

Addressing Sexual and Reproductive Health Issues of Young People in India: Ethical and Guiding Principles for Policies

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INTRODUCTION:

Young people, children and adolescents,² have always been the concern of society. This concern has been addressed in many ways. Programs have been formulated that care for the health, education, emotional and social well being of children. Laws and policies have been enacted to protect the needs of children as well as to ensure that their rights are fulfilled. Particular attention has been directed towards the vulnerable, those who lack the ‘safety net’ of the family or are placed in circumstances that place them at risk such as risk of acquiring HIV, facing stigma and discrimination, abusive relationships, trafficking, migration or living on the street. In different ways and together, government and civil society have been concerned about protecting and promoting the best interests of the child. Much has been written about what standards should be followed in this endeavor, implicitly stating that in working with children the highest ethical standards are needed.

This century has particularly challenged societies to address the devastation caused by HIV and because more and more young people are being affected by the pandemic there is an urgent need to address issues related to their sexual and reproductive health. These issues refer not only to the provision and access to information, skills and services but also how best to involve young people so that they learn to make choices that are safe and healthy. The inherent unequal nature of the relationship of adults who formulate policy and manage programs and the children and young people they work with and for suggests a need for guiding principles that both *empower and protect* children. It is this approach that particularly challenges policy makers, implementers and communities.

This discussion paper recognizes the extensive literature and experience related to the sexual and reproductive health and ethics of gathering information from young people. It does not attempt to summarize or critique this large body of available knowledge. Instead it discusses some pertinent issues that need to be addressed by policymakers, practitioners and civil society when working with young people and suggests some practical ways to address them. The paper argues that ethical and guiding principles are essential when working with young people in sexual and reproductive health (including HIV/AIDS) and discusses the many dilemmas and challenges associated with formulating and implementing them. Although this paper focuses on India, many issues resonate with those being discussed in other developing countries and in much of the international dialogue.

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² The paper follows the WHO definitions and uses the term ‘children’ for those under 18 years, ‘adolescents’ for those aged 10-19, youth for those aged 15-24 and young people to include those between ages 10-24.

This paper –

- Provides a summary of the sexual and reproductive health issues, including HIV, with young people in India
- Outlines relevant existing policy frameworks, international and national
- Identifies concerns and gaps in the national response
- Proposes a set of ethical and guiding principles for future policy dialogue and civil society debate and action.

BACKGROUND: A FOCUS ON SEXUAL AND REPRODUCTIVE HEALTH OF YOUNG PEOPLE

Increasing numbers and vulnerabilities

The need to address young people has never been so critical. It is a generation facing the greatest risk because of their sheer size and increasing vulnerability. Half the world's population is under the age of 25, about 1.7 billion youth aged 10-24 and another 1.2 billion aged 9 and younger following right behind. Most live in developing countries.³

Many definitions!

WHO defines *adolescents* as those between the ages of 10 – 19 years, *children* as any child below 18 years, *young persons* between ages 10 –24 and *youth* to ages 15-24. The term adolescent is essentially a Western concept indicating that children at this age have not assumed adult roles. However, many girls and boys in India are married or employed before the age of 18, both marriage and employment being indicators of adult roles. The terms “married adolescent” and “unmarried adolescent” are used widely but has inherent contradictions.

In India, the Census of India defines a child as below 14 years. For standard demographic data, social scientists include girls between the ages of 15-19 under the category of the girl child.⁴ The legal conception of the child varies from law to law. Policies also have no uniformity – the National Youth Policy includes the age group of 13 to 35 years, the National Health Policy 2002 talks only of children (and not young people) and the National AIDS Policy refers to youth between the ages of 15-25.

In this century, young people face one of the gravest challenges ever as they grow in a world of HIV/AIDS. More than 13 million children under age 15 have lost one or both parents to AIDS. A youth is infected with HIV every 14 seconds and youth and especially women account for nearly half of the new cases of HIV infection worldwide.⁵

³ UNFPA State of the World's Children 2003

⁴ Bajpai, Asha, 2003. *Child Rights in India*, India: Oxford Press

⁵ UNFPA, State of the World's Children, 2003

India has an enormous population of young people.⁶ About 21.4% of the total population in 1996 was estimated to be in the age group of 10-19 years.⁷ This demographic surge of young people however, also provides a window of opportunity to work with and understand the needs of young people.

Understanding the enormity of the problem in India⁸

Total population year 2000 (in thousands) **1,008,937**
Population ages 0-24 (% of total population) **52%**
Population ages 10-24 (% of total population) **30%**
Annual population growth rate **1.69%**
GNP per capita (PPP US\$, 1999)* **\$2,149**
Average births per woman 15-49 (TFR) **2.9**
Births to women ages 15-19 (as percent of all births) **9%**
Births to women ages 20-24 (as percent of all births) **40%**
Percent of 15-19 year-olds ever married (male/female) **10% / 36%**
Percent of 20-24 year-olds ever married (male/female) **40% / 83%**
Young married women (15-19) using any method of contraception (%) **8%**
HIV prevalence in females 15-24 **0.4 - 0.8%**
HIV prevalence in males 15-24 **0.1 - 0.6%**
Literacy among youth ages 15-24 (male/female) **79% / 59%**
Primary Gross Enrollment Ratio (male/female)** **109 / 90**
Secondary Gross Enrollment Ratio (male/female)** **59 / 39**

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.

** Total number of children enrolled for every 100 school age children,

A wide disparity on a number of development indicators exists between boys and girls and between urban and rural populations and challenges efforts to address them.

Young people are a diverse group

Children and adolescents, in India, form a very diverse group. About 78.4% live in the rural and the remaining (21.6%) in the urban areas. The mean age of marriage in the rural areas is 21.56 years for males and 16.67 years for females. More than 50% girls marry before age 18 and have at least one child by age 20^{9 10 11}.

⁶ Population Reference Bureau World Population Data Sheet 2003, Washington DC <http://www.prb.org/>

⁷ National Youth Policy, India 2000

⁸ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA. Sources: United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York:United Nations. World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank International Institute for Population Sciences (IIPS) and ORC Macro. 2000. *National Family Health Survey (NFHS-2), 1998-99*: India. Mumbai: IIPS.

United Nations Population Division. 2000. *World Marriage Patterns 2000*. New York: United Nations.

UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.

UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.

⁹ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA

Some children are especially vulnerable – street children, children of sex workers, trafficked children, children affected by HIV (having a parent or guardian living with HIV/AIDS or lost a parent to AIDS) and children infected with HIV. Away from the mainstream, these children face stigma and discrimination. Overall, girls are more vulnerable than boys because of their low social status, low self-esteem and poor access to education, information and services.

Young people are a distinct group and have a separate voice

Young people, children and adolescents are increasingly being understood as persons who need to be focused in their own right, having distinct needs that need to be addressed. This often means that traditional beliefs regarding young people have to be challenged and a unique ‘young people’ perspective developed that views them not as passive recipients of programs and policies but active participants deciding about their own life processes. A number of international events and instruments have helped to shape this thinking. (See next section)

“Will you be concerned with us for who we are now, not just for the adults we will become?”

Quote from In this Generation: Sexual and Reproductive Health Policies for a Youthful World, Population Action International

How big is the HIV/AIDS problem?

Accurate statistics regarding the HIV/AIDS epidemic in India has always been a bone of contention¹². The discrepancy is partly due to the difficulties in getting correct data with different states in India having different capabilities in doing so. For example, in 2002 the Government of India (GOI) and UNAIDS estimated that there were 4.58 million AIDS whereas the US National Intelligence Council (NIC)¹³ placed estimates between 5 and 8 million. Of these, 200,000 were said to be children below the age of 15. The number of AIDS orphans, children who have lost one or both parents, has not been measured but are estimated at 1.2 million children below the age of 15 years in India.¹⁴ Of the reported AIDS cases to date, those under age 30 represented 39.7 percent of cases.¹⁵

¹⁰ Indian Institute of Population Studies 2000. *National Family Health Survey II, 2000*. Mumbai, India: Indian Institute of Population Studies.

¹¹ Gupta, SD. 2003. *Adolescent Reproductive Health in India, Status, Policies, Programs and Issues*. Policy Project, India.

¹² Eberstadt, Nicholas. 2002. “The Future of AIDS.” *Foreign Affairs*. Nov-Dec 2002 Vol.81 Issue 6

¹³ US National Intelligence Council. 2002. *The Next Wave of HIV/AIDS, Nigeria, Ethiopia, Russia, India and China*, No. ICA 2002-04. September.

¹⁴ Human Rights Watch. 2004. *Future Forsaken: Abuses Against HIV affected children in India*, Background Pg. 1

¹⁵ NACO, National Baseline General Population Behavioural Surveillance Survey: 2001, New Delhi <<http://naco.nic.in/nacp/publctn.htm>>

The HIV/AIDS epidemic in India is mostly spread (80%) through the heterosexual route and there continues to be reluctance in bringing these issues into the public domain. The HIV/AIDS epidemic in the north-east of India is different and the result of intravenous drug use.

