Monitoring the UNGASS Goals of Sexual and Reproductive Health in the context of HIV/AIDS

India Country Report

Developed by:
The Cell for AIDS Research Action and Training,
Tata Institute of Social Sciences, Mumbai, India

For

Action Plus
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GLOSSARY of TERMS

1) HIV : Human Immunodeficiency Virus
2) AIDS: Acquired Immunodeficiency Syndrome
3) NACP: National AIDS Control Program
4) NRHM: National Rural Health Mission
5) RNTCP: Revised National Tuberculosis Control Program
6) GDP: Gross Domestic Product
7) RCH: Reproductive and Child Health
8) PHC: Primary Health Centre
9) CHC: Community Health Centre
10) MPW: Multi Purpose Worker
11) ANM: Auxiliary Nurse and Midwife
12) MNP: Minimum Needs Program
13) BMSP: Basic Minimum Services Program,
14) ICPD: International Conference on Population and Development
15) CEDAW: Convention on the Elimination of All Forms of Discrimination against Women
16) UIP: Universal Immunization Program
17) CSSM: Child Survival and Safe Motherhood
18) IMR: Infant Mortality Rate
19) MMR: Maternal Mortality Rate
20) ASHA: Accredited Social Health Activist
21) JSY: Janani Suraksha Yojana
22) MCH: Maternal and Child Health
23) NACB: National AIDS Control Board
24) IDU’s: Injecting Drug Users
25) PLHA: People Living with HIV/AIDS
26) SACS: State AIDS Control Society
27) DACS: District AIDS Control Society
28) PIP: Project Implementation Plan
29) GIPA: Greater Involvement of People Living with HIV/AIDS
30) ART: Anti Retroviral Treatment
31) CBO’s: Community Based Organisations
32) PIL: Public Interest Litigations
33) NCSR: National Campaign for Sexuality Rights
34) PPTCT: Prevention of Parent To Child Transmission
35) ITPA: Immoral Trafficking Prevention Act
36) MoWCD: Ministry of Women and Child Development
37) PSC: Parliamentary Standing Committee
38) VCTC: Voluntary Counseling and Testing Centre
39) ICTC: Integrated Counseling and Testing Centre
40) NFHS: National Family Health Survey
41) ICPS: Integrated Child Protection Scheme.
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Methodology

The process of paper writing began with setting the context/background to the paper through a desk review. The desk review was followed by data collection from a variety of sources that reflected the civil society’s responses.

A) The desk review involved:

1) Critically looking at concepts like sexual health, reproductive health, reproductive rights and sexual rights and their respective evolution.
2) Reviewing Indian literature from 1995 onwards to understand discourses, research findings, policies, programs (govt. and NGO based) on sexual and reproductive health.
3) Studying various international declarations as well as human rights instruments related to SRH e.g. Convention on the Elimination of All Forms of Discrimination against Women. ‘ICPD-Beijing and Cairo Declaration-94’, UNGASS Declaration.
4) Reviewing literature on the health care system in India, with specific reference to sexual and reproductive health. Along with this a review of literature in relation to NACP, particularly critiques of phase 1 and 2 was undertaken.
5) Sourcing civil society programs and services in relation to SRH.

Following the desk review, data was collected from the below listed sources. Qualitative data was collected with the help key informant interviews. The tool chosen and developed for these key informant interviews was an in-depth unstructured interview guide.

Along with key informant interviews, focus group discussions were also conducted. For these discussions a guide similar to that of the key informant interviews was developed. Focus group discussions were primarily used to capture voices from the community.

The sources of data range from the government leadership of the national HIV/AIDS programs, to networks of positive women to civil society organizations and activists.

Key Informant Interviews were conducted with:

- Civil Society Organization’s running programs on sexual and reproductive health, HIV/AIDS and gender.
- Leadership of positive people’s network
- Health care providers
- Academicians
- Ministries –Health and Family Welfare, Women and Child Development
- Joint Directors and Deputy Directors of the RCH Program, NACP
- Donor Community

Focus groups discussions were held with:
• Women in prostitution
• Injected Drug Users (IDU’s)
• MSM
• Transgenders
• People Living with HIV/AIDS – women and men
• Counselors within NACP
Chapter I: Country Profile

Introduction

India forms a natural sub-continent with the Himalayas to the north, the Arabian Sea and the Bay of Bengal, to the west and the east respectively. India’s neighbors are China, Bhutan, Nepal, Pakistan, Burma Bangladesh and Sri Lanka. The official language of India is Hindi, written in the Devanagri script and spoken by 30% of the population as a first language.
According to the Constitution, India is a “sovereign, socialist, secular, democratic republic.” and has a federal form of government. It is the largest state by population with a democratically-elected government. However, the central government in India has greater power in relation to its states. The Constitution of India lays down the basic structure of government under which the people are to be governed. The governance is based on a tiered system, wherein the Constitution of India appropriates the subjects on which each tier of government has executive powers.

India’s independent judicial system began under the British, and its concepts and procedures resemble those of Anglo-Saxon countries. The government exercises its broad administrative powers in the name of the President, whose duties are largely ceremonial. Currently Ms. Pratibha Patil (since 25 July 2007) and Mr. Hamid Ansari (since 11 August 2007) are holding the positions of the President and Vice President respectively. Real national executive power is centered in the Council of Ministers (Cabinet), led by the Prime Minister, currently, Dr. Manmohan Singh (since 22 May 2004). India’s bicameral Parliament consists of the Rajya Sabha (Council of States) and the Lok Sabha (House of the People).

India has 28 states and 7 Union Territories. Each state has its own legislative, executive and judicial machinery, corresponding to that of the Indian Union. The states chief ministers are responsible to the legislatures in the same way the Prime Minister is responsible to the Parliament. Each state also has a presidential appointed Governor.

The constitution uses the Seventh Schedule to delimit the subjects under three categories namely the union list, the state list and the concurrent list. The central government has the powers to enact laws on subjects under the union list, while the state governments have the powers to enact laws on subjects under the state list. Both the central as well as the state governments can enact laws on subjects under the concurrent lists. The union list contains 97 subjects of national importance like defense, foreign affairs, atomic energy, banking etc. The state list contains 66 subjects of local or state importance like police, local governments, trade, commerce, agriculture etc. Health is a state subject but national health programs like those of National AIDS Control Program (NACP), the National Rural Health Mission (NRHM) and Revised National Tuberculosis Control Program (RNTCP) are funded by the Central government. The concurrent list contains 47 subjects like criminal procedure, marriage and divorce, education etc. However, the laws enacted by the central government under the concurrent lists override the laws enacted by the state government when a conflict arises between those laws.

The constitution designates the Supreme Court, the High Courts and the Lower Courts as the authority to resolve disputes among the people as well as the disputes related the people and the government. The constitution through its articles related to the judicial system provides a way to question the laws of the government, if the common man finds the laws as unsuitable for any community in India. Separate personal law codes apply to Muslims, Christians and Hindus.
I: A: The Indian Economy

India is the world’s 12th largest economy and the third largest in Asia behind Japan and China with total GDP of around 1 trillion (\$1,000 billion). Services, Industry and Agriculture account for 55%, 27% and 18% of GDP respectively. Nearly two-thirds of the population depends on agriculture for its livelihood. 700 million Indians live on Rs.42 per day or less, but there is a large and growing middle class of 325-350 million with disposable income for consumer goods. Real GDP growth for the fiscal year ending March 31, 2007 was 9.4% up from 9.0% growth in the previous year. Growth for the year ending March 31, 2008 is expected to be between 8.5-9.0%. Foreign portfolio and direct investment inflows have risen significantly in recent years. They have contributed to $255 billion in foreign exchange reserves by June 2007. Government receipts from privatization were about $3 billion in fiscal year 2003-2004, but the privatization program has stalled since then.

I: B: The Basic Indicators

Although India occupies only 2.4% of the world’s land area, it supports over 15% of the world’s population. The total population is estimated at 1.12 billion in 2007 with an annual growth rate of 1.3%. About 70% live in more than 5,50,000 villages, and the remainder in more than 200 towns and cities. Although 81% of its people are Hindu, India also is the home for more than 138 million Muslims- one of the world’s largest Muslim populations. The population also includes Christians, Sikhs, Jains, Buddhists and Parsis.

The crude death declined from 25 per 1,000 population in 1951 to 8 in 2001 and 6.58 (2007est). The infant mortality rate has been halved from 120 per 1,000 live births in 1970’s to 60 in 2003 and 34.61 (2007est). Life expectancy at birth has risen from 36 years in 1951 to 62.5 years in 1998 – 2002 to 68.59 years (2007est). The crude birth rate declined from 42 in 1951 to 25 in 2002 and 6.58 deaths per 1000 population (2007est). The total fertility rate decreased from 6.0 in 1951 to 2.9 in 2003 and 2.81 (2007est). The maternal mortality ratio is estimated to have declined from 400 maternal deaths per 100,000 live births in 1997-98 to 300 in 2001-03.

The percentage of the population living below the poverty line decreased from 55% in 1973-74 to 36% in 1993-94. Evidence from the 61st round of NSS data shows that the extent of poverty decreased further from 26.1 % in 1999-2000 to 22.0 % in 2004-05. India’s literacy rate increased from 18% in 1951 to 66% in 2001. An important concern is the substantial gender gap in the literacy rate, with 54% of women and 76% of men being literate in 2001 and 74% of women and 89% of men in 2005-06. Gross enrolment as a percentage of the total child population age 6-10 years increased from 43% in 1950-51 to 98% in 2003-04. The corresponding increase among children age 11 – 14 from 13 % to 63%.
CHAPTER II: The Health Budget and Health Structure in India

II: A: Budgetary Allocations

Health in India, like most social sectors, is a state subject and the contribution of the state governments to health spending is between 80 and 85 per cent. While in the recent years the Union government has substantially hiked its contribution to the health budget increasing at 30 per cent per annum, in itself this makes a very small impact on the overall health budget. Presently, the health budget of state and central government combined is less than one percent of GDP.

In India there has been a growing analysis of health budgets and health expenditures. The economic reforms of the 90’s have created a trajectory of public health spending that shows a downward trend both in terms of share of the government budget as well as a proportion of the Gross Domestic Product. Prior to economic reforms in the mid-80s, public health expenditures had peaked 1.6 per cent of the GDP and was 3.95 per cent of government's budget. By 2001, these figures read a dismal 0.9 per cent and 2.7 per cent, respectively, and further down to 0.8 and 2.4 per cent in 2005. What was worse was the decline in new investments by the Ministry of Health as reflected in the decline in capital expenditures from a robust 12 per cent in 1986-87 to a mere four per cent in 2000-01 and only a slight improvement in 2004-05 at five per cent.\(^1\)

The table below looks at and summarises some of the key programmatic allocations in the Union Health Budget. Here we see that traditional sectors like hospitals, medical education and family planning services are now receiving a smaller chunk of the health budget in comparison to the “new” sectors like RCH, HIV/AIDS, immunization (especially pulse polio). From the 2005-06 budget onwards, NRHM has hijacked the RCH and Family Planning budgets giving a boost to rural health allocations.

