

National AIDS Control Programme

Phase IV

Youth and Adolescent: Working Group

Draft Report

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1. Introduction - Youth, Adolescents and HIV scenario

Populations of youth and adolescents in India:

Young people (aged 10-24 years) constituted almost 400 million and represented one third of the Indian population¹. Adolescents aged 10-19 years constitute 325 million of the population, which is one fourth of the total population. Compared to earlier generations the situation of young people in India has considerably improved; they are healthier, more urbanized and better educated than ever before. Nonetheless, the majority continue to experience major constraints in making informed life choices. It is generally acknowledge that significant proportion of young people experience high risk or unwanted sexual activity, do not receive prompt or appropriate care and experience adverse reproductive health outcomes². Indeed youth constitute a large proportion of the HIV positive population; it is estimated that over 35 percent of all reported HIV incidences in India occur among young people 15-24 years of age³.

The break-up of population between the ages of 10-24 years and 10-19 years is as follows -

Age Group	Total	Male	Female
10-24	403397807.3	207908082.7	195489724.7
10-19	302548355.5	155931062	146617293.5

(Source: Secondary analysis of data from National Family Health Surveys of India-1,2,3 (1992-2006)

A study entitled “Youth in India: Situation and Needs 2006-2007” conducted in six states of Andhra Pradesh, Bihar, Jharkhand, Maharashtra, Rajasthan and Tamil Nadu by International Institute for Population Sciences, Mumbai and Population Council, New Delhi found that: -

1. 11.4% of the population was aged between 10-14 years
2. 9.5% aged between 15-19 years
3. 8.6% aged between 20-24 years
4. 18% aged between 15-24 years

The above mentioned Youth Study focused on married young women, unmarried young women and unmarried young men aged 15-24 years. Indeed the above six states together represents 39% of the country’s population during the time of the survey which was conducted between January 2006 and April 2008.

Vulnerabilities of Adolescents/Youth between the ages of 10-25:

According to the study conducted by International Institute for Population Sciences, Mumbai and Population Council, Delhi in six States (2006-07) suggests that “Despite norms prohibiting pre-

¹ Secondary analysis of data from National Family Health Surveys of India -1,2,3 for the age group 15-24 years – MoHFW-GOI, 2009

² ‘Young people’s sexual and reproductive health in India; Policies, Programme and Realities’ – K.G.Santhya and Shireen J Jejeebhoy, Population Council, New Delhi

³ www.unaids.org.in

marital opposite sex relations, opportunities to form pre-marital romantic relationships did exist". Findings suggest that 23% of young men and 21% of young women had either been approached by or had approached a person of the opposite sex to form a romantic liaison. Moreover, 19% of young men and 9% of young women acknowledged the experience of a romantic partnership before marriage.

Further, it was found that the rural-urban differences were narrow, the salient findings of the study elucidate the same below -

1. One in seven young men (15%) and 4% young women had engaged in pre-marital sex with romantic and/or other partners
2. Rural young men were more likely than their urban counterparts to have experienced pre-marital sex (17% of rural young men compared to 10% of urban young men)
3. Rural young women were slightly more likely than their urban counterparts to report so (4% compared to 2%)
4. Consistent condom use was almost non-existent.
5. Among youth who had experienced pre-marital sex, only 13% of young men and 3% of young women reported that they had always used condom
6. Pre-marital sex is not always consensual
7. Pre-marital sexual experience was non-consensual for substantial minorities of young people, particularly young women and of them who had engaged in pre-marital sexual relations, 3% young men and almost one in five young women (18%) reported that they were forced to engage in sex.

It was found that a large proportion of girls marry early in India, before the age of 18 which is risky in terms of earlier sexual activity, pregnancy, STIs etc. Although the trends show that the number of girls marrying before the legal minimum age at marriage of 18 years has been decreasing over the time, still more than 47% of women aged 20-24 years get married by 18 years of age⁴.