The spread of the HIV epidemic in India is uneven with 6 of the 35 states indicating high prevalence rates of over 1%, which means that the HIV infection has moved from the traditionally high risk behaviour groups such as sex workers and mobile populations into the general population raising the risk of infection for young people.¹⁶ With India's 1 billion population, even a small shift in the prevalence rate results in large numbers.

Worldwide, over 10 million young people between ages 15-24 have HIV/AIDS. With almost all new infections and at least one-third of all new sexually transmitted infections occurring to people younger than 25, the problem is enormous¹⁷.

A broader understanding – sexual and reproductive health

Over the years, India has addressed issues related to sex and reproductive health in very different ways. For many years family planning and population education formed the content of sex education and reproductive health education. Programs were related to safe motherhood, small family norm and contraception. Addressing reproductive needs of young people has often been neglected because of the reluctance of policies and programs to accept that sex and sexuality have also to be addressed.

The HIV epidemic brought a narrow focus on transmission and prevention of HIV but also raised the issue of introducing sex and sexuality in awareness programs as the major route of HIV transmission in India was the heterosexual route. If these issues were a problem to discuss in a traditional society, it was more so when these issues needed to be discussed with young people. With more and more young people being infected by HIV, the need to discuss sex and sexuality became important. Because young people are in a developmental stage of their life and because of the diversity of young people (and their related vulnerabilities, see paragraph above) it was also important to address broader reproductive concerns and related issues of gender, decision making and addressing risk. There was a need for young people's sexual and reproductive health to go beyond the transmission of information to transmission of capacity – to take responsibility of their own health, relationships and roles in community life.¹⁸

¹⁶ Schaffer T., Mitra, P. January 2004. *India at the Crossroads*. A report of the CSES HIV/AIDS Delegation to India.

¹⁷ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

¹⁸ Ibid.

Contrary to popular belief, research indicates that unmarried adolescents may also be involved in sexual behaviour.¹⁹ One study indicated that of the boys who were sexually active, only 50% had used condoms.²⁰

POLICIES AND FRAMEWORKS FOR YOUNG PEOPLE

At the International level

The concept of rights is not new. Instruments such as the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), UN Special Session on HIV/AIDS Declaration of Commitment and the UN Special Session on Children Declaration “A World Fit for Children” and the Millennium Development Goals all have contributed to the concept of a rights based approach when working with children or young people. A landmark event that helped shed ambivalence towards the sexual and reproductive health needs of young people was the International Conference on Population and Development (ICPD) Programme of Action, followed by the ICPD+5 which recognized the vulnerability of young people to HIV and the need to address it.²¹

India is a signatory to these documents indicating that in principle, the government agrees to the notion that children have special rights and there is a need to address them.

Lessons from international frameworks

An ethical framework from the UN Convention on the Rights of the Child

By emphasizing the importance of Articles 2,3,6 and 12 in its first set of reporting guidelines to governments, the Committee on the Rights of the Child made the Convention into more than a set of obligations: they gave a *soul* and provided a clear ethical framework for policy towards children.

Article 2 espouses the principle that discrimination is not permitted, all rights apply to all children without exception and it is the duty of the state to ensure that children are protected from discrimination.

Article 3 enshrines the principle that in all actions concerning children, “the best interests of the child shall be a primary consideration”. It requires governments to provide adequate care for children when parents or others responsible fail to do so.

Article 6 confirms every child’s inherent right to life and right to development. It requires governments to ensure “to the maximum extent possible” the survival and development of the child.

¹⁹ Gupta S.D. et al 1998. *Report on Study of Reproductive Health and Sexual Behavior among Adolescents*. Jaipur, India: Indian Institute of Health Management Research (IIHMR)

²⁰ Abraham Leena. 2001. “Understanding Youth Sexuality: A Study of College Students in Mumbai City.” *The Indian Journal of Social Work* 62 (2)

²¹ Jejeebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

Article 12 insists upon every child's right to be heard, to express their views freely in all matters affecting them and to participate as full members of society. Governments are required to assure these rights.

Collectively these four articles set out a clear position:

- That children have equal values as human beings
- That the best interests of the child should be a primary consideration
- That due weight should be given to the child's opinion and
- That every child has rights

*From Towards a Children's Agenda, SCF*²²

The UN held a Special Session on Children in May 2002 as a follow-up to the 1990 World Summit for Children to examine the implementation of the Summit's goals and agenda. At the Special Session, states adopted a plan of action known as "A World Fit for Children", identifying 21 goals in four primary areas: promoting healthy lives, access to and completion of quality education, protection of children against abuse, violence and exploitation and fighting HIV/AIDS.²³

In addressing **ethical principles**, much work has been done to safeguard children and young people in research and information gathering especially in the context of HIV/AIDS and has benefited from the thinking that evolved in using human subjects for research in studies related to science and medicine. All ethical principles are broadly based on the principle that the activity should do no harm, minimize possible harm and maximize possible benefit.²⁴ Some countries, such as South Africa, Rwanda and Uganda have incorporated these ideas in their policies for children.

National Policy for Orphans and Vulnerable Children in Rwanda

The policy reiterates the laws of Rwanda (Law No. 27.2001) that relate to the rights of the children and the formal obligation of the government as signatories to the Convention of the Rights of the Child and the African Charter on the Rights and Welfare of the Child. Over and above this, the policy states there are **four overriding principles** for the protection of the child

- The principle of the best interest of the child
- The principle of non-discrimination
- The principle of the right to survival and development
- The principle of participation of the child in the actions and decisions that concern him/her

In addition, **specific principles** have been formulated to guide policy and programmes

- Programmes and services take into account cultural practices of Rwanda as well as the overriding development strategies in decentralization, education, health, justice, poverty reduction and reconciliation.

²² SCF UK. 1995. *Towards a children's agenda: New Challenges for Social Development in South Asia* Edition SCF UK.

²³ Stohl, Rachel. May 2002. *UN Holds Special Session on Children*, Center for Defense Information. A complete list of goals is available at www.unaids.org

²⁴ Laywer's Collective HIV/AIDS Unit, *Background Paper on Research Ethics*, India.

- A legal framework guides all action for orphans and other vulnerable children.
- Co-ordination and monitoring systems maximize the support for orphans and other vulnerable children and ensure their wellbeing.
- Programmes and services follow standard practices and clearly defined standards of quality.
- Research and consultation of the concerned target group forms the basis for all programmes in favour of orphans and other vulnerable children.
- Gender aspects must be included in all programmes.
- Staff with the appropriate capacities ensures the wellbeing of orphans and other vulnerable children.
- A focus on community based approaches which include the community and children in research and decision making; care and protection for vulnerable children are within the family and community and institution based solutions are the exception.

The integration of orphans' and other vulnerable children's issues in the national budget of Rwanda and poverty reduction strategies is in-built to provide the necessary support. Such policies demonstrate a nation's respect for the child and young person's voice and rights.

At the National level in India

The sexual and reproductive health needs of young people have found place in some of the newly formulated policies. For the first time, the National Population Policy 2000 acknowledges that adolescents have unmet sexual and reproductive needs. A Working Group was also set up by the National Population Commission to contribute to India's 10th Five Year Plan to focus on women, children and adolescents.²⁵

The view that the young person is in transition to becoming an adult however, persists and the new National Youth Policy Preamble states that the overall purpose is 'youth empowerment in different spheres of national life' and defines youth as ages between 13 to 35, although it recognizes a subset as those between 13-19 years.

When young people become part of a general policy that largely caters to adults, the approach and the framework do not reflect their special needs. For example, the National AIDS Policy which focuses on the population between 18-40, refers to "women, children and other vulnerable groups" thus denying that children and adolescents have special needs and rights that need to be addressed separately. It does not recognize adolescents as a separate group and refers to youth in the context of migrant labour.

The National Charter of Children 2003 informs us of the government's intent to address the needs of young children and although comprehensive in scope is fundamentally flawed – it has omitted the word 'rights' in most of the clauses in spite of the government

²⁵ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

being a signatory to the CRC. This movement away from an entitlement approach fails to demonstrate that the rights of children need to be protected.²⁶

Many Policies, problems in practice

There are many policies and laws that concern children and young people and address different aspects of their lives. Many would argue in India that in spite of the many policies and laws we have for children and adolescents, few are implemented. For example the National AIDS Policy is still a policy although India will enter into the third phase of its National AIDS Program and has addressed the epidemic for over 10 years.