<table>
<thead>
<tr>
<th>Programme</th>
<th>BE 2004-05</th>
<th>BE 2005-06</th>
<th>BE 2006-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals &amp; Dispensaries</td>
<td>240.75</td>
<td>268.70</td>
<td>263.25</td>
</tr>
<tr>
<td>Medical education &amp; Research</td>
<td>912.82</td>
<td>1397.33</td>
<td>1436.64</td>
</tr>
<tr>
<td>AYUSH</td>
<td>225.73</td>
<td>405.98</td>
<td>447.89</td>
</tr>
<tr>
<td>NACO - HIV/AIDS</td>
<td>232.00</td>
<td>476.50</td>
<td>636.67</td>
</tr>
<tr>
<td>RCH</td>
<td>710.51</td>
<td>881.73</td>
<td>1765.83</td>
</tr>
<tr>
<td>Pulse Polio</td>
<td>1186.40</td>
<td>832.00</td>
<td>1004.00</td>
</tr>
<tr>
<td>Routine Immunisation</td>
<td>472.60</td>
<td>326.50</td>
<td></td>
</tr>
<tr>
<td>FW services and contraception</td>
<td>1948.71</td>
<td>2412.41</td>
<td>1942.61</td>
</tr>
<tr>
<td>Area Projects</td>
<td>123.01</td>
<td>501.26</td>
<td>205.57</td>
</tr>
</tbody>
</table>
II: B: Privatization and Corporatisation of the Health Care

Health care in India has undergone significant structural changes in recent years with the increasing involvement of the corporate sector. While private health care, in the form of small and medium enterprises like nursing homes, has been prevalent in India for several decades, the entry of the corporate sector is relatively new. This phenomenon has triggered changes in other areas such as medical equipment import policy and health insurance.

The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy. The increasing cost of healthcare that is paid by ‘out of pocket’ payments is making healthcare unaffordable for a growing number of people. Although most consumers of corporate hospitals are from the upper and middle classes, the working and farmer classes also access these services since they perceive them as providing quality care. The proportion of people unable to afford basic healthcare has doubled in last decade. One in three people who need hospitalization and are paying out of pocket are forced to borrow money or sell assets to cover expenses. Over 20 million Indians are pushed below the poverty line every year because of the effect of out of pocket spending on health care. In the absence of an effective regulatory authority over the private healthcare sector the quality of medical care is constantly deteriorating. Powerful medical lobbies prevent government from formulating effective legislation or enforcing the existing ones. A recent World Bank report acknowledges the facts that doctors over-prescribe drugs recommend unnecessary investigations and treatment and fail to provide appropriate information for patients even in private healthcare sector. The same report also states the relation between quality and price that exists in the private healthcare system. The services offered at a very high price are excellent but are unaffordable for a common man.²

Privatization has influenced the perception and practice of the medical professional. With an increased reliance on high technology, there is a greater emphasis on specialization and a devalued role assigned to general practice. Higher salaries in the corporate sector have resulted in a movement of senior government doctors from teaching hospitals to corporate hospitals. This trend has been observed both in the metropolitan cities of Delhi and Hyderabad where a large number of senior specialists have resigned from government service to join corporate hospitals. They cited better working conditions and salaries as two important reasons for doing so. The emergence of large private hospitals has definitely pushed up the cost of medical care and the marketing strategy has helped project the view that higher cost means better care. In an unregulated market, the consumer cannot be certain about the costs to be borne.³
II: C: Health Structures Present in India

There exists in India a strong institutional setup for delivery of health services. Health however is largely a rural centered program. Urban health started as early as 1951 during the first five year plan, but the priority remained rural for decades. Unlike rural areas, with an organized 3 tier health delivery structure, there is no such structure available in urban areas.4

In the rural areas, Primary Health Care services are provided through a network of service delivery units called Sub Centers, Primary Health Centers and Community Health Centers. These services are established on certain population norms. Population Norms: The rural primary health care infrastructure has been developed as a three tier system and is based on the following population norms:

<table>
<thead>
<tr>
<th>Center</th>
<th>Population Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plain Area</td>
</tr>
<tr>
<td>Sub-Center</td>
<td>5000</td>
</tr>
<tr>
<td>PHC</td>
<td>30000</td>
</tr>
<tr>
<td>CHC</td>
<td>120000</td>
</tr>
</tbody>
</table>

The sub center is the most peripheral contact point between the PHC system and the community. It is manned by one Multi purpose Worker (male) and one Multi Purpose Worker (Female)/ANM. The PHC is the first contact point between village community and the Medical Officer. These are established and maintained by the State Governments under the Minimum Needs Program (MNP)/ Basic Minimum Services Program (BMSP). A PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for six Sub Centers it has 4-6 beds for patients. The activities of the PHC involve curative, preventive, promotive and Family Welfare Services.

The Community Health Centers are being established and maintained by the State Government under the MNP/BMS. It is manned by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 indoor beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral Centre for 4 PHC’s.5
CHAPTER III: Reproductive and Sexual Health in India

Introduction

Reproductive rights came into being with reference to women’s reproductive rights. The phrase ‘women’s reproductive rights’ to describe the concept of women’s right to decide if, when and how to have children has only been around since about 1979. The first formal declaration of reproductive rights appeared in 1968 at the United Nations International Conference on Human Rights, in Teheran, Iran. Reproductive rights were defined as the freedom of choice of “parents” who decide freely and responsibly the number and spacing of children, and the right to adequate education and information in that respect.

Following the conference in Teheran, the first World Conference on Population was held in Bucharest in the year 1974 where reproductive rights were once again discussed. There ensued at this conference a debate between advocates of development who believed that development is the best contraceptive and therefore, a necessary pre condition to sustained fertility decline and those who asserted that family planning services must be implemented to meet the high demand for fertility control which they believed existed.

At International Conference on Population and Development- Cairo in the year 1994, the nations of the world agreed that governments should give special attention to the health of women, the survival of infants and young children, the education of girls and in general, the empowerment of women. At the same time they should provide comprehensive reproductive health services to enable couples to achieve their reproductive goals and determine freely and responsibly the number and spacing of their children. The ICPD defines reproductive health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health – care services that will enable women to go safely through pregnancy and childbirth. Reproductive health also includes sexual health, the purpose of which is the enhancement of life and personal relations.6

Bearing in mind the above definition, reproductive rights came to embrace certain human rights that were already recognized in national laws, international human rights documents and other consensus documents. Among the international human rights treaties, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) takes an important place. In its approach, the Convention devotes attention to three dimensions of the situation of women. Civil rights and the legal status of women are dealt with on great detail. In addition and unlike other human rights treaties, the Convention is also concerned with the dimension of human reproduction as well as with the impact of cultural factors on gender relations. The preamble sets the tone by stating that” the role of women in procreation should not be a basis for discrimination. For example, it advocates, in Article 5, “a proper
understanding of maternity as a social function”, demanding fully shared responsibility for child rearing by both sexes.

However, reproductive health in India evolved post the ICPD. “Several factors, such as the recognition of the very slow decline in the birth rates, lack of motivation at all levels in the delivery of family planning services, concerns raised by women’s groups and other non governmental organizations regarding the narrow range of services offered, the program becoming target driven with little concern for women’s needs and the climate created by the ICPD, have been to a greater or lesser extent responsible for bringing about the shift in India’s approach”

III: A: The Evolution of Sexual and Reproductive Health in India

The Sexual and Reproductive services provided in the public health sector are as follows:

<table>
<thead>
<tr>
<th>Sub Centre</th>
<th>Primary Health Centre(PHC)</th>
<th>Community Health Centre(CHC)</th>
<th>District Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and child health; ANC; intranatal care in terms of institutional deliveries; skilled attendance at birth; ENC; prompt referral; maternal and child immunization.</td>
<td>Maternal and child health; including basic laboratory services to screen high risk pregnancies; 24 hour delivery- normal and assisted; ENC, including neo natal resuscitation; basic emergency obstetric care and pre referral management of obstetric and newborn complications; referral and transportation services ; routine immunization</td>
<td>Maternal and child health; 24 hour delivery- normal and assisted; essential and emergency obstetric care; including cesarean section and management of pregnancy and obstetric complications; blood storage and transfusion facilities; new born care; routine and emergency care of sick children; routine immunizations; laboratory services; referral and transportation services.</td>
<td>Secondary level care provider: specialist OB-GYN services- full range of obstetric and gynecological care and treatment; pediatrics; including neonatology; dermatology and venerology, including STI/RTI care; immunization and new born care.</td>
</tr>
<tr>
<td>Family planning and contraception: counseling and provision of birth spacing, including Copper T IUD insertion; counseling and referral for safe abortion.</td>
<td>Family planning and contraception; counseling and provision of birth spacing; including Copper T IUD insertion; performing male and female sterilization; counseling and referral for abortion; and medical termination of pregnancy using manual vacuum aspiration wherever trained personnel and facilities exist.</td>
<td>Full range of family planning services, including laparoscopic services; provision of safe abortion services</td>
<td>Full range of family planning services, including laparoscopy; abortions, including mid trimester abortions.</td>
</tr>
<tr>
<td>Management of RTI's/STI's, including counseling and treatment</td>
<td>RNTCP; National HIV/AIDS Control Program including basic screening tests for STI's; provision of PPTCT; condom</td>
<td>Management of RTI's/STI's, PPTCT; all national Health programmes including RNTCP.</td>
<td></td>
</tr>
</tbody>
</table>
In India since the mid-1970, women’s organizations, social activists and community based organizations had raised their voices against the contradictory positions taken by the GoI on population and family planning. While on one hand the Bucharest Conference espoused that “development is the best contraceptive”, in India family planning measures were intensified with women becoming the focus of sterilizations. In India the focus remained on achieving demographic targets by increasing contraceptive prevalence, notably female sterilization.

As a result many women activists and NGO’s had distanced themselves from the governments program and the population lobby or had begun to oppose it. There was little or no dialogue between them. The moderates, who argued for a more balanced view of population, women’s health and poverty linkages, were either silent or found their campaign/advocacy ineffective.

