and rights**

**How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in India?**

“India is committed but not yet turned it into legislations.”

**To what extent is the national response to AIDS ‘rights-based’?**
The policies on paper are right based but not in practice as the implementer’s are not trained and sensitive enough.

**To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?**

The policy makers conduct consultative meetings with the NGO representative but there is no clear process of recruiting them. Youth and general population are not part of the planning process.

**Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?**

They should be involved as part of the national HIV plan. There should be micro planning. Cross sectional women like rural/urban, married/unmarried should represent in designing the national plan.

**Summary**

**In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Mozambique?**

Link HIV with ICDS and Primary Health Care programs. Introduce special cell for young people. Introduce micro planning in slums and rural communities involving youths. Ensure user friendly youth services in health and education. All education institution should include HIV/AIDS in the curricula and introduce workplace policy.
General

What is your impression about the general situation of HIV prevention for girls and young women in India? Are things getting better or worse … and why?

It is slowly getting better for young girls and women particularly in the urban areas, but it is not the same in the rural areas. Information and accessibility of services are the two areas where the situation is getting better day by day for the urban population. The young women in the rural areas are acquiring infection everyday in large numbers due to early marriage, gender inequality, lack of empowerment and other socio cultural norms like in-equal power relation within family. In rural areas services are not available if they are available it is not accessed by young women due to the above mentioned reasons. Government has taken initiative but it is mostly centered round information sharing to reach the urban population.

Prevention component 1: Legal provision

In your opinion, what laws in India are making HIV prevention for girls and young women better or worse?

Laws are not directly link with HIV prevention initiative. The marriage law is definitely helping girls to defer marriage age that in turn results in more education, more negotiation skills and more empowerment. But this is not practiced everywhere. In rural areas girls are still married off at an early age and putting them more at risk for infection. Legalization of sex work will definitely help to reduce the infection rate, prevent sexual abuse and reduce stigma and discrimination as the profession will get an identity. Abortion law and domestic violence bills are going to help any HIV prevention initiative in the country. Overall the legislations in India are helping HIV prevention for girls and young women.

How does legislation affect different types of girls and young women and their vulnerability to HIV?

Legislations are meant to reduce vulnerability of young women and girls. Laws relating to anti trafficking, marriage and human rights are designed to help the girls and young women, provided it is enforced in a systematic way. Law enforcers are misusing their power that ultimately affecting the girls and women. Women are not aware of the basic Rights. Awareness of the Rights itself will reduce the vulnerability towards HIV/AIDS.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

More than introducing new legislations we must ensure that not only women but also men are aware of the basic rights of the women. This can only reduce gender based violence and stigma and discrimination towards women.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in India better or worse?
There are policies and protocols in relation to antenatal check-ups, VCTC, and condom. But they are not women friendly. The PPTCT program is not involving men and family members within the program. Therefore, post-delivery once the women are back to home, they are abused, tortured, and deprived of food and nutrition. Regarding condoms, people think condoms are for sex workers and MSMs. Young women will never talk of condoms due to cultural barriers. The VCTC programs are stand-alone programs and not integrated. Girls and young women are not using the services due to fear of stigma and discrimination. Protocols and policies considering these issues will help them to access services.

Do girls and young women – and also boys and young men – receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

There are government and UNICEF run programs in schools on sex education. “School AIDS Life Skills Education” or “SALSEP” and “School Health Education” program address life skills and sexual health issues in schools. These programs are not rights based and are not addressing the issues of stigma and discrimination. Sharing of life experiences would benefit the children on many sexual and reproductive health issues.

Overall, what policies or protocols could the government change, abolish, or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Policies that are talking of women friendly integrated prevention and care and support services for women are going to benefit girls and young women. Government should develop guidelines on marriage and newly wed couple counseling.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in India?

There are no specific services for young girls and women. The PPTCT services are targeted to prevent infection from mother to child and completely child centric. Female condom is not yet introduced by the government. STI services within the government hospital has designed clinic for men. The VCTCs are not women friendly. Very few have women staff. ART centers are not women friendly. No gynecologist and no internal coordination for women to access additional services. There is lack of privacy and confidentiality in the VCTCs for women.

