

# REPORT CARD

## HIV PREVENTION FOR GIRLS AND YOUNG WOMEN



### INDIA

#### COUNTRY CONTEXT:

Size of population (census of India, 2001):	1,028,610,328 <sup>1</sup>
Life expectancy at birth in 2001: 61.8 years (male), 64.1 years (female) <sup>2</sup>	
Percentage of population under 15 years:	35.4% <sup>3</sup>
Population below income poverty line of \$1 per day:	34.7% <sup>4</sup>
Female youth literacy rate (ages 15-24):	67.7 % <sup>5</sup>
Youth literacy rate (ages 15-24), 2004:	76.4% <sup>6</sup>
Median age at first marriage for women (ages 20-49) in 1998:	16.7 years <sup>7</sup>
Median age at first sex among females (ages 15-49) in 2004 <sup>8</sup> :	18 years <sup>8</sup>
Median age at first sex among females (ages 15-49) in 2004	21 years <sup>9</sup>
Health expenditure per capita per year (2001-2002):	\$25.00 <sup>10</sup>
Contraceptive prevalence rate <sup>11</sup> :	48.5 <sup>11</sup>
Fertility Rates (2004):	2.9 <sup>12</sup>
Maternal mortality rate per 100,000 live births (2001-2003):	301 <sup>13</sup>
Main religions: Hindu 80.5%   Muslim 13.4%   Christian 2.3%   Sikh 1.9%   other 1.8%   unspecified 0.1% <sup>14</sup>	
Main languages: Hindi is the national language. There are also 14 other official languages: Bengali   Telugu   Marathi   Tamil   Urdu   Gujarati   Malayalam   Kannada   Oriya   Punjabi   Assamese   Kashmiri   Sindhi   Sanskrit. English enjoys associate status and is an important language for national, political, and commercial communication <sup>15</sup>	

#### AIDS CONTEXT:

Number of people living with HIV and AIDS:	2.5 million <sup>16</sup>
Number of women (ages 15-24) living with HIV:	No data available
Number of men (ages 15-24) living with HIV:	No data available
Adult HIV prevalence 2006:	0.36% <sup>17</sup>
HIV prevalence among pregnant woman in 2005:	0.88% <sup>18</sup>
HIV prevalence among injecting drug users in 2005:	10.16% <sup>19</sup>
Number of deaths due to AIDS in 2005:	270,000 – 680,000 <sup>20</sup>
Estimated number of orphans due to HIV/AIDS (ages 0-17) in 2005:	No data available

#### HIV PREVENTION FOR GIRLS AND YOUNG WOMEN CONTEXT:

India accounts for almost 1.4 million of the estimated 1.6 million young people (ages 15 – 24) living with HIV in the WHO South-East Asia Region.<sup>21</sup> Awareness regarding HIV is lower among women, especially girls and young women in rural and tribal areas. Therefore, within the general population, women and young people are becoming increasingly more vulnerable to HIV infection. According to sentinel surveillance reports for 2005, 38.5 percent of HIV infected persons are women. The number of monogamous women getting infected from their husbands is rapidly increasing. Home remedies and self medication are commonplace across India, as is the belief in traditional healers.

### INTRODUCTION

#### THIS REPORT CARD AIMS TO PROVIDE A SUMMARY OF HIV PREVENTION FOR GIRLS AND YOUNG WOMEN IN INDIA.

This Report Card is one in a series produced by the International Planned Parenthood Federation (IPPF), under the umbrella of the Global Coalition on Women and AIDS, and with the support of the United Nations Population Fund (UNFPA) and Young Positives.

The Report Card is an **advocacy tool**. It aims to accelerate and improve the programmatic, policy and funding actions taken on HIV prevention for girls and young women in India. Its key audiences are **national, regional and international policy and decision-makers, programme managers and service providers**. It builds on global policy commitments, particularly those outlined in the Political Declaration on HIV/AIDS from the 2 June 2006 High-Level Meeting, to follow up on the United Nations General Assembly Special Session on AIDS (UNGASS).