Prior to the ICPD i.e. during the seventies, the National Family Planning Program that was initiated in 1951, was renamed as the Family Welfare Program to emphasize that it is not merely a birth control program. Since the mid- 60’s, attempts have been made to integrate the Indian family planning program with other programs, such as minimum needs, maternal and child health, and child survival and safe motherhood. The minimum needs program, initiated in the early 70’s sought to link family welfare and primary health care with efforts to alleviate poverty in the country. In the eighties, the maternal and child health program received a boost after the adoption of the National Health policy by Parliament in 1983.

The inclusion of initiatives such as the Universal Immunization Program (UIP) and the Safe Motherhood Program (CSSM) further widened the outreach. The close linkages between the health of the mother and young children saw the program coalesce into the Mother and Child Health (MCH). The focus of the MCH program was on antenatal care and the high risk group.

India responded to the ICPD by developing and implementing the present Reproductive and Child Health (RCH) program, formally inaugurated in 1997. The RCH program incorporated the components covered under the Child Survival and Safe Motherhood Program and includes additional component of STI’s and RTI’s. The RCH made steady progress towards achieving reproductive health and child health goals. Based on a public health approach, the RCH aimed at maximum coverage and promoted equity by improving accessibility and providing choices, especially for women, adolescents, socio-economically backward groups, tribals and slum dwellers. The RCH aimed to be participatory by involving all stakeholders, supporting decentralization and area specific planning.

While addressing the 37th Session of the Commission on Population and Development, Mr. Prasanna. Hota stated the important policy measures undertaken, in the implementation of the ICPD. They are as follows:

- Abolition of contraceptive target regime and movement towards decentralized, client centered reproductive health approach in which worker performances
are assessed through the expected level of achievement arrived through an assessment of community needs.

- Formulation of a National Population Policy that aims at achieving population stabilization by addressing unmet needs and decentralized planning and program implementation, and also affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services. Providing choice of spacing method, increasing male participation are the new initiatives.

- Legislative measures to ensure gender equity, equality and empowerment of women.

- Integration of HIV/AIDS program with RCH at primary health care institutions.

At the implementation level, RCH I saw limited involvement and ownership of states. It had a “one size fits all” design and a “stand alone public health approach”. There was a fragmented approach and duplication of services. RCH Phase II also aims to be implemented at a faster pace as compared to the first phase. Also utilization of public health facilities was very low during Phase I. RCH I was also criticized for lack of vision and policy guidelines. It was also centrally designed with little consultation. RCH Phase II was launched in 2005, (2005-2010). The design of RCH Phase II specifically seeks to address the lessons learnt from RCH Phase I. Strategies envisaged to address the lessons include:

- Planning will be based on the analysis of state level requirements as assessed from district level requirements.
- Plans to be prepared by states based on overall guidelines provided by the national framework.
- Capacity building in program management.
- Monitoring systems to be introduced.
- Taking into account both the user’s and provider’s perspective.
- Systematic efforts to improve quality through training, BCC, evaluation and feedback.
- Coordination with NACP and ICDS.

The RCH II is the flagship program of the National Rural Health Mission (2005-2012) (NRHM). The NRHM was formulated by the government to improve availability and access to quality health care to those residing in rural areas in particular, as well as poor women and children. The NRHM was formulated after a large number of consultations and many of the recommendations made on by civil society experts and representatives were accepted and incorporated into the many program documents. The NRHM has the following goals to achieve:

- Reduction In IMR and MMR
- Universal access to public health services such as women’s health, child health, water, sanitation, and hygiene, immunization and Nutrition
- Prevention and control of communicable and non communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
Promotion of healthy lifestyles.
- Revitalize local health traditions and mainstream AYUSH.

The NRHM also has the Plan of Action which is made up of 10 components. They are:

1. Accredited Social Health Activists (ASHA).
2. Strengthening Sub Centers.
4. Strengthening CHC’s for First Referral Care
5. District Health Plan
6. Converging Sanitation and Hygiene under NRHM.
7. Strengthening Disease Control Programs.
8. Public Private Partnership for Public Health Goals, including Regulation of Private Sector.
9. New Health Financing Mechanisms
10. Reorienting Health/Medical Education to support Rural Health Issues.

While reviewing the NRHM at the National Stakeholders Consultation on Aug 8th 2007, the Centre for Health and Social Justice, New Delhi listed some of the achievements of the NRHM. Accredited Social Health Activists (ASHA) selection had taken place in large numbers across the country. Communities are increasingly aware becoming aware of the Janani Suraksha Yojna (JSY) which is 100% centrally sponsored scheme and it integrates cash assistance with delivery and post delivery care. However there are many issues related to corruption and quality of care which need to be addressed urgently. Minor repairs were carried out in many places on Sub Centre buildings through untied funds. District planning processes were evident in some place. Panchayat Pradhans were found to have some knowledge of NRHM and JSY, indicating an involvement of PRI’s.

However reproductive and child health services need to be strengthened under the NRHM. The services include adolescent reproductive and sexual health issues, which are addressed only superficially. Gender training for healthcare providers, which has to be introduced immediately. Also gender training for healthcare providers needs to be introduced immediately.

III: B: Ill served/ overlooked areas in Reproductive and Sexual Health

After the RCH was launched in India, there still continued to be a lack of clarity between reproductive health and maternal and child health because of the paucity of information and data on the reproductive health situation in India. Aside from an extensive body of research on contraceptive prevalence and the Indian family planning program, research evidence has largely overlooked such topics as the magnitude of reproductive ill health, constrained reproductive choice, their determinants, and the consequences of ill health for individual’s lives. Also, questions remained concerning what reproductive health encompasses, how it differs from maternal and child health and family planning programs and why there is a need for a broad reproductive health orientation in India.
Maternal and child health (MCH) have for long been the primary focus of development and policy. Reproductive health needs especially adolescent reproductive health needs, remain poorly understood and ill served in India. While national strategies and programs have focused on children and pregnant women, neither services nor research has focused on adolescents and their unique health and information. In a country in which adolescents (aged 10-19) represent over one fifth of the population, the health consequences of this neglect take on enormous proportions. A number of recent publications have addressed the general issue of reproductive health and hazards among adolescents in developing countries. While there is a paucity of well conducted studies on sexual activity of adolescents in India, the overall conclusions drawn from various sources of information are the same. The studies show their vulnerability caused by their young age, their ignorance on matters related to sexuality and reproductive health, their lack of factual knowledge on contraception and their inability and unwillingness to use family planning and health services.

Sexual behaviour has been a relatively taboo topic in India until recently. Research in the reproductive and sexual health of marginalized groups is also largely missing. Very little research was carried out on this sensitive subject until heightened concerns about the spread of HIV/AIDS in the early 1990’s focused governmental and public attention on the sexual activities though to be central to the spread of the HIV virus. It was with the influence of the women’s movement, the struggle for gay and lesbian rights, and more recently the HIV/ AIDS epidemic that the term sexuality has found its way onto development and policy agendas.

There continue to be debates about the relationship between sexuality and reproductive health; however it is clear that reproductive health cannot be discussed without an understanding of sexuality. One outcome of this acceptance of the sexuality connection in reproductive health discourses is that it has remained just that - a connection. There is often a conflation of the terms ‘sexuality’ and ‘reproduction’, leading to the subsuming of the former under the latter.

III: C: Where is the Sexual and Reproductive health of men?

Historically the sexual health of men in low income countries has received very little attention, either from the research community or from public sector health care planners and providers. This situation is predicated on the fact that women bear a greater burden of reproductive mortality and morbidity as they shoulder the physical and most of social, responsibility for childbearing and childcare. Primary health care programs in many settings in south Asia primarily concentrate on maternal and child health and family planning services. Men are by program design, excluded from primary care level public sector health services. Thus they are forced to seek care from formal and informal private sector providers. Current interest in male sexual health has arisen in part from the need to address STI’s including HIV, and the focus is predominantly on transmissible diseases. Other sexual concerns, like sexual dysfunction and anxieties about failure or weakness have not been considered.
In India health care is geared towards women which is in fact aimed at children’s health. The father remains conspicuous by his absence, even though his sexual behaviour and neglect of his own reproductive health may have a strong bearing on the mother’s health. Men’s reproductive and sexual health is an issue that as not received any attention, either at the programmatic level or at the policy level. Although issues concerning maternal health and development find mention of men, no particular role is envisaged for them. In reproductive health, men’s roles are typically limited to fertility regulation and contraceptive use. Khan Et al, in a policy review of men’s involvement in reproductive health remarked: “Despite…top program managers being aware of the need to pursuing a broader approach to reproductive health issues and the importance of involving men, their main concerns is at present limited to strengthening delivery systems, with limited initiatives for involving men…in introducing no-scalpel vasectomy and promoting the use of condom.”

Also in RCH programs there is no separate space for men to address their sexual and reproductive health issues. “Besides, men, too, have reproductive and sexual health needs that should be addressed”
CHAPTER IV: HIV/AIDS in India

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide\textsuperscript{12}, India had no reported cases of HIV or AIDS. There was recognition, though, that this would not be the case for long, and concerns were raised about how India would cope once HIV and AIDS cases started to emerge. One report, published in a medical journal in January 1986, stated:

“Unlike developed countries, India lacks the scientific laboratories, research facilities, equipment, and medical personnel to deal with an AIDS epidemic. In addition, factors such as cultural taboos against discussions of sexual practices, poor coordination between local health authorities and their communities, widespread poverty and malnutrition, and a lack of capacity to test and store blood would severely hinder the ability of the government to control AIDS if the disease did become widespread.”

Later in the year, India’s first case of HIV was diagnosed in Chennai. In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread was observed among Injecting drug users in Manipur, Mizoram and Nagaland – three north–eastern states of India bordering Myanmar (Burma) . (NACO 2006)

By 1990, cases of HIV infection had been reported in every state of the country. Throughout the 1990s it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that has previously been seen as ‘low – risk’, such as housewives. In 1998, one author wrote:

“ HIV infection is now common in India; exactly what the prevalence is , is not known , but it can be stated without any fear of being wrong that the infection is widespread… it is spreading rapidly into those segments that society in India does not recognize as being at risk. AIDS is coming out of the closet”

The HIV/AIDS epidemic in India is characterized by heterogeneity; it seems to be following the type 4 pattern, where the epidemic shifts from the most vulnerable populations (such as women in prostitution, IDU, MSM) to bridge populations (clients of women in prostitution, STI patients, Partners of drug users) and then to the general populations. The shift usually occurs when the prevalence in the first group exceeds 5 %, with a two – three year time lag between shifts from one group to another.