Many programs have been developed and implemented on the basis of these policies. For example, the Reproductive and Child Health Programme II (RCH II) addresses the concerns of both adolescent boys and girls but falls short of offering contraceptive services to unmarried adolescents.²⁷ The Ministry of Youth Affairs and Sports oversees three major programs for youth – the National Service Scheme where university students provide community service, the Nehru Yuvak Kendras, which have a network of youth clubs, and the National Reconstruction Corps, which engages youth in “nation-building” activities. These have all mobilized young people but generally not on their own behalf. Youth are still viewed as what the state decides.²⁸

Programs for children and adolescents can be found in many places besides the Ministry of Youth Affairs and Sports. The Ministry of Education and state education departments provide free primary education to all children regardless of their status including HIV. The Department of Women and Children in the Ministry for Human Resource Development develops policies for women and children and coordinates other ministries’ activities in these areas besides managing the huge Integrated Child Development Services (ICDS) which provides services for preschool children including HIV affected children. The Ministry of Health and Family Welfare and state level health departments focus on reproductive and child health (the RCH program). The Ministry of Social Justice and Empowerment and the state departments are responsible for children in need for care and protection, orphans and neglected children, children out of school, including street children, and other marginalized groups. The Ministry of Labor and related state departments are responsible for removing children from hazardous and bonded labor and rehabilitating them.²⁹

KEY CONSIDERATIONS IN DEVELOPING ETHICAL AND GUIDING PRINCIPLES IN INDIA

²⁶ T. Rajyalakshmi, Law of Sorts, The Hindu Vol 20 Issue 20 Sept 27 – Oct 10, 2003

²⁷ Jejheebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

²⁸ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

²⁹ Future Forsaken.

Ethical and guiding principles are universal and based on the three broad principles of justice, beneficence and respect for persons. The principles however do not operate in a vacuum and each context determines how they are operationalized. By its very nature, therefore, ethical and guiding principles must be debated and discussed by children, practitioners, policymakers, families and communities to be truly accepted and implemented. Because they are principles, they can be enforced only because *everyone* considers it important to do so. Unlike rights, they are not defended in a court of law. In determining ethical and guiding principles in India, it is important to understand the vulnerabilities of children, the cultural context and the role of a rights based approach.

Vulnerabilities of young people

Existing vulnerabilities of young people are exacerbated by the HIV/AIDS epidemic with economic and social problems unleashing a vicious circular dynamic, adding to the risk factors for HIV infection.³⁰ The national response to HIV denies that young people could ever suffer from a full-blown AIDS epidemic.³¹ There is a separation of HIV from other aspects of reproductive health and rarely address the complicated social and personal factors that affect it.³² Any ethical guideline must address these vulnerabilities.

Girls are ‘doubly vulnerable’ – one because they are girls and second, because many of them are in circumstances that place them at risk such as living on the street, in brothels, as orphans, as labourers and as children affected and infected by HIV. Culturally girls have low status indicated by son preference, discrimination in nutrition and health care practices and sex-selective abortions. Lacking the power to negotiate safe sex, many young brides may be more vulnerable to HIV and STI than unmarried girls. Because more than 50% girls are married before the age of 18 and they form a sizeable number³³, the risk is immense. A study in Pune of 400 women attending a STI clinic found that 93% were married, 91% never had sex with anyone other than their husbands but 25% had STIs and 14% were HIV+.³⁴ Boys and young men are vulnerable too – they marry later but are anxious about their sexuality and make up the majority of clients at STI clinics.³⁵

A discussion on vulnerability would not be complete without a discussion on discrimination. HIV/AIDS affected and infected children are routinely discriminated in the educational and health systems by denying them access or violating their confidentiality or by the stigma they face.

³⁰ Mehta, M, The HIV/AIDS Crisis in India, South Asia Monitor CSIS No. 58 May 2003 www.csis.org

³¹ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Pg. 104. Population Action International. Washington, USA.

³² Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

³³ See Background: A focus on sexual and reproductive health of young people in this paper, Pg. 2

³⁴ Young People and HIV/AIDS: Opportunity in Crisis, UNICEF 2002.

³⁵ Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

Cultural Contexts

The problem of addressing sex and sexuality

Cultural and social taboos characterize India's response to reproductive health and HIV. This dilemma is reflected in the piecemeal and ineffective ways in which these issues have been addressed.

There is an unwillingness to accept that children and adolescents should know about sex and sexuality. Children are taught "population education" with a focus on demography and development, AIDS education narrowly focuses on the disease organism.³⁶ Both avoid discussing sex and sexuality. Usually there is a public uproar or objection by parents and teachers when sex education is introduced or if children have to be taught about condoms.^{37 38} Neither is sex education available for children out of school or in state institutions.

"We don't discuss condoms, not in schools. ...this is a blood based disease and you shouldn't get in contact with the other person's blood. In schools we don't say that you can get HIV by sex. Kerala is a very traditional society. I can't talk about it even in my wildest dreams." (Head of Kerala Education Department)

"Once they are in the government run homes, there is not much time or space to indulge in sexual activity. Sexual activity is taboo society. It is not to be talked about with children. So there are no awareness programs in the homes." (Director, Tamil Nadu Department of Social Defense)

"Home is a place where kids can ask about sexuality. If they ask, they are told to shut their mouths. If they ask in school, they are dubbed as a bad boy." (Project Director, Andhra Pradesh State AIDS Control Society)

As quoted in 'Future Forsaken' Section III Pg 2, Human Rights Watch 2004

Overall there is a critical need for accurate and easily available sexual information, products and services. Helplines instituted for information regarding HIV are flooded with requests for information regarding sex and sexuality. The reluctance of the government to introduce a rigorous sex education program is evident by the fact that although the program began in the 80's, only 50% of schools have been covered. Persistent ambivalence about sex education has also impeded the full implementation of a population and family life education program begun in the early 1980s. Although sex education has recently been included in India's National Curriculum, state officials dilute

³⁶ Ibid. Pg. 102

³⁷ Ibid. Pg. 103

³⁸ Future Forsaken, Human Rights Watch 2004

messages to which they object and teachers omit topics with which they are uncomfortable.

Further the information is provided only after the eighth standard when the majority of students have dropped out of school, especially girls. The quality of the information received is also questionable. Studies have shown that teachers are reluctant to discuss these topics with their students and often skip the topics in class. The approach to sex education is by and large biological and HIV education tends to address not gender roles and sexuality but parenting, disease and abstinence.³⁹ Maharashtra has introduced an interactive approach to HIV and sexual education and other states such as Andhra Pradesh and Tamil Nadu, which have introduced these topics into the secondary school, may have wide coverage but quality of instruction continues to be difficult to monitor.⁴⁰

The Committee on the Child Rights Convention (CRC)⁴¹ in 2004 reprimanded India for its poor track record on following up on the earlier recommendations and directed that it needed to strengthen efforts to raise awareness about HIV among adolescents particularly those belonging to vulnerable groups.

Rights based approach

An essential element in the promotion of sexual and reproductive health and rights for youth is the recognition of young people as individuals entitled to rights, and as key players in their own development. This is in contrast with a more protectionist approach towards children. In the context of sexual and reproductive health and especially HIV, this entitlement versus a protectionist debate is crucial. The entitlement approach makes us question our perception of young people as passive recipients and encourages us to incorporate a youth perspective in our work. In order to do so we need to begin creating more democratic and inclusive spaces of participation where young people have the freedom to talk, learn and work with their elders.

Legacy of Policies and Laws

The Indian traditional view of welfare is based on *daya, dana, dakshina, bhiksha, ahimsa, samya-bhava, swadharma and tyaga* loosely translated as compassion, self discipline, self sacrifice and consideration for others.⁴² Traditionally therefore, children were the recipients of the welfare approach. It was the Convention of the Rights of the Child, to which India along with other nations of the world became a signatory, that became a landmark in the shift to a more 'rights' approach. There was a great deal of debate in India as the rights approach clashed with the traditional perspective of performing one's duties.

³⁹ Future Forsaken, Human Rights Watch, 2004

⁴⁰ *ibid*

⁴¹ Committee on Child Rights Convention India, 2004

⁴² Bajpai, Asha, 2003. *Child Rights in India*, India: Oxford Press

The prevalent legal traditions and frameworks influence the ways we work with and respond to children and adolescents. By and large, Indian laws towards children are paternalistic and protectionist. In most Indian laws, persons below the age of 18 are considered as minors, in other words do not possess the ability to make decisions. This is manifested by providing an age bar for marriage, contracts and so on. Such a position creates difficulty in the context of HIV/AIDS as it is important for young people to participate so that they make safe choices. Children and adolescents, not being recognized as persons in their own rights, cannot access sexual or general health services without a guardian. Not only does this approach restrict the rights of children but also ignores the reality of a large number of children who live and work outside family structures. International law and policies recognize the need to address the sexual and reproductive health of children and adolescents in age-appropriate ways (India is a signatory to many of these instruments) and legal strategies in many countries have tried to provide children the same rights as adults in terms of confidentiality and consent to testing as well as how they would receive information that is age appropriate.⁴³

India has not lagged behind in protecting its children. The Constitution of India provides a protective umbrella for the rights of the child and there are over 250 Central and state statutes under which the child is covered in India.⁴⁴ But the laws and policies tend to work in isolation. The right to education is for example, linked to issues of child labour, juvenile justice, child marriage, health and nutrition. Besides there is confusion among the interpretation of the various laws and policies. For example, the 93rd Constitutional Amendment states that it is a fundamental right for children between the ages of 6 and 14 to attend school. The Child Labour (Prohibition and Regulation) Act 1986 lays down that children below fourteen years can work in ‘non-hazardous’ occupations and processes. Or the Child Marriage Restraint Act 1928, which sets a minimum age of marriage but does not make it void. Clearly, laws pertaining to children need to be reviewed in the light of the CRC and linked together⁴⁵.