The Report Card summarizes the **current situation of HIV prevention strategies and services for girls and young women ages 15-24 years in India**. It contains an analysis of five key components that influence HIV prevention, namely:

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

It also provides **recommendations** for key stakeholders to enhance action on HIV prevention strategies and services for girls and young women in India.

The Report Card is the basis of extensive research carried out during 2006 by IPPF, involving both desk research on published data and reports, and in-country research in India to provide more qualitative information. This research is detailed in full within a 'Research Dossier on HIV Prevention for Girls and Young Women in India' (available on request from IPPF).

Young people in India cannot be categorised as a homogenous group and different sub populations are exposed to different risk settings depending on location. Social and cultural factors influence discussions on issues around sex and sexuality, particularly in rural areas. Sexual harassment and physical abuse continue to affect single migrant women and those deserted by their husbands, making them particularly vulnerable and susceptible to commercial exploitation, and therefore, increasingly at risk of being infected by HIV. Poverty, as a result of a lack of resources and poor infrastructural support may force some women to trade sex for food and other necessities.<sup>22</sup>

### KEY POINTS:

- The minimum **legal age for marriage** for girls is **18 years**, however 72% of the population live in villages where family, caste and community norms are more influential. As a result a significant number of girls are married off far earlier.<sup>23</sup> For instance, **40 percent of girls in rural India (ages 15 to 19) are married** compared to only 8 percent of boys the same age.<sup>24</sup>
- Non-parental consent should not affect access to information and services, however, **minors without consent may not be able to access voluntary counselling and testing (VCT) services** as per existing guidelines.<sup>25</sup>
- **Abortion is legally available in India under certain specified situations**, including pregnancy as a result of rape or contraceptive failure. Minors require written consent from their parents or guardian.<sup>26</sup> The National AIDS Prevention and Control Policy states that there should be **no forcible abortion or even sterilisation on the grounds of HIV status** of women.<sup>27</sup>
- Although voluntary HIV testing is widely supported, cases of **people being tested without their consent or knowledge** are common in some hospitals.<sup>28</sup>
- 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'.<sup>29</sup> However, in reality, while stigma reduction is gaining attention on the ground through integration into HIV and AIDS programmes, the issue of gender-based violence, and its links to HIV and AIDS, often remains overlooked.<sup>30</sup>
- Some **sex workers** in India are organised into unions and support groups. For example, at least 200 sex workers in the southern Indian state of Tamil Nadu have formed an organisation to **seek recognition and to protect their rights**.<sup>31</sup>
- The Indian government has stated that it will take a **'Harm Minimisation' approach to Injecting Drug Users (IDUs)** by supporting Non-Governmental Organisations (NGOs) running harm reduction programmes. Greater convergence will be brought about between NGO based programmes for harm reduction and hospital-based rehabilitation programmes run by the government for IDUs.<sup>32</sup>

### QUOTES AND ISSUES:

- "India has legislation to support women's issues but the problem lies in effective enforcement of the laws. In spite of marriage, abortion and domestic violence acts, **cultural norms** play a major role in India. Girls are still married off as early as 12 years in rural and tribal areas."  
(Interview, Manager, Family Planning Association)
- "*Girls do not have much decision making power. **Gender discrimination is visible in every decision making process within the family.***"  
(Focus group discussion with girls and young women aged 13 – 24 years old, urban area)
- "There have been discussions at various fora for **making HIV testing mandatory**, for different populations. Fortunately no damage has yet been done. What is needed is more advocacy with stakeholders on rights related issues."  
(Interview, Representative, National Office of UN Agency)
- "***The law makers and enforcers are not sensitive enough to the young population. The Domestic Violence Act will hopefully protect married women from rape within marriage and, in turn, will reduce their vulnerability to HIV/AIDS.***"  
(Interview, Manager, Community Development NGO)
- "Women in prostitution are those mostly affected [by legislation] as there are **frequent raids in the brothel. There are instances of violence against sex workers**, especially young sex workers. Street children and orphans are abused similarly by the law enforcers."  
(Interview, Counsellor, Faith-Based Organisation)