Preventing the transmission of HIV is one of the most important challenges for adolescent survival and health. Although AIDS is estimated to be only the eighth leading cause of death among adolescents aged 15-19 years, and the sixth leading cause among 10-14 year-olds, it takes a disproportionately high toll in high-prevalence countries. Investment in HIV prevention and treatment is critical to reversing the spread of HIV in adolescence. Offering adolescents and young people high-quality reproductive health services and ensuring that they have sound knowledge of sexually transmitted infections, empowers them in their choices and behaviors. Making such services and knowledge available in early adolescence, particularly for girls, is imperative; by late adolescence, the risk of infection for young people in high-prevalence countries is already considerable⁵.

⁴ Reproductive and Sexual Health of Young People in India – Secondary analysis of data from National Family Health Surveys of India – 1,2,3 (1992-2006)

⁵ The State of World's Children 2011 – Adolescence – An age of opportunity, by UNICEF.

Why focus on adolescents?

Adolescents require particular attention because at this stage⁶:

- Their development may make them more vulnerable: They may have less knowledge, lack confidence and skills to make safer behavior choices, be less concerned about the future and more susceptible to positive and negative peer influence;
- They are less likely to identify themselves as being a member of an 'at risk group' which can make them harder to reach;
- They may be more easily exploited and abused;
- They are less likely to have access to or use available services because of a lack of awareness, limited resources or legal barriers to accessing services as a minor;
- They are in the main still children – interventions cannot respond to them in the same way they do for adults;
- Their behavior is less fixed, so risk behaviours are sometimes experimental and temporary.

Populations estimates of those at risk adolescents/youth:

Street and Working Children:

According to United Nations Commissioner for Human Rights (UNHCHR), India has the largest population street children in the world – with about 18 million children living and working on urban streets.

According to 2001 census, 78 million people are homeless in India and the country has the largest number of street children in the world. UNICEF's estimate of 11 million street children in India is considered to be conservative figure. The Indian Embassy has estimated that there are 314,700 street children in metros such as Mumbai, Kolkotta, Chennai, Kanpur, Bangalore, Hyderabad and are 100,000 in Delhi alone⁷.

UNICEF defines three types of street children (Leo Fonseka, formerly South Asia's UNICEF Regional Advisor on Urban social planning protection rights of children as indicated in the website of the consortium of street children): -

1. Street Living Children – Children who have run away from their families and live along on the street
2. Street working children – children who spend most their time on the streets, fending for themselves, but returning home on a regular basis
3. Children from street families – Children who live on the streets with their families

Vulnerability of Street Children to HIV and other STIs:

⁶ Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents, 2-4 September 2009, Geneva – UNICEF in collaboration with the Inter-Agency Task Team on HIV and Young People

⁷ <http://www.Railwaychildren.org.uk/asia.asp>

A national study of child abuse⁸ among street and working children in 2007 in India found -

- 65.9% of the street children lived with their families on the streets. Out of these children, 51.84% slept on the footpaths, 17.48% slept a night shelters and 30.67% slept in other places including under flyovers and bridges, railway platforms, bus stops, parks, market places
- The overall incidence of physical abuse among street children, either by family members or by others or both, was 66.8% across the states. Out of this, 54.62% were boys and 45.38% were girls
- On a study in India, out of the total number of child respondents reporting being forced to touch private parts of the body, 17.73% were street children. 22.77% reported having been sexually assaulted.

Another estimate says that there are 18 million street children in India, the highest number in the world⁹. If HIV continues to take its toll on the population, this number is likely to increase. For a host of reasons, street children are additionally vulnerable to HIV infection. Many of them are injecting drug users, living/working on the streets they are highly vulnerable to sexual abuse and they have very little access to safe healthcare. They face discrimination in hospitals, and are more often than not left to fend for themselves to get the care they need. As most of them are illiterate, they are unable to fill the requisite forms to avail of services. Without an adult accompanying them, they have little hope of getting access to health services. They are dependent on private and expensive health care providers¹⁰.

A study¹¹ among 326 street children using a pre-tested interview schedule reveals that 50.5% of children with a history of having had sex, had a history suggestive of STI infections during the past six months with the commonest symptom was a painless single ulcer (29.1%). All of them had sought treatment, albeit irregular and incomplete, even in personally supervised conditions, owing to reasons as external relief from symptoms with significantly improved medical care behaviors consequent to repeatedly cajoling, was sometimes construed as cure by the street children, for instance after one or two injections, these children get so much relief that they feel that have been cured and they do not come for the remaining treatment. When many of these children perceive that their disease has cured, they desist from further treatment even when they are informed that the treatment that they have received is incomplete and that they are still suffering from the disease till they take the full course of treatment. Some of them eventually do heed to repeated cajoling, for instance, one child who had tested positive for HIV takes regular treatment.