Indian law does not specifically deal with child specific issues in civil and criminal laws and children’s issues have been discussed mostly in the context of child labour and child marriages. In the context of HIV, children are now facing issues of inheritance, property rights, guardianship and adoption. Neither does India have a law that recognizes the crime of child sexual abuse and so provides no deterrent. The Indian state has interpreted its protective role for children and minors living in structures outside the family or in violent situations as limited to providing for their institutionalization. Under this law, the juvenile justice system has the power to test a child for HIV without his/her consent. There are no safeguards to protect medical records and a child can be isolated on the basis of her/his HIV positive status. Such provisions fail to recognize the rights of children (although India is a signatory to the CRC and other human rights policies) and the responsibility of the State. The provisions promote institutionalization rather than

⁴³ Lawyer’s Collective HIV/AIDS Unit, Background Paper on Children, <http://www.lawyerscollective.org/lc-hiv-aids/>

⁴⁴ *ibid*

⁴⁵ Bajpai, Asha, Child Rights in India, Oxford Press, India 2003

finding solutions first within families and communities and using institutionalization only as the last resort.⁴⁶

A paternalistic and protectionist approach towards children who are vulnerable and at risk can result in discrimination and is often seen in various educational and institutional settings. Compounded with traditional ambivalence towards sexual education and other discriminatory practices towards marginalized groups, children and adolescents find themselves at greater risk. Typically, the Indian system of education follows a didactic model and not an interactive one. Traditionally, the *guru-shishya* relationship between a teacher and a student was one of reverence and obeisance. But in the light of the challenges of HIV, an approach that promotes children's participation and decision making is critical. Those who have more power, teachers and policy makers have themselves been through a rigid educational system. For these reasons, ethical and guiding principles related to the sexual and reproductive health of young people must also address the role of adults who formulate policy and programs for children and adolescents.

The Committee on the Rights of the Child⁴⁷, which reviews the performance of states' compliance to the provisions of the Convention of the Rights of the Child (CRC) noted with regret that in India there are virtually no legal provisions guaranteeing children's participation in civil proceedings affecting their rights and well-being. The Committee welcomed the dissemination of its previous concluding observations and the various awareness-raising campaigns, but remained concerned that children and the public at large, as well as all groups of professionals working with and for children, were not sufficiently aware of the Convention and the rights-based approach enshrined therein.

It also went on to note the existence of the 1974 National Policy for Children, 1992 National Plan of Action for Children, discussions regarding the National Charter for Children to replace the Policy, as well as the drafting of a new Plan of Action for Children and was concerned that the National Charter for Children did not adopt a child-rights-based approach and did not explicitly include all the rights based principles of the Convention.

Competing rights

Although India is a signatory to the CRC, UNGASS and the Millennium Development Goals for Children, there are laws that compete with these rights. For example, according to the Juvenile Justice Act 2000, the juvenile justice system has the right to test a child for HIV without his or her consent. Children in hospitals do not have any safeguards to protect medical records. Even if rights of children to be informed and participate in decision-making are encouraged, *who* decides and *what* is the best interest of the child is a matter of debate.

⁴⁶Lawyer's Collective HIV/AIDS Unit, Background Paper on Children, <http://www.lawyerscollective.org/lc-hiv-aids/>

⁴⁷ Committee on Rights of the Child, Thirty second session 13-31 January 2003. CRC/GC/2003/3, 17 March 2003. Geneva:United Nations

Ethical Principles

Ethical guidelines are moral in nature, telling us what is right and wrong. Each society develops its own set of norms and ethical guidelines necessarily operate in such a context. In countries like India, where unlike the West which zealously protects and enforces individual rights, few laws and even fewer cases address issues of privacy, informed consent and related issues. With a huge backlog of cases, the judicial system is not an effective one for redress in India. Although this does not negate the need for legislation, in such a scenario the need for ethical guidelines is even more critical. The State with its legacy of paternalistic and protectionist laws and policies must take into consideration that individual rights are not superseded for public health concerns and that it is sensitive to the needs of children. Operationalization of ethical principles is very dependent on the context. For example, written documents are of little use when most persons cannot read and cannot comprehend the language or when a child gives consent because culturally one does not disagree with older people or when remuneration to poor people for research in reality becomes an inducement and a subtle form of coercion.

Ethical issues in research have been addressed internationally but of special concern has been the dilemmas raised by the HIV/AIDS epidemic and the growing number of children affected by it. On the one hand research and information gathering is required for better understanding and delivery of services but the issues of testing, confidentiality, informed consent and discrimination are complicated when it comes to children because of their vulnerability and age. There is no question that ethical guidelines need to protect children as well as enable them to participate in decision-making but how best to do it is challenging. This tension between a 'protectionist' approach and an 'entitlement' one advocated by the rights movement is a real one and either approach can be threatening to some children at some time. For example, children of sex workers need to be protected but they also must learn to make wise choices.

Some work in recent years has been related to addressing ethical issues by asking⁴⁸

- Is this truly in the best interests of the child?
- Will it do any harm or have a potential to do so in the future?
- How can children participate meaningfully, in age-appropriate ways?
- How can families/communities and more formal bodies like review boards regulate and protect children?

Overarching these concerns is the need for all those working with and for children – government officials, NGO representatives, families, communities, civil society – to be both transparent and accountable for their actions. A high commitment to implementing

⁴⁸ International policies and frameworks (described in the earlier section) among others, have contributed to this process. Initially the bio-medical model of research guided much of the thinking, it continues to have value but in working with children, the Convention for the Rights of the Children, Strategies for working with Young Children, A World Fit for Children and the UNGASS and numerous field and research experiences have helped to shape thinking on these issues.

ethical guidelines and establishing checks and balances must become accepted norms when working with and for children.

ETHICAL AND GUIDING PRINCIPLES⁴⁹

Ethical and guiding principles are essentially a “code of conduct”. Programs for young people are largely directive and not able to fully involve children and adolescents in a meaningful dialogue. The many crosscutting policies, paternalistic laws and the poor implementation of programs have resulted in very few working models that are available to guide programs. There is a need for principles – both ethical and guiding – to inform program and policy and practical ways of addressing them.

The ethical and guiding principles that have been explained below are an attempt to do so and hopefully will be discussed, revised or expanded through dialogue with young people, civil society and government. This draft list of ethical and guiding principles places the young person in the center of the dialogue.

The principles are based on the broad framework of the international instruments, frameworks and policies discussed in the earlier section as well as human rights literature pertaining to children.(Boyden, J et al, 1998; Ennew, J, 1994; Hawes, H 1997)⁵⁰. The discussions in the earlier sections illustrate the need for and guide the content of these principles. The principles have been grouped into three categories

A. Young people focus (Principles 1-4)

1. Gender concerns and issues should be integrated into programs and policies and include both boys and girls.
2. Meaningful and genuine participation of young people should be intrinsic in all policies and programs to ensure informed decision-making.
3. Programs and policies should individualize the young person, recognize their diversity
4. Programs and policies for sexual and reproductive health should be holistic recognizing that young people have many interrelated needs.

B. Human resources (Principles 5- 6)

5. Recognizing that working with young people requires special skills of facilitation and a rights based approach, programs and policies must

⁴⁹ The Oxford Dictionary defines Principles as fundamental concepts or assumptions on which a theory, system, or method is based; ethical as relating to moral principles or morally correct; ethics refers to the moral principles governing or influencing conduct.

⁵⁰ Boyden, J., Ling B. and Myers W.1998. *What Works for Working Children?* Sweden: Save the Children Sweden and UNICEF

Ennew, J. 1994. *Street and Working Children:A Guide to Planning*”. Development Manual 4, Save the Children UK

Hawes Hugh. 1997. *Health Promotion in Our Schools*.UK: Child-to-Child Trust

provide for ongoing capacity building to all those who work with and for them.

6. All those who work with and for children and young people should be accountable and responsible so that children come to no harm and their best interests are looked after.