### KEY POINTS:

- Originally formed in 1987, the National AIDS Prevention and Control Policy in India promotes **a full range and continuum of strategies**, including prevention, care, support and treatment. The overall goal of the National AIDS Control Programme (NACP) – Phase III (2006-2011) is to halt and reverse the epidemic in India over the next five years. This will be achieved through a four pronged strategy:
  - **Prevention of new infections** in high risk groups and the general population through:
    - Saturation of coverage of high risk groups with targeted interventions.
    - Scaled up intervention in the general population.
  - Providing **greater care, support and treatment** to a larger number of PLHIV.
  - Strengthening the **infrastructure, systems and human resources** in prevention, care, support and treatment programmes at district, state and national level.
  - Strengthening **nationwide strategic information management systems**.
  - The **guiding principles** include, a unifying code of the “three ones”; equity; respect for the rights of people living with HIV (PLHIV); civil society representation and participation; creation of an enabling environment for those infected to lead a life of dignity; universal access to prevention, care, support and treatment; responsive, proactive and dynamic human resources strategy; evidence based programmatic interventions; and a focus on results – monitoring and evaluation.<sup>33</sup>
- Socially marginalized groups such as PLHIV, sex workers, injecting drug users (IDUs) and street children are specifically mentioned in the National AIDS Prevention and Control Policy. The government aims to **improve the Sexually Transmitted Infection (STI) clinics and promote condom use**, targeting all vulnerable groups.<sup>34</sup>
- The country has **21 million students and non student youth volunteers** working with different organisations. Every year these organisations hold about 17,000 camps in community/village settings. During NACP III Adolescent Education Programme peer educator clubs in high schools will be strengthened and red ribbon clubs will be established in villages to **provide youth friendly counselling, life skills education, recreation and guidance** in a confidential and enabling environment.<sup>35</sup>
- Key national **statistics on HIV and AIDS are generally disaggregated by social grouping**.<sup>36</sup> Some reports are categorised by age and gender and are routinely published on the National AIDS Control Organisation website.<sup>37</sup>
- **Confidentiality** is emphasised in the National AIDS and Prevention Control Strategy.<sup>38</sup> However, there have been reports of people going for surgical procedures being involuntarily tested for HIV, and having their treatment cancelled if they test positive.<sup>39</sup>

- The **Adolescents Education Programme (AEP)** focuses on imparting **Adolescent Reproductive and Sexual Health information** including on HIV and the relevant life skills needed to cope with the situations that adolescents face. The Ministry of Human Resource Development has requested State Governments to implement the AEP incorporating relevant changes based on their socio-cultural context.<sup>40</sup>

### QUOTES AND ISSUES:

- **“Condom policy** has helped sex workers but women amongst the general population are still reluctant to be seen purchasing them.”  
(Interview, Manager, Family Planning Association)
- *“Young women will never talk of condoms due to cultural barriers. The voluntary counselling and testing (VCT) programs are stand alone programs and not integrated. Girls and young women are not using the services due to fear of stigma and discrimination.”*  
(Interview, Member, PLHIV Network)
- **“The National HIV/AIDS plan aims to integrate HIV with the existing Reproductive and Child Health program.** But the real challenge lies in training the staff on the issues and also reaching out to women in difficult situations.”  
(Interview, Representative, International Agency)
- *“The government should bring down the age of sex education in school as children are maturing at an early age. The curricula should attempt to address the fear and shame centring round reproductive and sexual health and also develop a policy to help out of school youth under this program.”*  
(Interview, Counselor, Faith-Based Organisation)
- **“Sex education in schools is a recent phenomenon** but there is absolutely no discussion around the issue. The students get no chance to clarify doubts and myths and misconceptions dominate their knowledge.”  
(Focus group discussion with girls and young women aged 15 – 24, rural area)
- *“Policy is required to reduce stigma and discrimination against people living with HIV to normalize the situation.”*  
(Interview, Manager, Family Planning Association)
- **“The convergence between adolescent SRH programmes and HIV/AIDS prevention interventions** such as VCT and prevention of parent to child transmission (PPTCT), proposed NACP-III is good. The challenge is in realising the same on the ground.”  
(Interview, Representative, National Office of UN Agency)