The above study found that half of street children were part of the study (50.5%) had a history suggestive of STI infections during the past six months, among the 95 children who had a past history of having had sex, suggesting that these children do engage in risky sexual practices, though lower than other studies. Discussions with the street children revealed that they do not use

⁸ Study on Child Abuse: India 2007, Ministry of Women & Child Development, Government of India, (Online) Available at <http://wcd.nic.in/childabuse.pdf>

⁹ A children of India's streets, International Herald Tribune, January 26, 2006

¹⁰ <http://www.hivaidsonline.in/index.php/Vulnerable-Groups/children-and-hiv-ii-vulnerability>

¹¹ STI profile and Treatment seeking behavior of Street Children in Surat – Patel NB, Bansal RK,

condoms while having anal sex. The study stressed the need for explaining the importance of condoms.

Trafficked Children and Children of Sex Workers:

As for the link between trafficking and HIV, India faces the greatest challenge in the region in terms of sheer numbers of people living with HIV (PLHIV) with approximately 40% of Asia's population, India has the largest number of PLHIV in the region. India has a high rate of human trafficking, both internal and international. India's situation is complex; India is simultaneously a source, transit and destination country for children trafficked for the purpose of sexual and labour exploitation¹².

As per National Crime Records Bureau, Crime in India (1999-2004) during the period 1999 – 2004, a total number of 50959 girls were trafficked and sexually abused/exploited in India.

Vulnerability of Children to HIV who are trafficked and in Sex work:

The practice of child trafficking has a heavy social cost. Those trafficked endure brutal conditions and malnutrition, which cause irreparable psychological and physical harm ranging from disease (including HIV/AIDS, sexually transmitted infections, pelvic inflammatory disease, tuberculosis and scabies), stunted growth, drug addiction, abuse and reproductive problems. Emotional problems are also common. As a result of child trafficking, victims are likely to suffer from anxiety, depression, and post-traumatic stress disorder. The cycle of trafficking is often inexhaustible. A child sold into one form of trafficking is not freed, but is sold into another form of trafficking upon entering into adulthood. Statistics show that 60 to 70 percent of females who are trafficked in to sex trade are raped and that 70 to 95 percent are physically assaulted. The abuses inflicted by trafficking fly in the face of a person's basic human rights. They violate the universal human right of life, liberty and freedom from slavery in all forms. Furthermore, they violate the right of a child to grow up in a protective environment and to be free from all forms of abuse and exploitation. The link between HIV/AIDS and child trafficking is an important one to highlight. Worldwide, approximately 42 million people are living with HIV/AIDS, and the problem is on the rise in India. Around the world, sex workers have a high incidence of HIV/AIDS and other sexually transmitted infections, and the same is true in India. Thus, trafficking has been a leading cause in the spread of HIV/AIDS and hence it becomes necessary to targeted intervention on HIV/AIDS amongst trafficked children and adolescent¹³.

Children, especially those who migrate, run away or wander on the streets alone are in greatest danger of being trafficked. Even when they migrate with parents, the pressures of urban life on new migrants, can rupture family ties, causing them to end up fending for themselves on the streets.

¹² Victims of Trafficking, Violence Protection Act of 2000, Trafficking in Persons Report, 2005 – USAID

¹³ India – Building a protective Environment for Children – Ministry of Women and Child Development

Rationale for the requirement of focused IPC intervention with MARA and Best Practices:

Who are MARA?