C. Enabling environment (Principles 7-9)

7. Programs and services should be youth centered and reinforce efforts to be effective.
8. Legal, policy and program frameworks should be reviewed with reference to a rights based approach which respects young people
9. Active participation of civil society, family and communities should be encouraged to create an enabling environment for young people

The young people focus principles ground the programs and the interpretation of policy in a rights based approach, the human resources principles state what is needed to implement them and the enabling environment principles ensure that delivery is effective. The human resource principles and the enabling environment principles ensure not only that the best interests of children are served but also that no harm comes to them.

Young people focus principles

1. Gender concerns and issues should be integrated into programs and policies and include both boys and girls.

Investing in and empowering girls and young women and including boys and young men to acquire more responsible roles is one of the most efficient and effective ways to advance the sexual and reproductive health of young people.⁵¹

India is a traditional male dominated society, with a strong preference for sons and a low status for girls. In the context of HIV/AIDS, gender increases the vulnerability of girls because of their inability to access information, negotiate safe sex even with their husbands and greater exploitation.

Adolescent married girls have special needs because of early marriage and subsequent lack of mobility and power in their own homes. Ways to increase the autonomy of these girls through non-formal education, livelihood programs, and life skills is important. Equally important is the need to target the male decision makers – their husbands.

Unmarried adolescent boys and girls provide a unique opportunity to challenge gender roles and foster healthy relationships. Boys and young men must understand the vulnerabilities of girls, the power dynamics of society that accords them low status, the need to empower them and the responsible ways in which boys and young men can behave.

⁵¹ UNFPA, State of the World Population 2003 Press Summary

Gender concerns therefore need to include *both* boys and girls and because gender affects so many aspects of life – health, reproductive health, education, HIV, livelihood, work responsibilities, nutrition – it is important that gender issues are *integrated* in *all* policies and programs in addition to having special programs for the girl child. Government programs have typically targeted the girl child whereas NGOs have demonstrated projects actively involving both boys and girls.

The *Balika Samriddhi Yojana* 1997 by the Government of India hopes to raise the status of girls by providing grants to the mother of a girl child which matures and is awarded if she remains unmarried till the age of 18. Scholarships are also provided for her education.

CARE India with UNFPA and Government of India have facilitated a project with adolescent girls in Madhya Pradesh. CARE uses the strategy of peer educators to sensitize adolescents on health issues. They train medical staff and community health workers on adolescent health issues who in turn train adolescent to become peer educators. An outreach strategy is used to reach out to girls. The Adolescent Girls Group (AGG) also has a skill –building component. The project involves adolescent boys, husbands of adolescent girls, parents, teachers and community leaders. Special IEC materials communicate to young people and referral services are provided through a network of youth friendly services. (YFS).

CEDPA (Center for Development and Population Activities), an international NGO works with local NGOs, UNFPA, UNESCO and USAID has adapted “Choose a Future: Issues and options for adolescent boys” to the Indian context and is implementing programs in 11 states. The package has been designed to challenge gender roles and address male involvement. It encourages the development of healthy relationships, responsible fatherhood and alternatives to violence.

Planned Parenthood Federation through “Couple to Couple: Improving the Reproductive Health of young couples in Rural India” employs peer couples to work with newly weds and other young couples to increase gender awareness, encourage supportive relationships and plan for new families together.

Empowerment for girls and responsible behavior for boys cannot be advocated through or limited to one training program or one workshop or one awareness week. Changing attitudes towards gender is a process and because gender permeates all aspects of our life and affects the way we think and feel, gender issues must be woven into all sectors and programs that work with young people. Examples of this are in education curricula, in livelihood programs, health awareness programs, prevention messages, nutrition programs and in communities through youth forums. Civil society and political debate must inform and support these endeavours.

2. Meaningful and genuine participation of young people should be intrinsic in all policies and programs to ensure informed decision-making.

Evidence shows that projects that involve children and young people are more likely to be successful and build self-esteem and confidence.⁵²

Participation is often misused to refer to any activity in which children and young people are present. Participation is the process of involving children and young people in making decisions about projects that aim to benefit them.⁵³ Because of cultural notions that only the older and more experienced are capable of making decisions, it is important that young people have a space and voice that is heard with respect. Participation necessarily needs to be interactive and ‘enter’ the world of young people through drama and folk communications, sports events, telephone hotlines, individual counseling, youth clubs as well as participatory education in more formal settings such as schools. Young people like to work with peers and groups. Many efforts use peer strategies such as the Child-to-Child approach or train peer counselors and educators.

Participation needs to be meaningful – it is not about tokenism, using young people as decorations or mouthpieces of adults. It is not about children being manipulated by adults and doing the work adults should be doing. It is about helping children initiate activities with the support of adults, later review their work and learn to do it better the next time.

There are three levels of participation which are in fact all about non-participation but commonly prevalent in programs with children and young people.⁵⁴

<u>Level</u>	<u>Description</u>	<u>Explanation</u>
One	Manipulation	Children are not consulted and do as they are told. This is based on the belief that adults alone know what is best for the programme.
Two	Decoration	Children have a ‘decorative’ function. They are invited, are physically present but do not participate or contribute.
Three	Tokenism	Very common. Projects are designed so that children have a voice but in reality they cannot say what they want to or how to say it. If they do express an opinion, it is discarded. .

There are five levels in which participation of young people grows so that they gradually get more empowered.

⁵² International HIV/AIDS Alliance, 2004. A Parrot on Your Shoulder. UK: International HIV/AIDS Alliance.

⁵³ Ibid.

⁵⁴ Zaveri Sonal, 2004 Life Skills Manual, Draft. Contact FHI India for details. Based on Roger Hart’s Ladder of Participation see Hart, Roger 1992. Ladder of Participation, Children’s Participation: From Tokenism to Citizenship. Florence Italy: UNICEF, International Development Center.

<u>Level</u>	<u>Description</u>	<u>Explanation</u>
Four	Assigned but informed	Adults prepare the plan and inform children. Children willingly participate but benefit is short-lived.
Five	Consulted and informed	Adults plan or decide but children are consulted and feedback taken seriously.
Six	Adult initiated, shared decisions with children	Adults plan or decide but involve children in planning, implementation and evaluation. Decisions are made jointly.
Seven	Child initiated and directed	This is the first step on the road to ownership and sustainability. The idea or plan originates from the children. The children also implement. Such examples are difficult to find.
Eight	Child initiated, shared decisions with adults	Children feel that to involve adults in their project does not mean that adults will control them. Needs trust.

When young people participate meaningfully, they become a powerful force for change in their own homes, with peers and in the wider community. Young people can participate through sports and religious associations, NGOs, youth centers and clubs but they must be trained and build capacity to work in teams, groups or as peer educators. All youth work needs to be supported by sharing experiences and through facilitation from adults.⁵⁵

Studies have shown repeatedly that young people have many misconceptions – for example many young people in India believe that HIV can be caused by a mosquito bite⁵⁶. Accurate information provided at the right age delays onset of sexual activity and encourages responsible behaviour.⁵⁷ Meaningful participation requires information to be available and in a manner understood by young people. When young people receive knowledge on inter-related issues they are in a better position to make wise choices. Young people need information on risk and protective sexual behaviour, condoms, physical maturation, counseling services, their right to access them, forming relationships and others.⁵⁸

Young people also have their own strengths and the **life skills** approach helps to build self-esteem, skills in problem-solving, decision making, communication and self awareness. With the life skills approach, young people get the tools to adopt safe behaviour. Only a few programs however currently work on these issues and many more are needed.

⁵⁵ UNAIDS, 1999. *Listen, Learn, Live! Key Issues and Ideas for Action*. Geneva: UNAIDS

⁵⁶ Young People and HIV: Opportunity in Crisis. 2002. UNICEF/UNAIDS/WHO

⁵⁷ International HIV/AIDS Alliance. 2004. *A Parrot on Your Shoulder*. UK: International HIV/AIDS Alliance.

⁵⁸ Jejeebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

The Bharat Scouts and Guides Healthy Adolescent project encourages young people to learn not only about the physiological aspects of reproductive health but promotes interactive discussions of gender relations, confidence and relationships. Through various participatory group activities, children and young people learn about HIV, reproductive health and growing up.⁵⁹

The Life Skills initiative under the Children Affected by AIDS (CAA) projects by FHI India is a nation-wide initiative with NGO partners using child participatory techniques to work on issues of reproductive health and HIV with children of sex workers, street children, vulnerable children in slums, HIV affected and infected children and young people who are injecting drug users. It includes a training of trainers program that builds capacities in facilitation skills and approaches in working with children. Children in teams and groups learn about risk behavior, making wise choices, communication, empathy and link their learning with life outside the training place. FHI provides intensive on site support and peer support. The pilot study was initiated with 400 children aged 9-18 years in 2003-4 in 11 organizations and initial results have been very promising.⁶⁰

3. Programs and policies should individualize the young person, recognize their diversity

Young people are very diverse and there are no ‘one size fit all’ approaches. Strategies to reach them must correspond to their life situations (married or unmarried; out of school or in school; employed or not; at special risk; HIV affected and infected).⁶¹ Because young people have a unique identity, it would be wrong to plan mass programs that ignore the diverse realities young people live in.