### KEY POINTS:

- The **National AIDS Control Programme (NACP)** includes 38 State/Union Territories Municipal AIDS Control Societies (SACS).<sup>41</sup> These are the main implementing arms of the National AIDS Control Programme.
- By March 2006, 2,815 **integrated HIV counselling and testing centres** were functioning in the country.<sup>42</sup>
- Women in rural India receive free VCT through **Maternal Child Health (MCH)** services during the antenatal period.<sup>43</sup>
- The National AIDS Control Organisation (NACO) is scaling up the **Prevention of Parent-to-Child Transmission (PPTCT)**. Currently 1,882 PPTCT centres, which include 502 stand-alone and 1,380 Integrated Counselling and Treatment Centres (ICTCs) are providing services through trained counsellors.<sup>44</sup>
- Under the second phase of the National AIDS Control Programme, 922 **Sexually Transmitted Infection (STI) clinics** were funded. The utilisation of these clinics has been sub-optimal. These clinics are also not linked to targeted interventions for high risk groups. However in the third phase of the programme, emphasis will be placed on **expanding services through effective integration with reproductive and child health programmes**.<sup>45</sup> However, coverage varies, and urban areas are far better serviced by STI clinics than rural areas.<sup>46</sup>
- Only **5-10% of people with STIs attend public sector facilities for treatment**. The majority of people choose to seek clinical assistance from various other formal, as well as informal sources, sometimes even resorting to self-medication where no services are available in rural areas.<sup>47</sup>
- As of December 2005, **Antiretroviral Treatment (ART) centres** had been set up in 52 hospitals in 25 states and the number of People Living with HIV and AIDS (PLHIV) on ART was 23,784.<sup>48</sup>
- NACP-III aims to **scale up access to ART** from 31,234 (6% of those requiring treatment) to 300,000 (63%) by 2011. Meanwhile it is estimated that the number of HIV/AIDS cases will fall from 508,200 in 2006 to 473,500 in 2011.<sup>49</sup> It is estimated that in order to meet targets, 250 ART centres across the country will have to be set up. Currently the **majority of people living with HIV (PLHIV) seek treatment from the private sector**. Accordingly programmes seek to build partnerships with private sector facilities, NGOs and other charitable organizations.<sup>50</sup>
- Following government encouragement, **NGOs are starting harm minimization programmes** available to injecting drug users (IDUs). They are providing bleach powder, clean syringes and needles as well as proper supervision by trained doctors/counsellors.<sup>51</sup>
- Initiatives exist, such as the Commonwealth Youth Programme (CYP), to **encourage dialogue on HIV/AIDS among young people** through education and training. The CYP project uses sport as a means of reaching detached young people in rural communities, and encourages their involvement in the fight against HIV/AIDS.<sup>52</sup>
- The Ministry of Health and Family Welfare (MOHFW) has initially funded procurement of 500,000 **female condoms for distribution** to groups at high risk of HIV infection as well as to the general population.<sup>53</sup> UNFPA is providing technical support for the pre-programme assessment for introduction of female condoms.<sup>54</sup> Additional efforts are required, however, to **make condoms more accessible**, particularly in lower prevalence states and in the rural areas.<sup>55</sup>