The spread of HIV within the country is as diverse as the societal patterns between its different regions, states and metropolitan areas.. The transmission route is predominantly heterosexual (85.7%), of except in the North Eastern states where injecting drug use is the main route of HIV transmission. A significant increase in injecting drug use, with drug – users switching from inhaling to over-the –counter injecting drug has occurred over the past years. The other routes of transmission by order of proportion includes perinatal (3.6%) infected needles and syringes (2.4%).
unsafe blood and blood products (2.0%) and unspecified and other routes of transmission (8%)

By 2000 HIV had spread extensively throughout the country. In 1990 there had been tens, THE MOST RECENT of thousands of people living with HIV in India; by 2000 this had risen to millions. (NACO 2002 – 2004)

In 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people living with HIV in India than in any other country in the world. However, the new 2006 estimates released on 06 July, 2007 by the National AIDS Control Organisation (NACO), supported by UNAIDS and WHO, indicate that national adult HIV prevalence in India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV in the country. These estimates are based on an expanded surveillance system and a revised and enhanced methodology.

Some AIDS activists are doubtful of the suggestion that the situation is improving, though:

“It is the reverse. All the NGO’s I know have recorded increases in the number of people accepting help because of HIV. I am really worried that we are just burying our head in the sand over this.”

Anjali Gopalan, the Naz Foundation, Delhi,13 Dr. Anubami Ramadoss, Union Minister for Health and Family Welfare said, “Revision of estimates based on more data and improved methodology marks a significant improvement in systems and capabilities to monitor the spread of HIV, a sign of the progress we have made in understanding the epidemic better. This is welcome progress. Unfortunately, the new figures still point towards a serious epidemic with the potential to trigger off if the prevention efforts identified in the NACP III are not scaled up rapidly and implemented in the desired manner. We must remember that India has nearly 30 lakh people living with HIV. These people are facing stigma, discrimination and irrational prejudice everyday of their lives and need all our support and understanding.” The Minister called upon his colleagues in the medical profession and civil society organizations to fight stigma and discrimination.

Resulting from a more robust and enhanced methodology, the revised estimates will be used to improve planning for prevention, care and treatment efforts. “While it is good news that the total number of HIV infection is lower than previously thought, we cannot be complacent. The steady and slow spread of the HIV infection is a worrying factor. The better understanding of India’s epidemic has certainly enabled us to have more focused HIV prevention and treatment strategies and more effective deployment of resources.” said Mr. Naresh Dayal, Secretary Health and Chair of National AIDS Control Board.

The new methods developed for the revised estimates has also been used to “back – calculate” the prevalence for years since 2002 based on a new set of assumptions and measures. These figures allow a fair comparison of year-on-year trends in HIV prevalence. They show an epidemic that is stable overtime with marginal decline in 2006.
There is lot of skepticism among the civil society regarding the methodology and the reduced estimates.

Commenting on the new estimates and guarding against their misinterpretation, Sujatha Rao, Additional Secretary and Director General, National AIDS Control Organisation said, “The calculation of figures for several years, using the new model helps us understand that the new lower estimates do not mean a sharp decline in the epidemic.” Cautioning against an easing off the momentum of the HIV response she added, “Using a similar methodology led to downward revision in estimates in some countries such as Zambia and Rwanda. We will convince all stakeholders to stay energized and to retain the hard-fought gains of the last decade.”

Showing confidence in the commitment of the Indian leadership, Dr. Denis Broun, UNAIDS Country Coordinator said, “The trends evident from the latest estimates validate India’s national AIDS strategy. Taking encouragement from the new lower estimates the national authorities should increase the strength of their HIV programme. We must scale-up efforts to reach universal access to HIV prevention, care and treatment. Though the proportion of people living with HIV is lower than previously estimated, India’s epidemic continues to be substantial in numbers. Despite the lower prevalence estimate the cost of prevention efforts required to control the epidemic remains the same.”

While overall, the HIV epidemic shows a stable trend in the recent years, there is variation between the states and population groups. Tamil Nadu and other southern states with high HIV burden where effective interventions have been in place for several years, HIV prevalence has begun to decline or stabilise. However HIV continues to emerge in new areas. The 2006 surveillance data has identified selected pockets of high prevalence in northern states. There are 29 districts with high prevalence, particularly in the states of west Bengal, Orissa, Rajasthan and Bihar. The 2006 surveillance figures show an increase in HIV infection among several groups at higher risk of HIV infection such as people who inject drugs and men who have sex with men. The HIV positivity among Injecting Drug Users (IDUs) has been found to be significantly high in metro cities of Chennai, Delhi and Chandigarh. Besides, the states of Orissa, Punjab, west Bengal, Uttar Pradesh and Kerala also show high prevalence among IDUs. While data does suggest that HIV prevalence levels are declining among sex workers in the southern states, overall prevalence levels among this group continue to be high, necessitating a scaling up of focused prevention efforts among these groups. “Only by controlling the epidemic among the vulnerable groups can the dynamics of the epidemic be broken.” Sujatha Rao, Additional Secretary and Director General, NACO.

The vast size of India makes it difficult to examine the effects of HIV on the country as a whole. The majority of states within India have a higher population than most African countries, so a more detailed picture of the crisis can be gained by looking at each state individually. The HIV data for most states is established through testing pregnant women at antenatal clinics. While this means that the data are only directly relevant to sexually active women, they still provide a reasonable indication as to the overall HIV prevalence of each area. The following states have recorded the highest levels of HIV prevalence at antenatal and Sexually Transmitted Infections (STI)
clinics over the recent years. (NACO 2006) Data for six states are also available from the National Family Health Survey III (2005-06, September 2007)

Andhra Pradesh

Andhra Pradesh in the southeast of the country has a total population of around 76 million, of whom 6 million live in and around the capital city of Hyderabad. The HIV prevalence at the antenatal clinics was around 2% in both 2004 and 2005 – higher than in any state – while the general population prevalence was 0.9% in 2005 – 2006. The vast majority of infections in Andhra Pradesh are believed to result from sexual transmission. HIV prevalence at STI clinics was 22.8% in 2005.

Goa

Goa is a very small state in the southwest of India, and is best known as a tourist destination. Tourism is so prominent that the number of tourists almost equals the resident population, which is about 1.3 million. The HIV prevalence at antenatal clinics was found to be above 1% in both 2002 and 2004, but was 0.5% in 2003 and 0% in 2005. The variation is likely due to the small number of women tested; the 2005 survey included only two antenatal sites. Prevalence at STI clinics was 14% in 2005, indicating that Goa has a serious epidemic of HIV.

Karnataka

Karnataka – a diverse state in the southwest of India – has a population of around 53 million. In Karnataka the average HIV prevalence at antenatal clinics has exceeded 1% in recent years. Among the general population, 0.69% was found to be infected in 2005-06. Districts with the highest prevalence tend to be located in and around the capital city of Bangalore in the southern part of the state, or in northern Karnataka’s “devadasi belt”. The devadasi women are historically dedicated to the service of Gods. These days, this has evolved into sanctioned prostitution, and as a result many women from this part of the country are supplied to the sex trade in bigger cities such as Mumbai. The average prevalence among female sex workers in Karnataka was 18% in 2005.

Maharashtra

Mumbai (Bombay) is the capital city of Maharashtra state and is the most populous city in India, with around 20 million inhabitants. Maharashtra is a very large state of three hundred thousand square kilometers, with a total population of around 97 million. The HIV prevalence at antenatal clinics in Maharashtra has exceeded 1% in all recent years, and surveys of female sex workers have found rates of infection above 20%. Very high rates are also found among injecting drug users and men who have sex with men. The 2005-2006 survey found an infection rate of 0.62% in the general population of Maharashtra.

Tamil Nadu

When surveillance systems in the southern Indian state of Tamil Nadu, home to 62 million people, showed that HIV infection rates among pregnant women were rising –
tripling to 1.25% between 1995 and 1997 – the State Government acted decisively. Funding for the Tamil Nadu State AIDS Control Society (TANSACS), which had been set up, was significantly increased. Along with non-governmental organisations and other partners, TANSACS developed an active AIDS prevention campaign. This included hiring a leading international advertising agency to promote condom use. The campaign also dealt with the ignorance and stigma associated with HIV infection. The HIV prevalence at antenatal clinics in Tamil Nadu 0.88% in 2002 and 0.5% in 2005, though several districts have rates above 1%. The general population survey of 2005-06 found a rate of 0.34% across the state. Prevalence among injecting drug users was 18% in 2005. Tamil Nadu had reported 52,036 AIDS cases to NACO by July 2005, which is by far the highest number of any state. (UNAIDS 2000)

Manipur

Manipur is a small state of some 2.2 million people in the northeast of India. The nearness of Manipur to Myanmar (Burma), and therefore to the Golden Triangle drug trail, has made it a major transit route for drug smuggling, with drugs easily available. HIV prevalence among injecting drug users is above 20%, and the virus is no longer confined to this group, but has spread further to the sexual partners and their children (Infochange 2003). The HIV prevalence at antenatal clinics in Manipur has exceeded 1% in all recent years. The 2005-2006 survey found that 1.13% of the general population was infected – the highest of all states surveyed.

Mizoram

The small northeastern state of Mizoram has fewer than a million inhabitants. In 1998, an HIV epidemic took off quickly among the state’s male injecting drug users, with some drugs clinics registering HIV rates of more than 70% among their patients. In recent years the average prevalence among this group has been much lower, at around 5%. HIV prevalence at antenatal clinics has exceeded 1% in most recent years, but 0.88% in 2005.

Nagaland:

Nagaland is a small northeastern state with a population of two million, where injecting drug use has again been the driving force behind the spread of HIV. In 2005, the HIV prevalence at antenatal clinics was 1.63%, and the rate among injecting drug use was 4.51%

National Response:

The identification of HIV positive individuals in 1986 resulted in the Government of India forming the National AIDS Board in the same year, headed by the Union Health Secretary. The National AIDS Control Programme was launched in 1987. In 1989, the government prepared a medium term plan with WHO collaboration (1990-1992). This plan focused on Maharashtra, Tamil Nadu, Manipur, West Bengal, Mumbai, Chennai, Calcutta and Delhi, those states and cities considered the worst affected. Initial activities under this plan focused on the strengthening of programme management capacities, targeted information, education and communication campaigns and surveillance.
A five year strategic plan (NACP Phase I) was developed and approved by the Government of India in 1992 during the 8th Five Year Plan. The Phase I and Phase II of NACP, originally conceived to be a five year project, was extended for two more years and the second phase will end in March 2006. Planning for Phase III has already begun with multisectoral participation and greater involvement of people living with HIV/AIDS (PLHA).