This means that services need to be tailored to different needs such as contraceptive supplies to unmarried youth, delaying child-bearing among the newly married, young people seeking treatment for STDs, HIV information and life skills for street youth. The new RCH II program does not adequately address the heterogeneity of youth in providing contraceptive services, different delivery modes for young men and women, the married and unmarried.⁶²

Operationally, this means that a needs assessment (where young people are actively involved in the assessment) is important when planning programs. It also means that because young people are growing and developing, their needs are constantly changing and programs must respond to these needs. A program for 10 year olds is very different

⁵⁹ See website <http://www.tbsgi.org/HAPI.htm>

⁶⁰ Zaveri, Sonal Presentation at the CAA Workshop, New Delhi, 2004. Manual is under production. For details contact Ms. Kathleen Kay, Country Director FHI India, New Delhi.

⁶¹ UNFPA, State of the World’s Population, 2003

⁶² Jejheebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

from that of 15 year olds not just in content but in the way issues have to be approached. Similarly programs for in school and out of school or rural and urban young people cannot be the same. The reality of a street child and that of a child growing up in institutions is very different. Programs must be adaptable to meet these needs.

The Ministry of Labor runs child labor projects covering 150,000 out-of-work children in states with high unemployment rates. Along with non-formal education, children are provided vocational training, supplementary nutrition and health care.

Committed Communities Development Trust (CCDT), an NGO in Mumbai runs shelters, day-care centers and non-formal education for children of sex workers and HIV+ children. As a policy, no child is tested and all children are taught universal precautions. Sexuality education and life skills education for different age levels and groups of children have been adapted. Counselors provide services for those in need of psychosocial care. It also works with child headed households and has strategies for home based care and young people support groups.

4. Programs and policies for sexual and reproductive health should be holistic recognizing that young people have many interrelated needs.

Young people's needs go beyond sexual and reproductive health and include concerns about marriage, employment, schooling that play an equal and important role in their lives. Programs need to recognize this multiplicity of concerns and design programs more holistically.⁶³ Some of the priorities identified by adolescents in many conferences and declarations relate to quality and access to education, water and sanitation, linkages between education and employment and protection of adolescents' rights.

The National AIDS Policy also advocates a multi-sectoral approach to combat the epidemic. By mainstreaming youth related issues in HIV and reproductive health into a number of sectors, a more holistic, sustained and cost-effective approach is possible. Operationally this would require persons from different sectors to plan together. This approach is uncommon because most departments have worked in isolation although the young person is the same target audience. To avoid mixed messages (which can be especially detrimental to young persons) and better utilization of funds and human resources, it is recommended that working groups and committees work towards a more integrated approach. Some may argue that youth concerns should be a shared responsibility not just that of the Department of Youth and Sports but of all departments, neither should reproductive health be the concern of the Dept. of Family Welfare alone or the concern regarding children's rights the domain of the Dept. of Woman and Child Development and the issue of HIV/AIDS, the sole responsibility of the National AIDS Control Organization.

⁶³ Jejheebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

Some countries such as Uganda, where HIV/AIDS has devastated the country, have adopted and use the multi-sectoral approach.

The Adolescent Girls Scheme launched in the early 1990s includes girls in the nationwide Integrated Child Development Scheme (essentially a program for children under five with children, women and community outreach components). It was the government's first attempt to integrate adolescents into an existing broad based program, with the potential of reaching millions of girls. One project taught girls how to run childcare centers, another sought to develop the health literacy and skills of girls who have dropped out of school. In 1994, about 450,000 11-18 year olds were participating in the program. A recent evaluation noted increased confidence among the girls and improvements in the delivery of health services.

Mamta, a Delhi based NGO uses non-formal education as an entry point to address adolescent health needs through clinics, counseling services, information and capacity-building programs. It disseminates health education and advocates for late marriage. It is increasingly advocating a more holistic approach to adolescent issues and works in ten states in the country.

The Better Life Options Program of CEDPA actively works with girls and boys to challenge gender bias. It addresses needs at three levels – non-formal education, skills and vocational training, family life and reproductive health and educational services. It also builds in community awareness activities to sensitize adults.

Adithi Bihar advocates adolescent girls program, which includes awareness building through non-formal education, income generation and self development. The program runs through its non-formal education centers and the Ballika Kishori Chetna Kendras or the Unmarried Girls Awareness Centers in 20 villages. The curriculum at these centers include legal literacy, health and sex education, information about government schemes as well as how to deal with sexual harassment and abuse. Girls also participate in income generation schemes such as goat-rearing, candle-making, poultry. The boys go to their own learning center where stereotyped gender roles are discussed, as is dowry and female infanticide.

Within the government sector, it would be useful to move from a sectoral and departmental approach to a more holistic one, which integrates services⁶⁴. For example, if a RCH program is being run in a district, this guideline would recommend that all programs and services for adolescents should support and supplement the program. Only then can a truly multi-sectoral approach emerge. School curriculum can support the program, the water and sanitation projects can advocate by involving both girls and boys in debating about gender roles (because women usually are the ones to fetch water), the ICDS program can sensitize women who attend the under five clinics about the girl child

⁶⁴ Bajpai, Asha. 2003 Child Rights in India. Oxford Press, India.

and the local village body can be sensitized to promoting late marriages and income generation activities for girls.

Such efforts are difficult to find in the government sector but are essential if sexual and reproductive health issues including HIV are to be mainstreamed. One attempt has been made by UNAIDS through its CHARCA project which works with the empowerment of adolescent girls in 6 districts by integrating all services and bringing them on a common platform. All UN agencies with their NGO partners and relevant government departments' work together on the project. It recognizes a high level of coordination but provides a comprehensive package to adolescent girls as well as brings value addition to the program through the combined expertise of different UN bodies.

A matrix would be useful for planning multisectoral programs and mainstreaming sexual and reproductive health issues. In this way, optimal utilization of resources and addressing the different concerns of children is possible. A hypothetical example is provided below:

Proposed project	Health NGO/Govt	Education NGO/Govt	Labour NGO/Govt	Youth Affairs and Sports NGO/Govt	Local Self Govt. NGO/Govt
Sexual health of street children	RCH programs, ICDS, health care centers to be youth friendly, nutrition programs	Non-formal education centers Life skills program	Child labour projects – protection of the child from hazardous work	Nehru yuvak kendras (peer and community programs for young people run by the government); recreation and sports facilities	Use of community/village bodies and associations to sensitize and create services such as night shelters
	Review sector policy and inter-relate with others	Review sector policy and inter-relate with others	Review sector policy and inter-relate with others	Review sector policy and inter-relate with others	Review sector policy and inter-relate with others

Human Resource Principles

5. Recognizing that working with young people requires special skills of facilitation and a rights based approach, programs and policies must provide for ongoing capacity building to all those who work with and for them.

Studies have indicated the lack of capacity of most service providers and planners in planning and implementing programs for young people. Both girls and boys often seek out less legitimate services out of worry about the lack of confidentiality, inability to pay and fear of being discovered by parents or scolded by service providers.⁶⁵ Service providers are judgmental and do not have accurate information on HIV/AIDS or regarding sex and sexuality issues which pushes young people either not to seek services or seek substandard ones.⁶⁶

The Committee on the Rights of the Child in its four-year review welcomed the dissemination of its previous observations and the various awareness-raising campaigns, but remained concerned that children and the public at large as well as all groups of professionals working with and for children, are not sufficiently aware of the Convention and the rights based approach.⁶⁷

Specific recommendations of The Committee on the Rights of the Child to the State were to undertake systematic education; that training was necessary for all professional groups working with and for children such as judges, lawyers, law enforcement officials, civil servants, municipal and local workers, personnel working in institutions and places of detention for children, teachers, health personnel, including psychologist and social workers. The committee also recommended that parliamentarians, community and religious leaders should also be sensitized.⁶⁸

The World Bank in 2003 reported that many NGOs lacked the capacity to implement national policies and that one third of the posts in all State AIDS Societies remained unfilled. This compounded with the fact that NACO, the apex body responsible for HIV programming in India did not specifically focus on children and adolescents, there is an overall paucity of technical capacity in working with young people.⁶⁹

Capacity building includes not only training, but ongoing sharing of experiences, mentoring, exchange of information, documentation and developing strategies cooperatively for young people.

6. All those who work with and for children and young people should be accountable and responsible so that children come to no harm and their best interests are looked after.