### QUOTES AND ISSUES:

- “There is a need to create **separate adolescent clinics** within the government health set up.” (Interview, Manager, Family Planning Association)
- “*There is no specific service for young girls and women. Services are the same for every individual. There is a dearth of free condoms and **female condoms are not available for free**. Women are shy to ask for condoms and they also lack the power to negotiate.*” (Interview, Counselor, Faith-Based Organisation)
- “**ARVs** are not available to everybody and providers have limited knowledge to address female issues. PPTCT services are available, but these services are child centred.” (Interview, Manager, Family Planning Association)
- “*Condoms are provided through the NGOs. They are giving free as well as socially marketed condoms. **STI and VCTC services are available within the government service network**. There is no “anganwadi” (integrated child development scheme) in our community.*” (Focus group discussion with girls and young women aged 13 – 24, urban area)
- “There are policies and protocols in relation to antenatal check ups, VCT 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 home they are abused. Regarding condoms, people think condoms are for sex workers and MSMs.” (Interview, HIV Officer, Family Planning Association)
- “*The voluntary counselling and testing (VCT) Centres are not women-friendly. Very few have women staff. **ART centres are not women friendly**. No gynaecologist and no internal coordination for women to access additional services. There is a lack of privacy and confidentiality in the VCT Centres for women.*” (Interview, Member, PLHIV Network)
- “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.” (Interview, Manager, Family Planning Association)
- “*There should be **greater emphasis on women’s issues in programmes that target men and boys**, to help them appreciate the key issues. There should also be an increase in the number of such programmes.*” (Interview, Representative, International Agency)
- “Many NGOs and State AIDS Control Societies **conduct awareness programs** in the community several times in a year. They conduct camps for youth and women.” (Focus group discussion with girls and young women aged 15 – 24, rural area)





### KEY POINTS:

- In reality, there are multiple **social, economical and programmatic barriers** to girls and young women accessing services:
  - Judgmental **attitudes of health workers**, parents, religious and traditional leaders.
  - The **stigma** associated with HIV and AIDS.
  - The **stigma** associated with **sex workers**, particularly those girls and young women who may be trafficked to large cities.<sup>56</sup>
  - Lack of **access to youth friendly services** in certain areas.
  - **Hidden costs** e.g. prescription drugs and other practical financial barriers.
  - Lack of **privacy and confidentiality**.
  - Powerful **traditional norms** of gender inequality including expectations for young women and girls to care for the sick.

All of these barriers particularly affect girls and women who are poor and/or in rural areas.
- There is **free anti-retroviral treatment (ART) at government hospitals for people living with HIV/AIDS** in the six high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur and Nagaland and in the capital city of Delhi.<sup>57</sup>
- **More males than females have access to voluntary counselling and testing (VCT)** for 10 rupees (approx. US \$0.20). Between October 04 and September 05, 576,512 males were tested in VCT centres, compared to 461,803 females.<sup>58</sup> Some people still have to travel for 4 hours to get to a VCT site.<sup>59</sup> **Scaling up VCT Centres** in the third phase of NACP, and convergence with the Government's Reproductive and Child Health programme **will bring services closer to poorer women and adolescent girls.**
- A **free condom distribution scheme** for those who cannot afford to pay is operated by the Department of Family Welfare. It procures condoms from various Indian manufacturers and supplies them to all the states for distribution to users for free through dispensaries and hospitals.<sup>60</sup>
- The government in India has introduced interventions that address HIV/AIDS among **men who have sex with men (MSM)**.<sup>61</sup> 70 percent of MSM respondents to a NACO initiated Behaviour Surveillance Survey reported that it was possible for them to access confidential HIV testing.
- In the majority of Indian states, **tough regulations make it hard to reach IDUs**. Harm reduction efforts (including needle and syringe exchanges) were introduced in some states such as Manipur.<sup>62</sup>



### QUOTES AND ISSUES:

- "Services are **not expensive** within the government health set up. It is not very far for urban people. It is a little **difficult for women coming from rural areas.**" (Focus group discussion with girls and young women aged 15 – 24, rural area)
- "Overall the situation is bad for girls and women as they are less educated, have no decision making power, no empowerment and are victims of abuse everywhere. The situation is particularly bad for **school going children living with HIV as they are stigmatized, discriminated and abused at every step by the school authority and students.**" (Interview, Counselor, Faith Based Organisation)
- "The **attitudes 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 also a huge gap existing today." (Interview, Manager, Community Development Trust)
- "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. Males & females are treated from the same chamber." (Focus group discussion with girls and young women aged 13 – 24, urban area)
- "The priority actions that are needed are awareness of available services, reducing distance in rural areas, suitable timings of services, **trained staff and reducing the cost of ART drugs.**" (Interview, Member, PLHIV Network)
- "It is difficult to access services for unmarried, out of school youth and people living with HIV/AIDS due to **stigma and discrimination.**" (Interview, Manager, Family Planning Association)
- "Any service is easier for married women to access. Even if the woman is a sex worker it is easier for married sex workers to access services." (Focus group discussion with girls and young women aged 15 – 24, rural area)
- "**Adolescent Reproductive Health services, recently introduced in the country, should be linked with the school system and work sites.** Close involvement of the community stakeholders would ensure better acceptance of services and better program implementation." (Interview, Representative, National Office of UN agency)