MARA (Most at risk adolescents) are defined as adolescents whose behaviour put them at risk of contracting HIV. These behaviours include penetrative vaginal or anal sex without condoms, and injecting drugs with non-sterile equipment that has been shared. Some group/individuals almost by definition adopt these behavior, are working definition of MARPs (Most at risk population) have been agreed, namely Sex Workers, IDUs and/or MSM. It should be noted that UNAIDS defines Sex Workers (SW), as adults over 18 years of age and affirms that all forms of the involvement of children (under the age of 18) in sex work and other forms of sexual exploitation and abuse contravenes United Nations Conventions and international human rights law. Children under 18 years of age who sell sex are victims of commercial sexual exploitation who cannot be viewed as SWs. It is important to remember that the behaviours that define MARA often overlap; e.g; a person uses drugs may sell sex in order to by drugs. Evidence informed advocacy and programming needs to be targeted to risk behaviours and to the settings where these behaviours are taking place. It is critical that countries 'know their epidemic' and understand what the data are telling them about who is at risk or vulnerable. MARA are a subset of young people and a subgroup of MARPs. HIV prevention services for at-risk adolescents and young people will differ from services for the general population of young people. Services for MARA may not need to vary widely from those required by at-risk adults, but they will probably need to be delivered in a very different way that is age-appropriate and that incorporates child-protection interventions when required.

Adolescents are more vulnerable when they lack knowledge and skills; cannot access services; are exposed to violence, exploitation and abuse; lack attachment to family and are denied opportunities to participate in society. Vulnerable adolescents are more likely to adopt behaviours that increase their risk of HIV as a result of circumstances that are often beyond their control. MARA are not always the same people as those who are vulnerable. Different tools are required to collect strategic information on their experience and the realities they face¹⁴.

A meeting report and discussion paper from the Interagency Youth Working Group, USAID, the United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team on HIV and Young People and FHI emphasized to call more attention to young people within the groups considered "most at risk" for HIV – those who sell sex, those who inject drugs and young men who have sex with men. Despite the growing attention that has been given to programming for these groups, little explicit focus has merged on the particular needs of young people in these populations. At the same time, efforts to prevent HIV among young people have tended to focus on the general population of young people, for whom more is known about effective programming, instead of focusing on young people in most-at-risk groups. As a result, young people who inject drugs or sell sex and young men who have sex with men are often not targeted in either type of programming.

Research has begun to show the importance of focusing on young people within most-at-risk populations, and there are increasing examples of programmatic approaches for meeting their

¹⁴ Consultation on Strategic information and HIV prevention among Most-at-Risk Adolescents – 2-4 September 2009, Geneva – UNICEF in collaboration with the Inter-Agency Task Team on HIV and Young People

needs. But many challenges remain, including the fact that there are significant differences among young people between the ages of 10 and 24. For example, United Nations has stressed that the term 'sex worker' can apply only to those at least 18 years of age because younger adolescents are considered to be victims of commercial sexual exploitation. In addition, much more work is needed to understand the intersection of programming between young people in general and young people most at risk of HIV and other sexual and reproductive health (RH) problems.

Given the overwhelming health challenges and human rights violations that are faced by young people selling sex, programmatic approaches are complex. The elements of combination prevention are necessary in framing the different types of programs that are needed (biomedical, behavioral and structural components) as are concepts of primary prevention, harm reduction, or some combination of these types of programs. While there is a primary responsibility of programs to reduce and work to eliminate the exploitation of children, there is also a need to address the immediate health concerns, including HIV risks, of those in situations of exploitation.

Best Practice:

In 1999, FHI was one of the pioneering organizations in India to link OVC and HIV/AIDS by addressing the needs of children living with, affected by and vulnerable to HIV/AIDS. Situation assessment studies revealed numerous runaway and street children, children of sex workers and children living in abusive conditions and at-risk of HIV infection. FHI's OVC activities began in the midst of a number of challenges and constraints. The government response to HIV/AIDS did not include OVC and was limited to targeted intervention with adult high-risk population groups; there was lack of data on the number of orphans and HIV-affected children; and the capacity of NGO working with children was limited, especially in HIV/AIDS programming. Six demonstration projects were initiated in 1999-2000 in Delhi, Mumbai, Chennai and Pondicherry.