“I wish government introduce women friendly VCTC and ART services in rural and urban health centers”

What type and scale of HIV prevention services are available for particular types of girls and young women? For example, what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive?

There are no services for out of school girls and unmarried young women other than targeted intervention in slums and rural areas. The school programs support girls going to school. Migrants are not part of core groups under targeted intervention. No positive prevention programs for PLHAs. The targeted intervention program is focused for core group like- Slum, Sex workers, MSM, street children, IVDUs and young population. Adolescent girls and young women are covered under these core groups.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

No separate services for boys and young men. They should be sensitized on women issues and the concept of gender equity and equality.
“Men can make a difference if they are more sensitive and responsible”.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

The services that are immediately required to improve HIV prevention for girls and young women are availability and accessibility of condom, women friendly VCTC, effective sex education and visibility of existing services.

**Prevention component 4: Accessibility of services**

What are the main barriers to girls and young women using HIV prevention services in India?

Cost is not a barrier as other than VCTC all the services are free. In rural areas location is one of the significant barriers as the health centers are many miles away from villages and doctors are not available during night hours. The concept of privacy and confidentiality does not exist. The staffs are judgmental, insensitive and belong to a different generation altogether. The other problems faced by most of the adolescents are too much control of parents and peer pressure. The constant fear of being sidelinied by peers, force them not to access services. There is no helpline exclusively for women to get information. Apart from this there are cultural and social norms, that stops them to access services.

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

Accessing services is easier for married women and school going girls. Out of school youth find it difficult to access information. It is difficult for PLHAs also due to stigma and discrimination.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Men should be sensitized on power relations and gender. If they are involved at the program level they will have better understanding of situations that women faces on a day to day life.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

The priority actions that are needed are awareness of available services, reduce distance in rural areas, suitable timings of services, trained staffs and reduce cost of ART drugs.

**Prevention component 5: Participation and rights**

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in India?

Though India is committed so far there is no policy implemented on these lines.

To what extent is the national response to AIDS 'rights-based'?

In the National Planning Phase-III rural health mission is linked with HIV/AIDS program. Reproductive and Child Health program is also going to integrate HIV/AIDS.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?

Network of positive people is involved but not young people.
Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

GIPA policy should be implemented. Youth should be involved in planning, implementation, monitoring and evaluation.

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Mozambique?

Involv[e] people for whom the program is made. No duplication of existing program and create more awareness among women on legislations.
General

What is your impression about the general situation of HIV prevention for girls and young women in India? Are things getting better or worse … and why?

The situation in India with the young girls and women in relation to available of services has reached a plateau. But in relation to infection it is getting worse with every passing day as girls and young women are becoming victims of sexually transmitted infections. Antenatal clinics are showing more infection among married women and abortion clinics are pointing to more infection among unmarried women. Married women are getting infection from their husband while young girls are mostly acquiring infection through risk behavior. Prevention programs are focused towards the core transmitter groups and very few NGO initiatives in the country are working with adolescents and young women. The situation is getting worse due to lack of effective plan, available services, lack of community involvement and lack of women at the policy makers and planners level.

Prevention component 1: Legal provision

In your opinion, what laws in India are making HIV prevention for girls and young women better or worse?

India has legislations to support women’s issues but the problem lies in effective enforcement of the laws. In spite of marriage, abortion and domestic violence bill, cultural norms plays major role in India. Girls are still married off as early as 12 years in rural and tribal areas. Most of the adolescent abortions are illegally done with the non-qualified practitioners and women are discriminated at household due to unequal power relationship. Therefore none of the legislations are helping women to prevent HIV/AIDS infections.

How does legislation affect different types of girls and young women and their vulnerability to HIV?

Sex work is not legalized in our country. Women in the profession are constantly abused by the law enforcers. Marriage law is not protecting women from gender based violence within marriages. There is no provision of voluntary testing within the marriage law. The abortion law also does not talk of VCTC services within its framework. There are no policies or program for positive prevention within marriages.

“Marriage is the biggest risk for young women in India to acquire HIV infection”

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Government should bring in workplace policy in the private sector. Some legislation to normalize the disease and policy to integrate HIV/AIDS into existing health set up.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in India better or worse?