⁶⁵ Ganatra, B and SS Hirve. 2000. "Induced Abortions: Decision Making Provider Choice and Morbidity Experience in Rural Adolescents", *International Conference on Adolescent Reproductive Health*, Mumbai, India 2000 as quoted in Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

⁶⁶ Ekstrand, M, et al. 2003. *HIV/AIDS in India: Country AIDS Policy Analysis Project*, Univ. of California, AIDS Research Institute.

⁶⁷ Convention on the Rights of the Child, Committee on the Rights of the Child: Thirty fifth session, Concluding observations India: February 2004. Para 23.

⁶⁸ Ibid para 24

⁶⁹ Future Forsaken, 2004 Human Rights Watch citing the World Bank's Mid-term Review of the Second National HIV/AIDS Control Project, 2003 reported in the Financial Times, Oct. 22, 2003 by Ray Marcelo "Fears Grow the AIDS may spin out of control in India".

Because of the stigma and discrimination attached to HIV and the taboos in discussing sexual health, it is important for all those who work with children and adolescents to be sensitive to their needs and aware of their rights. Psycho-social support to children is not even seen as a need by child service providers and there is a paucity of counselors who can work with young people.⁷⁰ It is not enough to state that those who work with and for children should receive training (see point above), they need to be accountable for their actions as well. For example, NGOs are known to publicize stories of HIV affected children. Careless discussion about the sexual behaviour of young people is not only a breach of confidentiality but will also profoundly affect young people emotionally and socially. When young people are used as ‘decoration’ or ‘manipulated’ to prove the participatory nature of programs, either in government run or NGO run programs, it disrespects young people but because of the powerful position of adults goes unnoticed.

In youth programs, although what or content is important, it is equally important how it is implemented. When processes are crucial for any program, it is important that the persons who are responsible for the process are accountable. Thus a well developed life skills program for young people may be harsh and insensitive only because the facilitator was ill prepared to work with young people. Because working with young people in sexual health and especially HIV/AIDS can have far-reaching consequences and is often complex, it is important that adults too understand their responsibilities.

Adults need to be accountable to young persons as well. This can be done by informing them of their rights, involving them in planning, monitoring and evaluating their own programs and services and by asking and using their feedback to make programs and policies better. Because young people are dependent on adults, accountability by adults is often ignored.

Enabling Environment Principles

7. Programs and services should be youth centered and reinforce efforts to be effective.

Planning must be evidence based. There is little data available on young people. There is a need to disaggregate the data by age and gender – more information is needed about the 10-15 and the 15-19 year olds. Besides official statistics in India do not correspond to international definitions.⁷¹ The Ministry of Social Justice and Empowerment and the corresponding state level departments are responsible for children in conflict with the law and in need of care and protection, which includes street children but admit that they have no estimate regarding how many children they are responsible for.⁷² Assessments should be participatory and reflect the perspective of adolescents in many areas – behavior, myths and misconceptions, practices and risks associated with sexual and reproductive

⁷⁰ Ekstrand, M et al. 2003. HIV/AIDS in India, Country AIDS Policy Analysis Project, University of California, San Francisco.

⁷¹ Nanda, A. R., Addressing the Reproductive Health Needs of Adolescents in India: Directions for Programs, International Conference on Adolescent Reproductive Health, Mumbai, India 2000

⁷² As told to investigators for Future Forsaken Report, 2004. Human Rights Watch.

health.⁷³ Good policy depends on the assessment and evaluation of outcomes and the availability of child-centered data and indicators.

Programs should reach out to young people whether they are in school, communities, workplaces or on the street. Services need to be friendly to youth, provide space for privacy and confidentiality, so that they can freely access them and provide services in a non-threatening manner.

Because many of the services that young people will access are linked, it is necessary to ensure that all programs and services follow the same ethical and guiding principles and in this way reinforce ethical principles. For example, a life skills class in a school will be effective if all teachers in the school support the effort; a community counselor is effective only when the hospital where referrals take place is also supportive. Even within NGOs, the person who runs the reproductive health program must ensure that the livelihood program and the formal education program are also youth centered.

The **Safdarjung Hospital** in New Delhi, one of the largest public hospitals in the country, has begun a pilot study on how existing health services can be made youth friendly.⁷⁴

Parivar Seva Sanstha, an NGO promotes sex education in Orissa state, not only delivering services but also working with media and government representatives.

International Center for Research on Women (ICRW) coordinates a multi-site intervention and research program to develop effective programs for sexual and reproductive health for adolescents in India. Research included community data on urban and rural adolescents lives especially their reproductive health needs. The studies confirmed lack of power, decision making opportunity, autonomy and access to services as underlying risks for reproductive health and especially so for girls and for the unmarried. Phase I (1996-1999) addressed the paucity of basic research on adolescents' reproductive needs and Phase II (1999-2005) will develop and test interventions with partner organizations using multiple approaches based on needs identified in Phase I.

Although there are many programs that raise awareness among young people, build self-efficacy and provide friendly services, they have been poorly researched and evidence is needed if the learnings have to be put to scale.^{75 76}

⁷³ Gupta, S.D. 2003. *Adolescent Reproductive Health In India: Status, Policies, Programs and Issues*. Policy Project.

⁷⁴ *ibid*

⁷⁵ Jejheebhoy, S, Sebastian. M. 2003. *Actions that Protect: Promoting Sexual and Reproductive Health and Choice among Young People in India*, Regional Working Papers No. 18. India: Population Council

⁷⁶ UNFPA, 2000. *Adolescents in India, A Profile*, India: UNFPA

8. Legal, policy and program frameworks should be reviewed with reference to a rights based approach which respects young people

Existing policies and strategies are complementary and supplementary to each other and need to be integrated when operationalized to avoid the duplication of efforts and more synergy in outcomes.⁷⁷ A comprehensive law for children that integrates the Convention on the Rights of the Child and the four sets of civil, political, social –economic and cultural rights of every child – their right to survival, development, protection and participation is required.⁷⁸

There is a need for a child and young people focus. The legal system should interpret the laws in the context of rights and standards given in the CRC – only then can the child or young person access the court system for justice. The legal system also needs reform in that it needs to have a child focus. Without linking policies and laws on the rights based approach, the young person cannot secure their rights or obtain justice.

Enforcement of legislation is essential if any of the programs are to be successful. Legal reform alone does not bring justice. Inter-agency structures and systems need to be worked out as do awareness building among service providers – doctors, police, lawyers, trade unions, social workers, teachers and others – who can advocate and assert the rights of children and young people.⁷⁹

9. Active participation of civil society, family and communities should be encouraged to create an enabling environment for young people

In every society, some social norms make it harder for young people to protect themselves from HIV infection. These norms shape expectations about how men and women should behave, their sexual and social roles and cultural taboos and are deeply ingrained in families, communities, schools and media that surround and shape a child and young person's life. When adults learn to respect and listen to young people, and not just influence them, a true partnership emerges resulting in more creative, relevant policies and programs that are 'owned' by both adults and young people.⁸⁰ Most adults feel that they already 'know' about what young people feel and want because they were once young too. Therefore it is felt unnecessary to consult and ask young people about their views. Facilitation also requires special preparation and many adults are unwilling to do so.⁸¹

When families and communities accept youth friendly services in sexual and reproductive health, young people are reassured and are more likely to use them.⁸² What is needed therefore is the sensitization of parents and other trusted adults to provide

⁷⁷ Gupta, S.D. 2003. Adolescent Reproductive Health In India: Status, Policies, Programs and Issues. Policy Project.

⁷⁸ Bajpai, Asha.2003. Child Rights in India. Oxford Press. India

⁷⁹ Bajpai, Asha. 2003. Child Rights in India, Oxford Press, India.

⁸⁰ UNAIDS. 1999. *Listen, Learn, Live- Key Issues and Ideas for Action*. World AIDS Campaign for Children and Young People. Geneva: UNAIDS

⁸¹ Towards A Children's Agenda, SCF 1995

supportive environments for young people. This may mean having programs at the community level that enables parents and community member to overcome their discomfort, increase their own knowledge of reproductive health, concerns of youth and learn to communicate with young people. Involving adults who make a difference in the lives of young people can reinforce issues such as the legal age of marriage, empowering girls and making boys more responsible.

Pathfinder and partner organizations launched adolescent reproductive health programs in several Indian states with the objective of influencing parents, families and teachers of adolescents as a way to improve the general environment into which adolescents enter sexual activity and marriage. To win over gatekeepers such as parents and teachers, program staff emphasize the scope, importance and benefits of their efforts. They also encourage parents and adolescents to communicate with each other by increasing their knowledge and general comfort level related to sexual and reproductive health. Program staff was trained to acquire skills in dealing with sexual issues. The program aims to help young people delay sexual debut, increase the age of marriage of girls, to delay having the first child after marriage and to lower STDs.⁸³

Planned Parenthood Federation’s project “Reproductive Health through Advocacy and Services” is part of a larger program to improve the reproductive health and rights of adolescents and youth in the Indian states of Bihar and West Bengal. The program aims to improve the general reproductive health of adolescents and young people and develop the capacity of NGOs, private providers, and government facilities to plan, sustain, and advocate for adolescent and youth reproductive health programs.