### KEY POINTS:

- India ratified the **Convention on the Rights of the Child** in 1992 and the **Convention on the Elimination of All Forms of Discrimination Against Women** in 1993.<sup>63</sup> It has not signed the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages.<sup>64</sup>
- There are various programmes which highlight **HIV and AIDS awareness amongst young people**. These include the Universities Talk AIDS (UTA) and the Adolescent Education Programme which covers 144,409 schools and aims to reach around 33 million students annually.<sup>65</sup>
- The **Coordinated HIV/AIDS Response through Capacity Building and Awareness (Charca)** project is a coordinated effort of the UN system in India to increase capacities and reduce the vulnerability of young women in the 13 – 25 age group to STIs and HIV infection.<sup>66</sup>
- A cornerstone of young people's involvement was the **National Youth Parliament**. This youth parliament was convened with a special focus to seek **inputs from young people on the draft legislation on HIV/AIDS**. Over 4,000 young people from all districts of the country participated in this two-day event. The inter Parliamentary Forum on HIV/AIDS, NACO and UN Agencies organized the event.<sup>67</sup>
- The Minister of Health & Family Welfare, the Secretary of the Ministry of Women & Child Development and the Secretary for the National Commission for Women are all members of the **National AIDS Committee**. However, the Committee **does not include NGOs and people living with HIV (PLHIV)**.<sup>68</sup>
- NACO has tried to incorporate the **greater involvement of people with AIDS (GIPA)**, and those directly affected by HIV/AIDS. In 2003 it commenced a partnership with INP+ and UNDP to organize the Leadership for Results Programme. Three workshops were organised in Delhi, Cochin and Kolkata with several positive outcomes.<sup>69</sup>
- Support from NACO and UNDP helped establish INP+, a national, community based NGO, representing the needs of PLHIV. INP+ now has **up to 15 state level networks of people living with HIV/AIDS**. These provide a voice for PLHIV 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 PLHIV. Through INP+ positive women's groups have been updated with current knowledge on human rights, treatment literacy and positive living.<sup>70</sup>

### QUOTES AND ISSUES:

- "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 programmes."  
(Interview, Representative, International Agency)
- "Only one NGO attempted to bring girls and boys in the same platform through peer education program. The community feels there should be programs **jointly for boys and girls in the community**.  
(Focus group discussion with girls and young women aged 13 – 24, urban area)
- "There is a need to form a young people's 'Advisory Panel' and to **involve student unions** in designing programs for the youth."  
(Interview, Representative, National Office of UN Agency)
- "There **are street dramas, student rallies and mass events that 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."  
(Focus group discussion with girls and young women aged 15 – 24, rural area)
- "**Girls and young women should be involved at the planning level**. The more they are involved the more effective the intervention would be."  
(Interview, Counselor, Faith Based Organisation)
- "**Involve grass roots people in national decision making processes**. Spotting them at the community level and building their capacity would help to ensure their involvement."  
(Interview, Representative, International Agency)
- "My husband **refuses to use condoms** as he thinks that condoms are for unmarried people."  
(Focus group discussion with girls and young women aged 15 – 24, rural area)
- "**GIPA policy should be implemented**. Youth should be involved in planning, implementation, monitoring and evaluation."  
(Interview, Member, PLHIV Network)