Antenatal services within the Reproductive and Child Health framework have helped women to access services for PPTCT. Condom policy has helped sex workers, but definitely
not general population as women does not come forward to ask for condoms. None of the women in India access VCTC services voluntarily therefore the testing centers are not truly VCTCs but CTCs. Effective and appropriate implementation of the existing policies and protocols will help young girls and women to prevent HIV infection.

**Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?**

Government and UNICEF are jointly running school health programs. The government program focuses on sexual and reproductive health issues whereas the UNICEF program focuses on life skills programs. The life skill program is right based. FPAllIndia across all the states are running adolescent friendly clinic where information are given and human rights are ensured for out of school youth.

**Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?**

Policy is required to reduce stigma and discrimination to normalize the situation. Policy should be framed to integrate HIV into existing government health schemes. It is also required to activate the rural primary health care centers.

**Prevention component 3: Availability of services**

**What type and scale of HIV prevention services are available for girls and young women in India?**

HIV prevention services for girls and young women are limited to information and availability of free male condoms. There is no provision of female condoms in the national program yet. STI services are designed to cater to male community. STI drugs are not always available within the government setup. VCTCs are less in numbers and not women friendly. ARVs are not available to everybody and providers have limited knowledge to address female issues. PPTCT services are available but its child centered.

**What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive?**

Other than sex workers and IVDUs there are no specific programs for the rest of the groups on prevention. They are targeted under slum intervention with prevention messages. Information and availability of free male condoms are the two components under prevention.

**What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?**

There is no specific prevention services and information for young boys and men. This creates imbalance in gender and power equations within the society.

**Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?**

There is a need to create a separate adolescent clinic within the government health setup. Life skills education should be part of all school health education programs. HIV/AIDS should be integrated with existing primary health care and Integrated Child Development Schemes. Information should be backed by services and referral linkages.

**Prevention component 4: Accessibility of services**
What are the main barriers to girls and young women using HIV prevention services in India?

The main barriers are location in rural areas, no privacy and confidentiality, insensitive attitudes of service providers, timings and cultural norms. Within service providers the biggest barrier is non availability of essential medicines and services for young girls and women.

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

It is difficult to access services for unmarried, out of school youth and people living with HIV/AIDS due to stigma and discrimination.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Boys and young men can play crucial role in positive prevention and gender discrimination by behaving more responsibly.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Introduce more outlets of services, easily available correct information backed with services, introduce behavior change communication for men to help women access and use more services.

Prevention component 5: Participation and rights

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in India?

India is committed to the both but its implementation is limited.

To what extent is the national response to AIDS ‘rights-based’?

National AIDS control Plan- Phase III is based on “Human Rights” and has involved people living with HIV/AIDS.

To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?

Only people living with HIV/AIDS are involved and no member from the general community is involved in national planning.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Young girls should be involved meaningfully in planning, evaluation and future actions.

“Involve NGOs as they have more knowledge and access to community and are better accepted by the community than government.”

Summary

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Mozambique?
Encourage people to voluntarily access VCTC services. Involve young people in program planning. Provide information backed with services and linkages. Involve PLHAs at every level of HIV prevention programs particularly women living with HIV/AIDS.
One-to-one interview: Dr. E Mohamed Rafique (male)
Resource person and moderator, AIDS community UNAIDS (New Delhi)
Mr. Gurumurthy Rangaiyan, (male)
National Program Officer UNAIDS (New Delhi)

General

What is your impression about the general situation of HIV prevention for girls and young women in India? Are things getting better or worse ... and why?

In relation to prevention the efforts are being tightened up by the National AIDS Control Organization. The National AIDS Control Plan (NACP-II and III) was designed to have effective prevention program to decrease vulnerability of young girls and women. In a vast country like India the epidemic pattern is different from region to region. Therefore the capacity to response varies from region to region. India has failed to motivate community gatekeepers to reach out young women and children through prevention initiatives. The general situation is slowly moving upwards but to improve it further we need to mainstream HIV and upscale existing community responses.

Prevention component 1: Legal provision

In your opinion, what laws in India are making HIV prevention for girls and young women better or worse?