Sanjay, Anurag and Rahul ran away from home and ended up at the New Delhi Railway Station. They were identified by peer educators from Salaam Baalak Trust, an NGO working with street and working children in Central Delhi and were motivated to join the Government Railway Police Centre run by Salaam Baalak Trust. Two year later, they started working as peer educators for the centre while also accessing educational and health care services. They earn a living at the station selling newspapers and cleaning trains

Salaam Baalak Trust was supported by USAID/FHI from September 1999 to September 2006 to reduce the HIV/AIDS vulnerability of street and runaway children. The project is currently being supported by USAID under the SASMATH project with FHI (2006-2011)

From 1997 – 2007 Family Health International (FHI), India reached out to 1,607,561 direct beneficiaries which include 49,455 Orphans and Vulnerable Children (Street children) and 17,919 drug users consisting of street children through Impact project. The Impact project was implemented in six states of Andhra Pradesh, Delhi, Maharashtra, Manipur, Nagaland, Tamil Nadu and Union territory of Pondicherry. The strategic approach of the Impact project was: -

1. Supporting the capacity strengthening of Indian organizations including government, USAID supported bilateral partners and local organizations
2. Developing innovative demonstration projects in underserved areas and learning sites to influence national policy and programmes in India

There were 43 partners who implemented OVC projects as part of Impact programme which was 33% of the total partnerships.

2. Catagorisation of youth / children under NACP III and recommendations under NACP IV for effective programming : CATAGORISATION OF YOUNG PEOPLE

Youth are not a homogeneous group and different sub-populations of young people are exposed to different risk settings. For effective HIV prevention programming, young people are categorize into three groups based on the level of their risk and vulnerability to HIV infection. These are

- a. **Young People in general population** (in schools, colleges, universities, uniformed services and out of school/nonstudent youth in community). This category will be covered through curricular and the mainstreaming and convergence efforts initiated by relevant ministries/government departments. Out-of-school youth will be covered through a number of district-wide innovative (peer education, ASHA, Nehru Yuva Kendra Sangathan, SABLA scheme etc) programmes in the states. Linkages will be strengthened between Adolescent friendly health facilities and schools and communities. Information, skill and health service Interventions will be monitored and evaluated to ensure that they respond to the needs of young people.
- b. **Especially vulnerable young people** are vulnerable because of individual characteristics, like age, education, psychological, Lack of parental guidance and support (living on the streets or in institutions), Poverty, exploitation and abuse (family/community) and easy access to psychoactive drugs (family/community) this category will be addressed through information, skills, health services, counseling and protection and poverty reduction interventions in ways especially suited to the alleviation of impact. Initiatives will largely focus on working with existing youth service organizations with careful attention in selecting, training and culturally appropriate interventions.
- c. **Young People most at risk** of infection young people who are engaged in behaviours that put them at high risk of HIV (adolescents in sex work, young IDUs, Unprotected sex with multiple partners (anal sex increases the risk of becoming infected). This category will be covered by TIs through comprehensive package of services on prevention, treatment, care and support services through dedicated workers and NGOS/ CBOs. TI services providers will trained on adolescent friendly health services in addition to HIV/AIDS training that is provided under NACP to ensuring that young people are able to meet with trained, friendly, non-judgmental health workers in privacy with assurance of confidentiality. Intervention will be carefully evaluated for impact and processes to increase knowledge of what is effective among young people most at risk.

3. Ongoing interventions under NACP III, strengths, weaknesses, challenges and suggestions for effective programming

ADOLESCENCE EDUCATION PROGRAM – GAPS

- Unable to scale up in all states
- Delay in execution of programs in suspended states, affects the reach
- Lack of uniform efforts to involve all stakeholders at different levels for program strengthening and to avoid duplicity of effort
- Non-availability of information on reach , coverage ,quality and impact
- Lack of advocacy initiatives with political leaders for developing strong political will
- Need to strengthen monitoring and evaluation at state and national level
- Lack of capacity building for peer educators to enable them disseminate information
- Limited linkages with health services
- Non availability of activity calendar matching with academic calendar
- Inhibitions among teachers particularly in handling co-education students
- Less interactive opportunities and follow-up learning for students- implemented more as one time activity

Adolescence Education Program: recommendations for strengthening the effective implementation during NACP IV-

- Involvement of parliamentarian forum for development of political will at state level.
- Involvement of DAPCU in monitoring and coordination –formation of committees in non DAPCU distt.
- Need assessment of adolescent needs at state level
- Formation of Distt. adolescent resource team(DART) with involvement of civil society organization
- Involvement of private school associations-forums
- Enforce HIV/AIDS policy in all schools