There should be information sharing and mutual learning with NGOs and government, community organizations and civil society – only then can a common understanding of young people’s sexual and reproductive concerns be possible.

Operationalizing Ethical and Guiding Principles

A **checklist** is a practical way to operationalize the ethical and guiding principles. Policies and programs must adhere to **ALL** principles and not just a few.

Gender	1. Have we addressed gender issues that relate to both boys and girls? Have we looked at needs of both married and unmarried young people? How will we help boys and girls develop healthy relationships with each other?
Participation	2. Have we truly involved young people and made sure they are not decorative, or a token or just being manipulated? Have we involved ALL young people and not just a few

⁸² UNFPA, State of the World’s Population, 2003

⁸³ Masilamani, R, Building a Supportive Environment for Adolescent Reproductive Health Programs in India: Essential Program Components, ??????

	who are the best? Have we provided them with relevant information, services and life skills so that they can participate? Have we developed peer, team or group programs and support groups so that young people can learn from each other?
Diversity	3. Do we understand that young people live in diverse circumstances and that programs must be adapted to their needs? Do we have enough information about their lives and needs to plan programs and formulate policy?
“Whole Person”	4. Have we addressed broader concerns of young people that affect their sexual and reproductive health? Have we broadened our scope from a narrow HIV or reproductive focus and address the whole person?
Training Adults	5. Have we trained all those who work with and for children, directly or indirectly in facilitations skills for working with young people and shared information about young people’s development needs and rights? Have we built in continuous learning – through experience sharing workshops, exposure visits, mentor support, training of trainers and other means?
Transparency and accountability	6. What systems do we have in place that monitors how adults facilitate, implement and formulate policy in the young person’s best interest and with a rights based approach? How are adults accountable to young persons?
Youth centered across all programs	7. How youth centered and friendly are our programs and services? Have we developed links with other sectors to synergize, integrate and mainstream sexual and reproductive health issues to address the whole person? Do we collect and analyze youth specific data to inform policy and program?
Legal and policy issues	8. Have legal and policy frameworks been reviewed to see how rights and youth focus they are? How are policies and laws being disseminated and debated?
Involvement of family, community, civil society	9. Have we mobilized and advocated to family, communities and civil society to support and provide an enabling environment for young people?

A CRITICAL ROLE FOR CIVIL SOCIETY

Years of experience has shown the inefficacy of the many laws and policies meant to address young people. Rights based conventions, which have been ratified, do not find a place or are marginal in both old and new policies. Even where available, they are rarely legislated or defended. In such a scenario, the role of civil society is critical to mobilize and provide a forum for active debate regarding young people’s issues. Decisions regarding sexual and reproductive health by young people can have far reaching

consequences, especially with HIV/AIDS, and it is of great importance that civil society works with young people to create an environment where these issues are discussed openly, with understanding and compassion. Protecting young people from HIV is a responsibility for all sectors and sections of society and there must be a commitment at all levels to pool resources and form partnerships. Partners must include young people, communities, schools, NGOs, Community based organizations, faith based organizations, private sector, academic and research institutions, local governing bodies and of course, donors and governments.

Panchayati Raj or local self-government institutions provide a unique opportunity in India to mobilize civil society particularly in rural India, where about seventy percent of the population resides. *Panchayats* are local elected bodies responsible for decision-making and implementation of the development programs at the local level. They can not only engage and sensitize parents, teachers, service providers and young people in dialogue but also ensure availability and utilization of services at the local level.

Several child rights have become a reality as a result of consistent and hard efforts of grassroots organizations, social movements, people's organizations, coalitions and advocates who have helped change people's perspective both in approach and attitude.⁸⁴ Such an approach and support from adults is absolutely necessary to address young people's sexual and reproductive health concerns. Some of the problems described below indicate why we need the wider engagement of civil society.

- SANGRAM is an NGO that works in the villages of Maharashtra and have found a lack of options for girls orphaned by AIDS with relatives being reluctant to take care of them. This has resulted in pushing down the already low average age of marriage – if they have no alternative, HIV+ parents may marry off their daughters before they die so that the girls have someone to look after them. Reports from other parts of the country tell the same story.⁸⁵ Some children stay with elderly grandparents and face the prospect of being orphaned again.
- There is widespread discrimination in the health services for children and young people. In some cases, treatment provided is only symptomatic when surgery is required, symbols are used (and not the word HIV) to designate an HIV+ person and ward attendants are capable of shouting ‘Bring that HIV child for X-rays’ down the corridor so all can hear, making the principle of confidentiality a mockery.⁸⁶
- The famous case of two children Benjy and Benson being denied education in the local school in Kerala hit the headlines. Their parents had died of AIDS and were in the care of grandparents. Various protests took place by teachers, parents and the community and even school children themselves. The children were asked not

⁸⁴ Bajpai, Asha. 2003. *Child Rights in India*. Oxford Press. India.

⁸⁵ Future Forsaken. 2004, Human Rights Watch.

⁸⁶ Bharat, Shalini. 2001. *India: HIV and AIDS-related Discrimination, Stigmatization and Denial*. UNAIDS Best Practice Collection. Geneva:UNAIDS

to come to school, made to sit separately, attend home tuition, other children boycotted the school and it was only the intervention of many players including the local priest that helped resolve the crisis.⁸⁷

- Many young people are denied admission in institutions. They are children of sex workers or those who are HIV+ or have parents who are HIV+. Some have to undergo mandatory testing although it goes against the policy; others are shunted from place to place. Some end up on the streets and face greater sexual risk. The Committee on the Rights of the Child noted that children affected by HIV might be pushed into sex work or other hazardous labor to survive, look after their sick parents or pay for school fees. Organizations working with street children support these findings and note the risk of consensual and non consensual sex and contracting HIV,⁸⁸

A civil society that recognizes its critical role and engages available associations⁸⁹ (such as the Panchayati Raj, professional associations, social institutions and other less formal structures) in debate and discussion can create a supportive environment for young people. Such a vibrant civil society can make sure that every young person in every community is equipped with information about sexual and reproductive health and HIV, knows how to prevent HIV/STD and how to access services, skills to practice safe behavior. This means creating a culture of zero tolerance for any sort of violence and sexual abuse against young people.⁹⁰ When civil society is engaged, it also monitors progress automatically. An enlightened political leadership can enhance the efforts of civil society. In an unusual move, parliamentarians across parties in India and civil society have been working closely since 2002 with Lawyer's Collective to draft legislation related to HIV/AIDS.⁹¹

In conclusion,

Ethical and Guiding Principles inform programs and guide policy. The ethical and guiding principles provide a *framework* and shape the nation's *approach* to children and adolescents. These principles can inform policies – both existing or new – that relate to the sexual and reproductive health of children and adolescents as well as provide for local implementation, using the checklist, without excessive oversight⁹².

The ethical and guiding principles offer an opportunity to work effectively with young people in ways that will empower them so that they are better equipped to deal with future challenges. They are guiding principles for those who formulate and implement

⁸⁷ Future Forsaken, 2004. Human Rights Watch.

⁸⁸ The Association Francois-Xavier Bagnoud (FXB) and Naz Foundation (India) reported these findings in Future Forsaken, 2004 a report by Human Rights Watch.

⁸⁹ Edwards, Michael. 2004. Civil Society. Blackwell Publishing Ltd. UK

⁹⁰ Young People in Crisis: Opportunity in Crisis, 2002., UNICEF/UNAIDS/WHO

⁹¹ Schaffer, T and Mitra P, India at the Crossroads- Confronting the AIDS Challenge, CSIS 2004

⁹² Greene, M, Rasek, Z and Amen, K. 2002. *In this Generation: Sexual and Reproductive Health Policies for a Youthful World*. Population Action International. Washington, USA.

policy and programs reminding them that the best intent must be guided by *how* we work with children. Guiding principles are not guidelines – guidelines are often rules and instructions provided by those who formulate policy. They represent a top-down approach whereas the notion of guiding principles enables those that implement policy to engage in discussion regarding how these guiding principles can be adapted to the specific program or activity they are responsible for. In a sense, it serves also as a ‘litmus test’ and helps to reorient programs and activities.

The dissemination of these guiding principles of course would play a very important role and that is why the role of civil society is considered critical. In the final analysis, no effort should be considered too daunting when it comes to addressing children and young people’s sexual and reproductive health needs, particularly when the risk of HIV and its effects on the lives of people is so well known. Our determination to use and implement these ethical and guiding principles is a testimony of our respect for young people. This much we owe to our future, our children and young people.