The objective of NACP I was to initiate a major effort in the prevention of HIV transmission and reduce future morbidity, mortality, and the impact of AIDS. The project was implemented as a centrally sponsored scheme with cent percent financial assistance to the states and union territories from the government of India. At start-up, the limited national capacity to deal with HIV/AIDS called for a simple, realistic and flexible framework which included five basic components.

- Strengthening management capacity for HIV/AIDS control
- Promoting public awareness and community support
- Improving blood safety and rational use
- Controlling sexually transmitted disease
- Building surveillance and clinical management

Under the strategic plan, the National AIDS Control Board and the National AIDS Control Organisation (NACO) was set up in 1992 within the Ministry of Health and Family Welfare with full financial and administrative powers. Setting up of State/Municipal AIDS Cells was initiated in 1992-93. In 1994, NACO prescribed Societies as a model for all states/union territories, following the example of converting the Tamil Nadu State AIDS Cell into Tamil Nadu State AIDS Control Society in order to provide autonomy and flexibility in implementation of programmes.

The key lessons in the process of implementation that formed the basis for planning for Phase II of NACP included:

- At institutional level it recognized the need for participatory approach, decentralizing the programme to the state and municipal corporation level, advocacy and networking among various sectors.

- At the technical level it recognized the need for a multi-pronged approach in planning and prioritising programme interventions and dissemination of information to persons at risk. For effective control of the spread of the virus from people practicing high risk behaviour, it was realized that high level of coverage of vulnerable population through targeted intervention is required.
Creation of an enabling environment through policy advocacy and empowerment of marginalized groups is also needed for behaviour change and reducing stigma and discrimination. The need for high quality epidemiological and management information system was seen as an integral component for programme implementation.

- At operational level we learnt the need to address the differences in the performance of different states, need for a computerised financial management system, decentralized auditing system and an enhanced regional approach to the programme.

Although the strategic plan proposed (for the NACP I) was very good, operationalising it was not easy. The task was made more difficult by the failure of the program to generate commitment and a sense of urgency at various levels.”

At the conceptual level there were problems in defining the epidemic, in a way which would be understood and accepted and further also communicated to the general public.

There was inadequate staffing at various levels which reflected the low priority given to the program. However those officials who were acquainted with the epidemic were not given any systematic support or guidance which resulted in them relying on their own judgments that were not always beneficial to the program.

Those individuals who were ready to respond to the epidemic, were demoralized either by the long procedures/paperwork required for disbursement of funds, making utilization of vast funds difficult or the delayed and uneven procurement and distribution of essentials such as blood bank equipment, testing kits and even condoms.

Research in the initial stages epidemic was sparse and hence stretched to generalizations. Not only was there no consensus on the magnitude of the problem but also there was hesitancy on the part of NACO to support research findings that are counter to prevailing cultural notions. This all eventually resulted in the strengthening doubts about whether there was a problem at all. Finally, the approach was based on the assumption that the program knew what was best and thus obviously disregarded other underlying developmental factors such as poverty and gender inequalities based on class and caste.

Besides these shortcomings there were many gaps in the basic program. One of the biggest gaps was the absence of human rights. “There have been innumerable instances when health care providers, both within and outside the government system, supposedly trained to deal with HIV/AIDS have refused treatment to, or have been negligent, rude and discriminatory towards patients; ........ or where children have been denied education because their parents are HIV positive.” At the initial stage of the epidemic an effort was made to set up a committee which would look into the legal and ethical issues around HIV/AIDS, however this effort did not see the light of the day.

The proposal for the Phase II of NACP which was formulated through a participatory process was implemented in all the 35 States / Union Territories and three Municipal Corporation - owing to the vastness of the state and the population of the cities within the states it was decided to open District State AIDS Control Societies (DACS) apart from the State AIDS Control Societies (SACS) for the cities of Ahmedabad in the state of Gujarat, Chennai in Tamil Nadu and Mumbai in Maharashtra. Based on the different stakeholder consultations at the state level, state Project Implementation Plans (PIP) were developed that were collated to develop the national PIP. The Two key objectives of NACP II were:

- To reduce the spread of HIV Infection &
- To strengthen India’s capacity to respond to HIV/AIDS on a long term basis

Thus greater emphasis was places on targeted interventions for highly vulnerable population, preventive interventions among general population, low cost AIDS care, institutional strengthening and inter-sectoral collaboration. The NACP II aimed at:

- Shifting the focus from awareness raising to changing behaviour through targeted intervention
- Decentralization of flexible, need- and evidence based delivery
- Encouraging voluntary counseling and testing
- Supporting structured and evidence based annual reviews and operational research and
- Encourage management reforms for SACS and procurement practices

The key lessons learned from NACP- II include - saturation of coverage of highly vulnerable groups through TI, aggressive condom promotion including social marketing, greater focus on vulnerable states with poor health indicators, need for capacity building of NACO and SACS and continuity in staffing, strengthening monitoring and evaluation mechanisms at all levels, duplication and scattered response by stakeholders, greater attention to MSMs and IDUs, integrating prevention, care and support, need for greater focus on youth, developing effective partnership with the private sector for STD control, tackling stigma and discrimination more effectively.

Policy initiatives taken during NACP II include: adoption of National AIDS Prevention and Control Policy (2002), National Blood Policy, Strategy for Greater Involvement of People Living with HIV/AIDS (GIPA), launching the National Rural Health Mission (NRHM), launching of the National Adolescent Programme, provision of Anti- retroviral treatment (ART), formation of an inter- ministerial group for mainstreaming and setting up of the National Council on AIDS, chaired by the Prime minister (NACP – III, NACO- 2007)
A nationwide program on prevention of parent to child transmission of HIV was launched. But the fact that a large majority of pregnant women go to private hospitals, nursing homes and antenatal clinics was overlooked in the PMTCT. There was also no clear cut policy for non PPTCT sites, which includes private hospitals, and government hospitals at the primary and secondary levels with respect to referrals for HIV testing and counseling.

The NACP II has shown strong will and commitment in terms of using mass media strategies for creating awareness and prevention. But within mass media women, traditional folk lore and songs seem to have taken a backseat to be replaced by wry humor and up market slick packaging for key messages across mass media, which usually target the male.

In the area of training, NACP II provided extensive training programs as a result of which a good amount of persons are available at the district level for the implementation of the program. But experience showed that there was a huge time gap between training given to the team and actual initiation of the program. Also a “one size fits all” approach has been used which has adversely affected the program. There existed a lack of coordination at the district level.

Focused interventions with groups of people such as sex workers, truck drivers, and intravenous drug users have helped to a great extent in preventing the spread of diseases and keeping the overall prevalence low. These groups are part of the general population but the NACP II disregarded this fact and treated them as separate entities which further stigmatized the group and undermined the very process of prevention. Also addressing only the prevention side made the program lopsided.

NACP Phase III (2007 – 2012)

Based on lessons learned and achievements made in Phase I and II, the NACP III was launched in the year 2007. The NACP III has evolved through a year long preparatory process that included wide ranging consultations through 14 working groups, e forums, and civil society organizations, PHLA networks, NGOs/CBOs, national expert groups, development partners and the World Bank led appraisal team. All this has led a consensus about the goals, objectives and overall framework of the NACP III. The primary goal of the NACP – III is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care & Support and treatment. This will be achieved through four stages namely:

- Prevention of new infections in high risk groups and general population through saturation of coverage of high risk groups with targeted interventions and scaled up interventions in the general population.
- Providing greater care & support and treatment to a larger number of people living with HIV/AIDS
- Strengthening the infrastructure, systems and human resources in prevention, care and support and treatment program at the district, state and national levels
- Strengthening a nationwide Strategic Information Management System
The NACP III also incorporates the Three Ones Framework – *One agreed action framework, One HIV/AIDS coordinating authority and One agreed National Monitoring and Evaluation System*. The thrust area for NACP III is to move from program mode and changing the role of NACO from implementing agency to program catalyst. A special attention is drawn towards mainstreaming and partnership development.

The inclusion of the results of the recent National Family Household Survey 3 (NFHS 3) (the National Family Household Survey was conducted in 2005-06) in the estimation process contributed significantly to the revised estimates. Over 100000 people were tested for HIV in the survey which was the first national population based survey to include a component on HIV. (NFHS3, 2007)

In addition India has expanded its HIV sentinel surveillance system in recent years and the number of surveillance sites has increased from 155 to in 1998 to 1120 in 2006. Data from pregnant women attending antenatal clinics, people attending sexually transmitted infections clinics and population groups that are at a higher risk of exposure to HIV are included in the surveillance. Prevalence rates vary greatly between states and regions. Even in the four southern states (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) where the large residing, HIV prevalence varies and the epidemic tends to be concentrated in certain districts. An earlier analysis of sentinel surveillance data also showed that HIV prevalence was about five times higher than in northern states in 2000- 2004. However pockets of HIV prevalence (mainly among population groups at high risk of exposure to HIV) have also been identified in states where overall prevalence is generally low, warning against complacency.

Data from expanded 2006 sentinel surveillance show stable or declining prevalence among pregnant women in Tamil Nadu, Maharashtra, Karnataka and Andhra Pradesh, but high HIV prevalence among drug users and men who have sex with men in a few states. In the north east, where the use of drug injecting equipment is a key risk factor, HIV appears to be spreading mainly as a result of unprotected sex between sex workers and their clients, and their respective other sex partners.
CHAPTER V: Civil Society Response

V: A: Non Governmental Organizations Pave the Way

While government efforts in India have not moved beyond planning, NGO’s through their community-based programs have found ways to approach reproductive health from a broader perspective.

The civil society response has been varied in the field of reproductive and sexual health. At one level civil society organizations have responded where the Government program has failed to reach or has been ineffective like OPD services in urban slums, interventions with school drop outs and sexual minorities. At another level, the CSO’s have been innovative in their interventions and have set an example as well as parameters for the government to follow like those of home based care, rights of sexual minorities and sex workers. Some of the organizations that have either been pioneers or have developed innovative interventions in the field are: The Institute of Health Management (Pune), Lawyers Collective (Delhi), Masum(Pune), Naz India Foundation(Delhi), Tarshi(Delhi), Sangama(Banglore) and Darbar Mahila Samkya Committee(Kolkata).

These civil society organizations have been networking with each other and have been able to successfully make a difference in the lives of the communities. However the reach of the CSO’s is limited and hence a majority of the population is still left out. The government has failed to make any linkages with the CSO’s and thus what could have been a fine balance of reach and effectiveness is missing.

The interventions of the CSO’s range broadly in areas of the absence of reproductive and sexual health services in the urban areas, life skill education for adolescents with focus on HIV/AIDS, involvement of men in reproductive health, counseling, advocacy, sexuality and sexual minorities and the target free approach.