Innovation

- Use of multi –media packages for promoting interactive group education
- Use social networks (facebook etc)
- Peer led approach 1:100
- Convergence between ARSH strategy and AEP
- Integrating HIV/AIDS in existing curriculum of students and in teachers training programs
- Enhance response of private schools
- Undertake concurrent evaluation and impact assessment studies
- Technical support to education department to plan, roll out and expedite utilization of budget with phase out plan to be in place
- Adolescent friendly program title with branding

- Linkages to prevention, treatment and SRH services
- IEC and BCC resource kit in form of comics, stories and games –supported with library – entertainment approach

Red Ribbon Clubs (RRC) in Colleges – GAPS

- Lack of adequate capacity of peer educators-teachers –selectively
- Guidelines are still in draft stage
- Blood donation focused without any comprehensive activities organized specific to HIV prevention
- Restricted to RRC members –minimal efforts to reach out the entire college youth
- Lack of convergence and coordination among different student clubs available in college
- Lack of involvement of private colleges

Red Ribbon Club - recommendations for NACP-IV:

Convergence-

- Integrating HIV in all youth club activities
- Converging RRC with NSS to integrate and Strengthen the programme
- Capacity building of peers and teachers
- Develop and disseminate Youth friendly IEC and BCC material
- Increase program Monitoring and Develop a M&E framework and standardized reporting software
- Enhancing private colleges response
- Linkage with referral services

Innovation

- Introduce innovative approaches such as, Helpline for youth, Interactive web based learning
- Use of social network
- Outsourcing the service to ensure timely rollout
- Centre of excellence on youth at distt level /regional level
- Mass media campaigns to encourage youth to go for HIV /STI testing and treatment
- SMS /voice mail to address youth
- Involve young positive people addressing youth on HIV preventive
- Documentation and dissemination of best practices to all stakeholders at regular intervals
- Media and political advocacy
- National level quiz program
- Youth friendly kiosks at strategic locations
- Review and revision of all tool kits and sharing with SACS during first quarter
- Self learning multi- media package for youth to learn comprehensive information on HIV/AIDS/STI-Linkages with help line.
- RRC Activities should be classified as activities within RRC, within the college and outside college

- Early involvement in RRC

Out of School Youth- Gaps :

- Major gaps in coverage of reaching the unreached youth
- Minimal IEC and BCC package for addressing out of school youth
- Lack of capacity building to strengthen communication agents to reach youth
- Sub group need to be defined with package of services-heterogeneous group
- Minimal youth coverage at district level and in different settings- vulnerable youth segment wise, which is not even defined
- No programs for high risk / vulnerable youth in non link workers villages

Out-of-school Youth recommendations –

- Develop size estimation, indicators, target and coverage /M&E plan
- Specific youth plans for metro-cities
- Developing comprehensive plan for urban youth
- Introducing youth friendly communication –edutainment including sports
- Revise, evaluate and adapt teens clubs formed by NYKS and ICDS
- Involvement of TI NGO and CBOs for reaching out to migrants
- Youth friendly IEC materials and strengthen rural libraries
- Linkage with health programs, services including health camps
- Mid media activities including folk and local youth lead theatre to be strengthened
- Shift from awareness to increase in risk perception and support informed decisions
- Help line
- Distt level communication campaign to address most at risk population
- Branding of clubs with state specific names
- Periodic evaluation, revisiting program based on research
- Greater involvement of local NGOs /CBOs/FBOs/PRIs
- Involving positive youth in communication
- Greater coordination between consultant youth and mainstreaming consultant
- State level HIV/AIDS youth coordination committee
- Sensitization and planning meeting with vice chancellors of different universities
- Mobile vans to visit colleges to compliment the RRC activities
- Greater involvement of DAPCU in coordination and convergence and monitoring
- Media advocacy by involving professional advocacy agencies
- Greater involvement and networking of program implementers and organization working for youth
- Establishing national technical resource group on youth
- Developing specific policy and guidelines for dealing with minors
- Formation of youth coordination committee at national or state level or establishing national advisory council on youth