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- <sup>1</sup> The percentage of people ages 15-24 who can, with understanding, both read and write a short, simple statement about their everyday life.
- <sup>2</sup> The age by which one half of young women ages 15-49 have had penetrative sex (median age).
- <sup>3</sup> The percentage of married women in union ages 15-49 who are using, or whose partners are using, any form of contraception, whether modern or traditional.
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- <sup>6</sup> UNDP (2004) Human Development Report 2006: India (Date accessed 31/07/07)
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- <sup>17</sup> UNAIDS India Website (Date accessed 31/07/07)
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- <sup>19</sup> Avert Website India HIV and AIDS statistics (Date accessed 17/02/07)
- <sup>20</sup> UNAIDS (2006) Report on the Global AIDS Epidemic (Date accessed 11/07/06)
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- <sup>22</sup> Government of India (2005), National Aids Control Organisation and Ministry of Health and Family Welfare, Progress Report on the Declaration of Commitment on HIV/AIDS United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (Date accessed 15/02/07)
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- <sup>25</sup> Government of India (2004), National AIDS Control Organisation, Ministry of Health and Family Welfare Government of India, Voluntary Counseling & Testing: Operational Guidelines: 2004 (Date accessed 12/07/06)
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- <sup>27</sup> Government of India, National AIDS Prevention and Control Policy (Date accessed 19/12/06)
- <sup>28</sup> Avert website (Date accessed 19/12/06)
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# RECOMMENDATIONS



Based on this Report Card, a number of programmatic, policy and funding actions could be recommended to enhance HIV prevention for girls and young women in India. It is proposed that key stakeholders – including government, relevant intergovernmental and non-governmental organisations, and donors – should consider these actions...

## LEGAL PROVISION

1. Remove the current provision that requires **parental consent for HIV testing of minors** to enable and encourage increased access to services..

## POLICY PROVISION

2. Review and strengthen India's action in the light of the aspects of the **Political Declaration on HIV/AIDS** from the 2 June 2006 High-Level Meeting (to follow up on UNGASS) that particularly relate to HIV prevention for girls and young women. These include sections: 7, 8, 11, 15, 21, 22, 26, 27, 29, 30, 31 and 34.
3. Ensure comprehensive training of health care workers on issues relating to **stigma and discrimination** and **privacy and confidentiality** so as to foster an inclusive environment that will not deter people (particularly young girls and women and those in rural areas) from accessing services.
4. Strong commitment to **support comprehensive life skills and sexuality education programs** should be made, especially in rural areas. Specifically:
  - Teachers should receive adequate support to put life skills education (including relationship skills) into effective practice.
  - Peer educators should be equipped to provide referrals to services in the community.
  - Male and female condoms should be more accessible to young people.
  - Teachers should receive adequate training and support in HIV prevention and safer sex.

## AVAILABILITY OF SERVICES

5. Promote universal access to **antiretroviral therapy**, while also promoting positive prevention (prevention for and with people living with HIV). It is important to ensure that **girls and young women living with HIV**, including those who are **poor and in rural areas** receive treatment in an environment that not only addresses their HIV status, but recognizes their Sexual and Reproductive Health (SRH) needs.

6. Introduce and **promote a positive model of voluntary counselling and testing (VCT) in rural areas** – one that emphasises the benefits of knowing your HIV status within a safe and supportive environment, guarantees confidentiality and helps girls and young women in terms of notifying their partners, families and communities

## ACCESSIBILITY OF SERVICES

7. Ensure **privacy (audio and visual) and confidentiality** in health care services.
8. Undertake a **national mass media campaign with HIV prevention messages** for all sections of society, targeted, in particular towards young women and other vulnerable and high risk groups.
9. **Voluntary counselling and testing services** must become more widely available and accessible to vulnerable groups including young people, women, mobile and migrant populations and other groups such as injecting drug users (IDUs), sex workers and men who have sex with men (MSM).

## PARTICIPATION AND RIGHTS

10. The national response to HIV and AIDS should build on the progress made so far in terms of **developing an even stronger rights based approach to HIV prevention**. It is critical to ensure that **the rights of most vulnerable groups of people living with HIV (PLHIV) are not violated and discriminated against**, in particular, women's right to access abortion services if they are living with HIV.
11. **Work with boys and men** to improve their understanding and behaviour around sexual health and HIV prevention issues so as to reduce the transmission of HIV and STIs to their regular and recreational partners
12. Further efforts should be made to promote the **greater involvement of PLHIV** in national HIV programme and policy decision making bodies, including the National AIDS Committee

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