Some of the programs that CSO’s have implemented in these areas are:

- A life skills program for adolescents with focus on school drop outs and working girls.
- Youth federation for AIDS prevention through which the CSO, mobilises people for various activities, and campaigns against the spread of AIDS.
- A feminist health centre to educate women about STD’s, HIV and AIDS, where women are encouraged to talk about their sexuality. A Rational Drugs Counter, which sells basic drugs under their generic names for low costs. Condoms are also distributed free. Attached to the drugs counter is a Pregnancy Care Center,
- Advocating for measures that secure sex workers' right to live with dignity and right to health, safety and livelihood, to be free of violence and free HIV infections. A project to draft legislation tackling HIV/AIDS and issues surrounding it and simultaneously works to influence the government’s health policy.
- Sensitizing the government to different issues related to the epidemic include the amendment of Section 377 of the Indian penal code commonly known as
the ‘Anti sodomy Law’. This act criminalizes same sex sexual behavior irrespective of the consent of the people involved thereby proving to be one of the most significant barriers in effective HIV/AIDS interventions with sexual minorities.

✓ In December 2002, the CSO filed a Public Interest Litigation (PIL) to challenge section 377 of the Indian Penal Code in the Delhi High Court

✓ Projects that work directly with the MSM community and the trans gender community. 17

✓ The Home Based Care Program to address the need for services and support to families with one or more member living with HIV.

✓ Encouraging new leaders in the area of sexuality.

✓ Setting up and enhancing the quality of helpline services on issues relating to sexuality;18

✓ HIV has a serious impact on the lives of Hijras, Kothis and Doubledeckers (HKD).there are programs that works to reduce the HIV incidence among these constituencies.Additionally, they connect people to the Drop-in-Centers (DIC).

✓ Establishing sexworkers Union that are affiliated with New Trade Union Initiative (NTUI), a federation of independent trade unions. Efforts are being made to create an all India sexworkers union.

✓ National Campaign for Sexuality Rights(NCSR) is a nation-wide campaign working for sexuality rights and the rights of sexuality minorities in India. The campaign is collective effort of groups, movements, individuals and organizations from all over India. At present NCSR has more than 50 organizations as part of its collective process. It raises issues related to sexuality minorities rights issues on different platforms from local to national and international levels (World Social Forum, Karnataka Social Forum, Bangalore Social Forum, International Womens Day, May Day, Human Rights Day, World AIDS Day, National Womens Conference etc...). At present, the campaigns primary focus is on repealing Section 377 of the Indian Penal Code (IPC), which criminalizes adult consensual non-reproductive sexual practices.

✓ Programs that implement STD/HIV intervention among street-based sex workers and their clients. 19
Chapter VI: The Government of India’s response on the UNGASS Goals of Sexual and Reproductive Health.

Goal 54 – Prevention

“By 2005, reduce the amount of HIV infected breast fed babies in about 20%, and by 2010 in about 50% offering to 80% of all pregnant women prenatal services with information, psychological support, and other HIV prevention services, growing the availability of efficient treatment to reduce the transmission of the virus from mother to child and giving access to treatment for HIV infected women and babies, and offering access to treatment for HIV infected women that should include psychological support and the voluntary and confidential testing services, access to treatment, particularly the antiretroviral therapy and, when appropriate, to the substitute of breast milk, and a continuous series of attention services.”

Issues related to this indicator:

It has been estimated that out of 27 million pregnancies in India, nearly 189,000 occur in HIV-positive mothers, leading to an estimated cohort of 56,700 infected babies). PPTCT program using Nevirapine was initiated in the country in 2001. However, by 2004, only 3.94% of all pregnant women received HIV counseling and testing, and only 2.35% of the HIV-positive pregnant women received antiretroviral drug prophylaxis. PPTCT program has been scaled up in the country with Nevirapine as the regimen of choice. With single-drug regimen, there has been a reduction of perinatal transmission of HIV from 40% to 11-13%. With effective ART, elective cesarean section and exclusive breast feeding, it has fallen to 2%. Although the regimen is simple to deliver and has an efficacy rate of 48% in prevention of HIV transmission in the mother-baby pair, data suggests that there is increased drug resistance to ART in mothers who were treated with prophylactic single-dose Nevirapine. A preliminary report from South Africa suggested that reducing viral replication by combining single-dose Nevirapine with postnatal AZT/3TC may lower Nevirapine resistance in women to about 10%.

The PPTCT programme in India is the only entry point for women in the programme. However the focus of the programme is primarily on the prevention of the infection to the children with very little involvement of the husband or partners. The programme does not go beyond the aspect of prevention to look into aspects of rights of the women to that extent even well being, health or nutrition of the woman. There have been reported incidence of discrimination and violence as the infection is first deducted among the women. There has been increasing concern within the civil society regarding possibility of Nevirapine resistance among women.

In India, an estimated 21 percent of the over 5 million people living with HIV are women of reproductive age. The national prevention of parent-to-child transmission program (PPTCT) looks to antenatal care (ANC) as an entry point to preventing HIV transmission from mother to child. But does the program also serve as an entry point to other key HIV and reproductive health services for HIV-infected mothers and their
children? To explore the extent to which these services are linked, researchers from Horizons and two Indian NGOs conducted a study in three high prevalence states (Andhra Pradesh, Karnataka, and Manipur). A total of 41 in-depth interviews and 268 structured interviews were held with HIV-positive pregnant and postpartum women (0–24 month’s post-delivery) who had received PPTCT services. In addition, 32 service providers and program managers of public sector and NGO-run PPTCT programs were interviewed. When asked about their HIV testing experience, almost 70 percent of women interviewed said they were first tested during ANC. A very high proportion of the women’s husbands had also undergone HIV testing, generally after their status was detected. Almost all of the women reported that their ANC providers informed them of medication they could take to reduce risk of HIV transmission to their child. A large majority of postpartum women reported taking the medication as recommended: 60 percent took Nevirapine and 21 percent were on AZT; one-tenth did not remember if they took any medicine. Among the women who did not take any medicine (8 percent), most indicated that it was because they had delivered at home and visited the clinic after giving birth. The vast majority of postpartum women (82 percent) reported that their babies had received syrup medication. Six percent reported that their infants did not receive the medication and 8 percent did not remember. Only 42 percent of the youngest and second-youngest children of the 211 women with living children had been tested for HIV. The children of 20 of these women had tested HIV-positive and about half were informed about antiretroviral therapy (ART) for their child. Only two women reported that their child was currently on ART. Among postpartum women, 87 percent did not want to have another child. However, among these women, only 44 percent reported using condoms and 6 percent reported having had a sterilization operation. Four out of ten women who did not want more children were not using any family planning method to prevent unintended pregnancies. Although about 40 percent of the women were aware of treatment for HIV, only 18 percent mentioned that their PMTCT provider had informed them about it and only one-third were told about CD4 testing. Furthermore, only 7 percent of women were currently on ART and only two women stated that their PMTCT providers referred them to the treatment facility. Results from this study indicate that HIV-positive women who are receiving services in an ANC setting have unmet needs for sexual and reproductive health care and treatment services. PPTCT programs need to understand these women’s fertility intentions and provide appropriate information on family planning methods. Also, despite the fact that free treatment is provided through the public sector, most of the women were not informed about treatment facilities or the need for CD4 testing. Linkages between PPTCT services and HIV care as well as family planning services need to be strengthened and providers need to be trained to make appropriate referrals to vital services.

Goal 62 – Reduction of Vulnerability

“By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behavior and injecting drug use, have in place in all countries strategies, policies and programmes that identify and being to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/ or commodities for self-
protection, and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set target for achievement”.

Issues related to this indicator:

In June 2007, the US Department of State released the 'Trafficking in Persons Report', which placed India on the Tier 2 watch list for the fourth year in a row for failing to effectively combat trafficking. India was actually a borderline case. Had Deputy Secretary of State John Negroponte had his way, India could have very well been a Tier 3 country, meaning worst offender, but Secretary of State Condoleezza Rice intervened and agreed to undertake a special evaluation in six months' time. That deadline expires this December. Consequently, the National AIDS Control Organisation (NACO) has been campaigning via the public media to present India's unfailing commitment to combating trafficking. However, these 'well meaning' efforts have only resulted in a raw deal for sex workers. Two recent anti-trafficking campaigns by MTV and the UN Office on Drugs and Crime (UNODC) perpetuate the image of the sex worker as the agency-less trafficked woman. A list of anti-trafficking organizations in India has been provided on EXIT's portal, but the work of sex workers' collectives - Self Regulatory Boards (SRBs) of the Durbar Mahila Samanyaya Committee (DMSC), Kolkata, and the Mohalla Committees of Veshya Anyay Mukti Parishad (VAMP), Sangli, which are internationally recognized models for anti-trafficking work - is not mentioned. Is it so difficult to imagine that sex workers can also articulate the right to sex work as strongly as their right against trafficking and exploitation? Disturbed by the UNODC campaign - which also stated that India is among the top human trafficking destinations in South Asia, with over 35,000 young girls and women from Bangladesh and Nepal being brought here every year - both DMSC and VAMP have responded strongly. In an open letter, the DMSC alleged that these statistics were merely anecdotal, and that the anti-trafficking strategy of UNODC does not make sex workers stakeholders in the campaign. "Being engaged in anti-trafficking programmes in West Bengal for the last 12 years we know the inner workings/strategies of the traffickers. Without sex workers' participation, trafficking cannot be stopped - SRBs are a conclusive example of this. We run 30 SRBs across the state. We can immediately ascertain whether a newcomer has come willingly or has been trafficked. If she is trafficked, we send her back home... the local stakeholders and the police have developed a strong network and under our vigilance a trafficker, however well-connected, cannot escape," DMSC's letter states. Meena Seshu of VAMP says, "They will have to accept that the community can actually identify and address violations it faces - with or without outside help. History has recorded that generations of outsiders and outside interventions have tried but failed miserably. Be it the SRB or the VAMP Mohalla Committees, we need to recognize and be encouraging of their smallest successes."