Laws are not effectively enforced. Anti women beliefs and customs are practiced. Community has to be moved to address these issues under the umbrella of existing laws. Sex work is not legalized and we should ensure that they get human rights before creating another law. Laws are always welcome in any society but every law should ensure equal rights to women. We need to strengthen other family planning methods for people to access before talking of MTP ACT.

How does legislation affect different types of girls and young women and their vulnerability to HIV?

It is affecting girls and young women because we live in a patriarchal society. Every group of women is vulnerable in such a society. There is domestic violence, gender discrimination and discrimination towards vulnerable groups. All these increases women's vulnerability as they are illiterate, not empowered and no access to information. This is particularly true with rural and tribal women of Indian society.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Introducing law is not the solution. We cannot abandon old laws and bring in new laws. To fast track the process we need to amend the existing law to suit young girls and women. Laws should give women equal rights and should not have religious or cultural influences.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in India better or worse?

The National HIV/AIDS plan aims to integrate HIV with the existing Reproductive and Child Health program. ICDS and PPTCT programs are also planned to get integrated. It also include female condom as one of its immediate activity. But the real challenge lies in training the staff on the issues and also reaching out to women in difficult situations. The STI component of women is neglected because of lack of policy and treatment protocol. No
documentation of existing programs to improve quality. VCTCs are not visible and accessible to women.

Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

Sex education is compulsory in all schools. No uniformity in curricula, No tested material available, no established monitoring and evaluation mechanism, implementers are not trained and sexual and reproductive health and Rights are not talked about.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Reproductive and Child Health approach of Government of India and NACP-III in next 5 years will address young girls and women. Government need to introduce uniform sex education curricula and periodic evaluation of such programs.

**Prevention component 3: Availability of services**

What type and scale of HIV prevention services are available for girls and young women in India?

The existing prevention program for girls and young women need to be scaled up. We have less number of programs for married women. The program is focused on the core transmitter group. States are ensuring availability of services other than the northern part of the country where service delivery is not adequately addressed.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive*?

We do not have any prevention initiatives other than targeted intervention for at risk groups. If women are not falling under these groups then they are left out of the programs.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

No specific programs available for men and boys. But to ensure well being of the girls and young women we should have programs focused towards men and boys on women’s issues. Due to this domestic and gender violence are increasing and women are becoming more vulnerable within or outside marriage.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

We need to ensure accessibility of services for women, Change in attitude of staff, introducing women friendly medical curricula in medical colleges and empowerment of women.

**Prevention component 4: Accessibility of services**

What are the main barriers to girls and young women using HIV prevention services in India?

The main barriers are cultural barriers. The gatekeepers of the community like the in-laws, leaders, health workers are not sensitive. Cost, location and time are the other significant barriers. Private public partnership and integration of programs will help overcoming few socio-cultural barriers.
Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?

It is difficult particularly for unmarried girls. People living with HIV are always stigmatized.

What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Boys and men can play a major role by understanding women’s vulnerability and by participating in women’s reproductive and sexual health program.

Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Community gatekeepers should be sensitized and make all prevention services available and accessible to women and girls.

**Prevention component 5: Participation and rights**

How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in India?

The commitments are yet to be included in our existing prevention programs.

**To what extent is the national response to AIDS ‘rights-based’?**

It is based on Human Rights. But including rights within the existing program is not the solution. We have to ensure that it is accepted by general population. It is required to tone down the existing law to suit mass sentiments.

**To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?**

Women at risk and people living with HIV/AIDS are involved in national planning. But rotation of such people is required to bring in new perspective to the programs.

Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

Involve grass root people in national decision making process. Not only involvement but spotting them at the community, building their capacity and mainstreming them into planning will help.

**Summary**

In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Mozambique?

Policy makers should fast track solutions for sexual harassment with a strong deterrent, donors should year mark funds for women specifically young girls and women and women should lead women’s program at the community level.
General

What is your impression about the general situation of HIV prevention for girls and young women in India? Are things getting better or worse … and why?