One of the major sources that fuel this tension between sex workers and anti-trafficking work is the US government's policy on HIV/AIDS and trafficking. Governments in India and the Global South have been required to take cognizance of the 2003 United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act (Global AIDS Act) and the Trafficking Victims Protection Reauthorization Act. The
US Global AIDS Act bars the use of federal funds to "promote, support, or advocate the legalization or practice of prostitution". A report by the Centre for Health and Gender Equity in the US points out: "Organizations receiving US global HIV/AIDS funding also must adopt specific organization-wide positions that explicitly oppose prostitution and trafficking. Such funding restrictions force organizations working in public health from Southern countries that heavily rely on US funding to comply with an ideological litmus test that often runs counter to both public health practice and human rights standards." In 2005, when it returned a $12,000 grant from USAID (the US frontline funding agency), because it did not wish to be bound by such conditions, VAMP was falsely accused of engaging in child trafficking. Anti-trafficking policy and campaigns have always tended to wrongly collate trafficking and sex work based on the assumption that trafficked women are always forced into sex work. But it overlooks many other occupations that the trafficked women may take up; it denies women the agency they can exercise to migrate on their own; and it does not address the violence and abuse they might face in the process of being trafficked. Moreover, anti-trafficking measures seldom privilege the experiences of sex workers - who collectively also combat trafficking - to devise policies. Sex workers are also wrongly identified as the primary vectors for the spread of HIV/AIDS. The idea is to stop HIV/AIDS from leaving the 'bodies' of sex workers, and, through married male clients, reaching the wives and the family. While there are mandatory health check-ups of sex workers to safeguard families, there are hardly any measures to create enabling and safe working conditions for sex workers.

Immoral Traffic (Prevention) Act 956 (ITPA) is the principal Act which deals with sex work in India. The present framework is far from perfect and sex workers continue to be harassed at the hands of the police. However, to add to the already existing woes of sex workers, the Ministry of Woman and Child Development has proposed certain amendments to the Act, which can only have a detrimental effect to the problem at hand. While the objective of bringing in an amendment to already existing laws is to improve the law and make it more in sync with existing conditions. In this case however, it seems to be moving in the opposite direction. In the amendments proposed by the MoWCD (Ministry of Women and Child Development) all sex workers are regarded as trafficked victims and there is no space for those who choose to work in this profession voluntarily. Sex workers may have gone it not the profession due to poverty or any other reason but as a result, can they also be treated a trafficked? The provision that has proved to be the most controversial in the existing debate over the amendments is the one, which seeks to criminalize clients. The understanding seems to be to kill the demand and therefore stop the supply. The obvious impact of this move is apprehended to adversely impact sex workers' livelihoods, drive them underground and severely hamper the HIV intervention, which has taken years to stabilize and make a difference in the lives of sex workers. In an effort to placate the sex workers the MoWCD has also suggested removing the provision which criminalizes soliciting in public places by sex workers but the effects of this positive move can well be negated by bringing in other detrimental provisions. The sex workers federation and HIV intervention program which work for their rights have opposed these amendments. As a result of this, the proposed amendments were referred to Parliamentary Standing Committee (PSC). The PSC received both written and oral submissions from the concerned stakeholders. Based on these submissions the PSC brought out recommendations on the proposed ITPA amendment bill 2006.
which highlighted the fact that the Act should be reviewed in its entirety and the proposed amendments adverse impact on the public health aspects. However MoWCD failed to incorporate the recommendations of PSC and made minor changes in the proposed amendments. The revised bill was tabled in the cabinet for approval. Some of the cabinet ministers strongly opposed the proposed amendments raising concerns about the impact of the amendments. Major areas of concern were the impact on community and HIV intervention programmes currently run by National Aids Control Organization (NACO).n light of the disagreement or absence of consensus among the cabinet members the bill has been referred to the Group of Ministers (GoM) for further review of the bill. The GoM have already met once and are expected to come out with their recommendation on the Immoral Traffic (Prevention) Act 1956 soon. The proposed amendments has seen the community and stakeholders react very strongly and publicly. It remains to be seen whether the government can react positively to their demands and address their concerns adequately.24

Goal 63 – Reduction of Vulnerability

“By 2003, establish and /or reinforce strategies, norms, and programs that recognize the importance of the family to reduce vulnerability, among other things, educating and orienting children, and that takes in consideration the cultural, religious, and ethical factors in order to reduce vulnerability of children and youth with the secured access to primary and secondary schools, with study programs for adolescents that include HIV/AIDS; protected and safe surroundings, specially for girls; broadening good quality services of information, sexual health education, and psychological support for youth; strengthening of sexual reproductive health programs, and the inclusion, as much as possible, of the families in the planning, execution, and evaluation of HIV / AIDS attention programs.”

Issues related to this indicator:

The HIV/AIDS programme in India is largely administered through the Health Care System and is riding on a public health system that is weak where the government contribution is reducing and private players are taking over. The health care system including the public health care system in India is not conceptualized on a rights and entitlement framework. At the same time the health system is not sensitized and equipped to deal with marginalized communities. At another level there is a disconnect between the Reproductive and Child Health Programme, the National Rural Health Mission, Family Planning Programme and the HIV/AIDS programme which are all run as vertical programmes within the health system. At the programmatic level the National AIDS Control Programme is not embedded on a rights framework rather the focus is largely prevention and disease control. Given this backdrop there are very little or no spaces for using the concept of family or developing strategies of family involvement. Further more the presence of a concentrated epidemic has lead to an exclusive focus on targeted intervention with women in prostitution, Men who have sex with men, Intravenous Drug Users leaving out a whole range of populations like men, women and youth. There is very little or no entry point for women in the service delivery system other than the PPTCT programme, where once again the focus is only on the women and very little or no
involvement of men in the programmes. The husband or partners of the women who are detected positive were referred to the Voluntary and Counseling Testing Centers for testing and counseling until 2006. The Integrated Counseling and Testing Centers have been introduced in March 2006 to take care of this disconnects.

Questions that assess the acceptability of providing information in schools on HIV/AIDS and related family life topics were included for the first time in National Family Health Survey III (NFHS III). NFHS III asked all respondents whether they thought that boys and girls in school should be taught about the following topics: moral values, changes in the bodies of boys and girls at puberty (including menstruation), sex and sexual behaviour, contraception, HIV/AIDS, and condom use to avoid sexually transmitted diseases. For each of these topics respondents were first asked whether they believe the topic sold be taught in school. Women and men were asked these questions separately for boys and girls.

HIV/AIDS is a topic which majority of women and men agree should be taught in school: almost two out of three women (63%) and more than four out of five men (81%-82%) say that this topic should be taught to both boys and girls. However, women who agree are most likely to say that the topic should be first taught to children when they are a least 16 years old (42-43%) and somewhat less likely to say that it should be first taught to children age 13-15 years old. Men by contrast are slightly more likely to say that it should be first taught to children when they are 13 - 15 years old than when children are 16 years or older. Topics related to HIV/AIDS are sex and sexual behaviour and condom use to avoid sexually transmitted diseases. Even for the teaching of these topics, although the approval is somewhat lower than for the other topics being taught in school and approval is even higher among men at 62% for teaching about sexual behaviour and 68-70% for teaching condoms. For these topics too, the favored age at introduction of the topic is 16yeras or older. However, among both men and women, a significant proportion also feels that they can be taught at ages 13-15.

About half of women approve of teaching girls about contraception and somewhat less approve of teaching boys (42%) about contraception. A majority of those who agree say that the topic of contraception should be first taught when children are at least 16 years old. By contrast, about two thirds of men say that contraception should be a topic taught in school. However as is the case for women, most men who approve of teaching about contraception in school say that it should be taught when children are 16 years or older.

In the states of Bihar, West Bengal, Assam and Rajasthan less than half of the women approve of teaching this topic to girls and boys in schools. Among men, approval for teaching girls and boys about HIV/AIDS is 70 % or higher in 24 states. The only states where the percentage is below 70 for both boys and girls are Jharkhand, Orissa, W Bengal, Assam and Meghalaya. Even in these states, however, about two-thirds of men and approve.

Approval of teaching of sex and sexual behaviour in school and condom use to prevent sexually transmitted diseases are relatively low in several states, particularly women. Nonetheless, a majority of women approve of teaching the topic of sex and sexual behaviour to girls in 13 states and to boys in 10 states. A majority of women
approve of teaching about condom use to prevent sexually transmitted disease to girls in 11 states and to boys in 10 states. A majority of men approve of teaching sex and sexual behaviour, as well as condom use for prevention of STI, to girls and boys in almost all states. The only states where most men do not agree are Orissa, Assam and W Bengal.

Finally, the approval among women of teaching of contraception in school is relatively low in a large number of states, particularly for teaching the topic to boys. Overall, the majority of women agree that the topic should be taught in schools to girls in 14 states but to boys only in seven states. Approval of teaching this topic to girls and boys is lowest in Assam (19% and 15%) respectively. Approval among men about teaching contraception in school is quite high, however. The majority of men approve of teaching girls about contraception in school in 26 states and teaching boys about contraception in 25 states. Again men in Assam, Orissa and W Bengal have lower levels of approval.

The National AIDS Control Organisation (NACO) subscribes to the fact that empowering youth with age appropriate knowledge about the development of the body, sexuality and modes of transmission and prevention of sexually transmitted infections, and the means of maintaining a healthy and safe sexual life is important for the health and welfare of future generations, but is also a key to fighting the spread of HIV/AIDS. Accordingly a sex education program and syllabus has been developed by the Ministry of Human Resource Development, the National AIDS Control Organization, UNICEF and the National Council of Education Research and Training. The UNICEF manual was introduced in schools by the Ministry of Human Resource Development in 2004. However this manual has irked fundamentalist and conservative political groups across religious lines precisely the Rashtriya Swayamsevak Sangh (RSS) and the Shiksha Bachao Andolan Samiti. These groups demanded a ban on the manual.

The manual was introduced in State Boards in 11 states, who rejected the same, calling it explicit. The states of Gujarat and Madhya Pradesh were the first to ban it, followed by the state of Maharashtra, Rajasthan, Karnataka and Orissa. A lot of furor was created in all these states.

In Maharashtra, the members of the Parliament gheraoed the Education Minister Hassan Mushrifff and demanded an immediate ban on the books. Some members tore copies of the books.

Under fire from treasury and opposition benches, the minister also cancelled the adolescence sex behaviour program scheduled to be introduced from the next academic year.

According to members opposing the manual, they allege that the state government has been influenced by the West and by agencies like UNICEF which wanted sex education to be introduced from Class VI.

The manual was revised and is expected to come out with necessary changes by January 2008. The Rajya Sabha Committee of Petitions headed by M Venkaiah Naidu
decided in a meeting that National AIDS Control Organisation (NACO) should work jointly with Central Board of Secondary Education to come up with the revised manual.

The Naidu panel seized the issue on the basis of two petitions that Rajya Sabha had received from the public in which introduction of sex education at primary and secondary level for creating awareness about HIV/AIDS was claimed to be an absolutely ill-advised step. Petitioners from Maharashtra had also stated that the available literature published by UNICEF itself was not worthy of being used for teaching the students.

The manual will be put to field testing before being distributed.

“There is support and concern about these issues in the committee but it was felt that the manual could have been less explicit and obvious. The same issues will be addressed but the pedagogy and strategy would be different and better. We stand by the commitment that the adolescent issues need to be projected correctly but they will now be done in a subtle manner” said NACO Director General Dr. K Sujatha Rao.

It was also discussed by Central Board of Secondary Education chief Ashok Ganguly, joint secretary of Union ministry of human resource development (MHRD) SC Khuntia and Expressions India chief Jitendra Nagpal, on having only one manual for adolescent education. "It was discussed that there shouldn't be too many manuals for adolescent education. We would work with CBSE and Expressions India to bring out the revised manual," said NACO Director General Dr. K Sujatha Rao.

Recently, the CBSE-UNFPA manual, which had first come out in 2005, was also revised after receiving feedback from teachers. Words like masturbation, arousal and sexual intercourse were deleted besides few colorful diagrams describing the journey from puberty to young adulthood.

Ironically however sexual activity among children enjoys social sanction, thanks to the institution of child marriage. Even the government of India acknowledges this fact. The NFHS III accounts for more than half of all young women becoming sexually active by the age of 18. And almost one woman in every five gets pregnant by the age of 15. In some regions of India over 50% of women are married between the ages of 15-19 years.

A study conducted by FPAI among educated urban youth revealed that the average age when adolescent males had their first sexual experience was 14.8 years. Even if one chooses to disregard data about pre marital sexual activities among adolescents, the high rate of early marriages in India make it undeniable that there is a sexually active young population. Further more the School AIDS Programme can only reach out to children within the formal education system and largely leaves out street children or orphans.

Goal 64: Vulnerability Reduction

“By 2003, develop and / or strengthen national strategies, policies and programs, supported by regional and international initiatives, as appropriate, through a
participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise”.

Issues related to this indicator:

A smaller percentage of Hindu (61%) and Muslim (55%) women have heard of AIDS than women from other religions. More than three quarters of Sikh, Christian, Buddhist/Neo Buddhists and Jain women have heard of AIDS. A smaller proportion of scheduled tribe women have heard of AIDS (39%) than scheduled caste women (55%), women from other backward classes (59%), and women not belonging to any of these castes or tribes (73%).

Presently, NACP-III awaits the approval of the Cabinet Committee on Economic Affairs. It has already crossed various government processes supposedly instituted to ensure full scrutiny. Earlier, the Union Finance Minister, in his Budget speech, had declared a forthcoming programme for high-risk persons in every district of the country, making generous provisioning for HIV/AIDS. Despite its current turmoil, the World Bank on April 26 announced $250 million credit for NACP-III. The NACP-III investment plan of Rs11,585 crore constitutes five-fold-plus jump to intensify strategies and the implementation carried out during NACP-II that officially ended on March 31, 2006 (Now, retroactively covered by World Bank NACP-III). Interestingly, only Rs 8023 crore is within the national budget. Direct donor funding of Rs 3,562 crore is committed outside the government. To whom and for what is not clarified even in the Union Cabinet papers. At the same time, a government committed to downsizing will add 1371 new posts, plus 1200 contractual posts to service NACP-III, the quadrupling NACO staff. Ironically, NACP-II is currently being evaluated by a consortium of three agencies, including an American university. The nod to proceed with more of the same, therefore, precedes final feedback on a programme already seriously censured by the Public Accounts Committee and the Comptroller-General of Audits and Accounts. Expediently, directions to incorporate recommendations as available are given. Unfortunately, no one of consequence in the august corridors of power is asking questions. Not on the massive resources committed prior to end-evaluation (scheduled for several years earlier) nor on the absence of public disclosure/debate on evaluation findings integral to a democracy before forging ahead on a scale in a tricky societal area. Nor is there questioning on Rs 3562 crore committed outside the government by the Gates Foundation, the Clinton Foundation, bilateral/others, altogether 20 donor agencies, big and small. By now we are used to governmental cavalier in disregard of resources and priorities. Civil society’s conspicuous silence on this issue is curious. But then, stakes exist from Rs 800 crore already distributed during NACP-II to 1200 NGOs for the controversial Targeted Interventions for High Risk Persons (TIs) plus more through the donors permitted functioning outside government budgets/accountability. The huge funding commitment complacently shrugged off in government expenditure circles as “mostly not our money” and so implicitly a free lunch (an oxymoron) is earmarked for a roadmap based on numbers seriously challenged as almost half the NACO, UNAIDS, World Bank 5-6 million HIV-infected count in India. (Earlier, external agencies’
estimates scaled 20-30 million HIV infected by 2005-07!). The challenge on the estimate-size comes from diverse, including impeccable, sources this time. No less than the erstwhile global-HIV/AIDS surveillance chief of the WHO has unequivocally stated publicly: “HIV/AIDS figures in India will have to be drastically slashed as a result of more accurate data.” Dr James Chin provides insights on over-inflation of India’s HIV numbers, also that UNAIDS estimates across the world were grossly inflated; many African countries’ figures stand halved following new evidence underlining past miscalculations. The ground data from an extensive study in Andhra Pradesh’s high prevalence Guntur district by the prestigious Hyderabad-based Administrative Institute highlights a correction of 60 per cent in that district’s surveillance figures and, by extrapolation, nation-wide. Similar drastically lower levels are reflected in the data from over one lakh blood samples taken during the Third National Health and Fertility Survey findings that stand suppressed under re-analysis.

In 2000 when NACP-II commenced, the Independent Commission on Health, assisted by leading Indian epidemiologists, had documented NACO’s totally arbitrary assumptions/unjustified escalation of HIV infection estimates. Estimating the size of HIV-infected numbers is no idle number-crunching game but a basic scientific prerequisite for sound and accountable government policy design/direction. Therefore, it needs sorting out before NACP-III commences if more are not to become party to the scam of ever-higher budgets committed for dealing with what does not exist on that magnified scale. At the same time, the primary health care sector is so starved of resources as to be dysfunctional. Two-thirds of NACP-III’s Rs11,585 crore is for prevention and Rs2000 crore of the Government of India’s Rs2861 crore contribution on condoms alone. Topping operational targets described as “core indicators for monitoring NACP-III” is its central TI prevention package for high risk/vulnerable population — setting up 2100 collectives comprising one million women-in-prostitution, 1.5 million men-having-sex-with-men, 0.19 million injecting drug users and distribution of 3500 million condoms. Two major issues need flagging in this context. One, estimates of persons in high-risk sexual practices comprising NACP-III’s key operational targets are even more cavalierly estimated than overall HIV estimates. The Report of the Expert Group on High Risk Estimation — availed of under the Right to Information Act — is an eye-opener. The expensive “mappings” funded as a major NACP-II research activity are dismissed as “crude estimates”. Thereafter, arbitrary manifold number hiking takes place on the basis of untested assumptions and small studies. Thus, “mappings” of half a million women-in-prostitution escalates to 1.2 million. The extrapolation of men-having-sex-with-men is even more extraordinary: from mappings of just .01 per cent of the adult male population with homosexual experience the expert group accomplishes a swift climb, assuming 5 per cent of the two-thirds of all adult males in this category, one-fifth further assumed to have more than five partners, thus yielding 2.3 million men-having-sex-with-men more-than-five-men category. Operational targets are 80 per cent of such incestuous expert committee-based target sketching. Other ethical issues aside, serious issues arise on the fiscal and administrative integrity of ill-founded programming, consuming the lion’s share of the NACP-III resources. Two, despite explicit instructions to NACO from the HRD Parliamentary Standing Committee examining amendments to the Immoral Traffic Prevention Act-immoral traffic being inextricably linked with HIV/AIDS issues - to broad-based TIs to focus on rescue,
skill-building, rehabilitation and reintegration of prostituted persons, there is no provision. The sum-total currently available with the Women and Child Department to fund rehabilitation for all destitute/needy women and children in the country, including victims of immoral trafficking, is Rs22 crore. These figures illumine the mockery of rescue and rehabilitation efforts.

Rescue and rehabilitation is rendered untenable when faced with the onslaught of Rs800 crore-plus already disbursed, another nearly Rs3000 crore (not counting Rs2000 crore for condoms) available only for “non-judgmental” mobilisation and collectivisation of high-risk sex persons around the limited services package of condoms/ STD /ART referrals with society mandated to assist dignity in sex-sale activity, even to ensure “safe spaces” for “safe sex”.

GOAL 65 - Orphans.

“By 2003, develop, and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans girls and boys infected and affected by HIV/AIDS, including the provision of appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance’,

Issues related to this indicator:

Approximately 50,000 children below 15 years are infected by HIV every year. According to recent NACO statistics, this number has risen by another 10,000 and as per 2006, 60,000 children are born infected with HIV. However activists say that the actual number is approximately, 2, 50,000. Prior to the NACP III, there was no mention of children affected or infected by HIV/AIDS. NACP–III plans to improve this through early diagnosis and treatment of HIV exposed children; comprehensive guidelines on paediatric HIV care for each level of the health system; special training to counsellors for counselling HIV positive children; linkages with social sector programmes for accessing social support for infected children; outreach and transportation subsidy to facilitate ART and follow up, nutritional, educational, recreational and skill development support, and by establishing and enforcing minimum standards of care and protection in institutional, foster care and community-based care systems.

The Integrated Child Protection Scheme concretises the government/State responsibility for creating a system to protect children in the country. One of the key principles that underlie the ICPS approach is Intersectoral linkages and responsibilities. The principle states that child protection needs dedicated sectoral focus as well as strengthening protection, awareness and protection response from other sectors outside the traditional protection sector including in emergencies and HIV/AIDS.
The ICPS has classified children into 4 major groups: Child in need of care and protection; children in conflict with Law; Children in contact with law and any other vulnerable child. It is the latter (any other vulnerable child.) group that children infected and/or affected by HIV/AIDS are included.

The ICPS intends to provide for care and support services for children affected by HIV/AIDS. For this it has envisaged various strategies which are based on four parameters namely: Prevention, Protection, Awareness and Capacity Building and Research and Document. The strategies include, 'development of special packages for children abandoned on account of HIV/AIDS, ensuring a supportive and enabling environment for care and protection of children affected by HIV/AIDS. In order to provide protection, care and support to meet both psychological and material needs of these children and also those children vulnerable to HIV/AIDS, the scheme intends to support setting up of specialised shelter homes. These shelter homes shall create necessary infrastructure and promote all round development of children. Such homes shall have a child friendly atmosphere. The Scheme shall provide financial support for setting up shelter homes for children infected and affected by HIV/AIDS. The details are being worked out. The Scheme shall also support non-institutional care for children infected and affected by HIV/AIDS, which parts of the Sponsorship and Foster Care Placement program at district level.
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