In India the government is tackling the HIV/AIDS issue of young women and girl through three major departments. Women and Child department is looking after adolescent health and development with focus on developing life skills. The youth Ministry is focusing on out of school youth by establishing “Teen Clubs”. The Education Department is reaching our school going youth through “School health education” program. The National AIDS Control Organization has developed the NACP-III and the focus is on prevention with 85% of total fund allotted for prevention activities. But whether these initiatives are going to reach the women and young girls is in question. Due to implementation problems the general situation for girls and women are not getting better. Strengthening the implementation mechanism will benefit this group in the long run.

Prevention component 1: Legal provision

In your opinion, what laws in India are making HIV prevention for girls and young women better or worse?

There is no deterrent from the legal frame work in prevention work for young girls and women. The deterrent is from the cultural ethos of our society. Legislations had always helped our country particularly women. Lack of awareness among women and cultural norms have always prevented them from using existing services. Enforcement of legislations needs to be strengthened.

“The ACT and sexual act has no relations.”

How does legislation affect different types of girls and young women and their vulnerability to HIV?

It is significantly affecting young girls and women because the law makers have made the law but have not provided space for women to receive benefits from it. Government has not sensitized the law enforcers on women’s issues and has not mainstreamed HIV/AIDS issues within various government departments. All these put young girls and women in more vulnerable situation.

Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Government should focus on law implementation rather than changing, abolishing or introducing new laws.

Prevention component 2: Policy provision

What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in India better or worse?

The existing Reproductive and Child health Strategy for ANC care, availability of free male condoms and establishment of VCTC has helped young girls and women. But, Government should link Adolescent Reproductive and Sexual Health site, NACO VCTC and PPTCT centers. In integration initiative the capacity building of the health workers is crucial.
Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

Government and private schools are implementing School health education program and HIV/AIDS is an important component to it. Government has roped in UNICEF to bring in participation and rights perspective to the existing efforts.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Protocols for ensuring integration among the different government department should be implemented and monitored from time to time.

Prevention component 3: Availability of services

What type and scale of HIV prevention services are available for girls and young women in India?

The existing prevention efforts are not enough in numbers. But even the existing ones are not utilized by young girls and young women. People’s acceptance of the existing program is lacking due to lack of visibility and accessibility. The aim should be on generating demands within the community to reach out vulnerable women and girls and sustain the efforts.

What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are: Unmarried? Out of school? Involved in sex work? Orphaned? Injecting drug users? Migrants? Refugees? HIV positive? etc?

We do not have services specifically for orphaned, refugees and unmarried. Other groups are falling under NACO targeted intervention efforts.

What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

The services for boys and young men are no different from girls and young women. Due to absence of the concept of equity and equality and gender discrimination in our society girls and young women are deprived of their rights.

Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

We need to introduce mechanism to reach the rural and tribal women with correct information, utilization of existing services, introduction of routine HIV testing in all ANC clinics, addressing gender issues, sensitize political leaders at the village level to improve their receptivity to programs.

Prevention component 4: Accessibility of services

What are the main barriers to girls and young women using HIV prevention services in India?

The main barriers for young girls and women are physical mobility constrained with gender issues, No integrated services but stand alone HIV programs, approach is service oriented and not interactive. Location, attitude, cost and cultural norms are other significant barriers.

Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are: Married or unmarried? In school or out of school? HIV positive?
Accessing HIV standalone services are difficult for everybody. It has to be integrated under the umbrella of reproductive and sexual health services.

**What role do boys and young men have in making HIV prevention services easier and better for girls and young women?**

They have to be responsible and should have knowledge and information particularly on young girls and women issues, not only HIV/AIDS but also other related issues.

**Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?**

Services should be dealt with proper linkages with schools and worksites and involving the key stakeholders of the community in program implementation.

**Prevention component 5: Participation and rights**

*How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in India?*

India is in the process of mainstreaming and integrating many policies and international commitments. These efforts will take time to be translated into practice.

*To what extent is the national response to AIDS 'rights-based'?*

NACP-III addresses human rights concern.

*To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level?*

The national level planning involves consultation at the state level with the youth. **Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?**

There is a need to form young people’s "Advisory Panel" and involve student unions in designing programs for the youth.

**Summary**

*In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Mozambique?*

We need to introduce: Targeted intervention for adolescents, Ensuring link between reproductive and sexual health and HIV/AIDS, De-franchise efforts and activities and introduce policy favoring adolescents and young women.