- Detailed guidelines to address youth through Link Worker Scheme need to be evolved along with specific budget allocation
- SACS should develop youth specific IEC to address rural youth through LWS
- Need for establishing a platform for experience sharing and exchange of best practices among RRCs
- The existing TRG need to be revived and activated at national level, similarly at state level, similar TRG also established.
- Need to evolve a plan along with roles and responsibilities at different organizations at different levels
- Document the innovative initiatives undertaken by bilateral, unilateral and multi-lateral agencies on youth – consolidate the experiences and scale-up as per requirements.
- Develop system for recognizing the best organizations contributing towards youth programming.
- Networking of all organizations working for youth in the country to ensure uniformity, avoid duplication, effective utilization of resources and scale-up
- Information on HIV prevention and treatment and Promote individual behaviour change, condoms, harm reduction services if injecting drugs, services for prompt diagnosis and treatment of STI, Counseling and testing for HIV referral to HIV treatment and support services

4. Program recommendation for reaching out to vulnerable youth, adolescents and children under NACP IV with recommendations for innovations

Program operationalization with suggestive activities ministry/ department wise on mainstreaming, convergence, integration and direct implementation

Experience of working with various ministries in NACP III presented varied experiences. While it was easy to make headway with some ministries certain others posed challenges.

In NACP IV it is proposed that the work with different ministries will continue to ensure a sustainable response that is well integrated into each identified ministry.

Proposed Ministries for HIV integration, mainstreaming and convergence

- Ministry of Health and Family Welfare (MOHFW)
- Ministry of Women and Child (MWCD)
- Ministry of Youth Affairs and Sports
- Ministry of Human Resource Development (MHRD)
- Ministry of Social Justice and Empowerment (MSJE)
- Ministry of Minority - OBC/SC/ST schemes, Women leadership schemes
- Department of **Prohibition**- prevent alcohol use its now become part of legislation on excise- data captured for underage drinking and substance use

- Ministry of Labour – working children/ adolescents, domestic, child labour

Ministry of Health and Family Welfare (MOHFW)

Beginning with its own parent ministry, NACO to work toward integrating the HIV response into the existing reproductive and child health programmes. NACO will work with specific existing programmes and schemes under the National Rural Health Mission. *Janani Suraksha Yojana (JSY)*, Adolescent Reproductive and Sexual Health (ARSH), Family Planning (including abortion) programme, School Health Programme are some potential programmes and schemes for integration. These programmes are national programmes and hence implemented in a uniform manner across the country. It would be important for NACO to be informed on the extent and quality of implementation of the relevant existing programmes under NRHM and understand the challenges and then put a joint plan of action in place.

Activities

The activities will involve

- Identifying current status of HIV in the existing programmes,
- Sensitizing the key personnel on HIV
- Reviewing capacities and skills of staff to work on HIV
- Developing a training curriculum
- Training resource persons
- Conducting training of key personnel
- Developing indicators for measuring progress
- Follow up of training in the field on how HIV programme is being delivered among youth/ adolescents
- Joint review and reporting by NRHM and NACO staff at national, state and district level.

Ministry of Women and Child

This ministry provides a unique opportunity for mainstreaming HIV programme. The ICDS programme already reaches out to mother and young adolescent girls through its Anganwadis and workers.

The Sabla scheme being implemented in 200 districts since November 2010 in the country has elements favorable for integration. It proposes to reach out to girls between 10-18 years of age in and out of school in all the villages in 200 districts currently. This is a health, nutrition, livelihood and life skill programme for the adolescent girls where girls will be organized into groups by the AWW. HIV can be built into this programme with ease. Participation of males is not a part of this programme but is an element which NACO can bring in, as without male participation empowerment of girls is incomplete.

The ongoing ICDS programme with its nutritional component needs to be strengthened by creating awareness on nutritional needs of women and children living with HIV and provide it to those who are beneficiaries under the ICDS.

The central government programme, Integrated Child Protection Scheme, is a scheme which seeks to provide for care and protection of all the children in conflict with law and children in need of care and protection. One of the specific objectives of ICPS is to initiate any other need based specialized innovative services including child guidance and counseling especially to combat drug abuse, HIV/AIDS and sexual abuse.

Through its Children in Need of Care & Protection component the Scheme supports setting up:

- State Child Protection Unit
- Children's Homes
- Shelter Homes
- After-care organizations
- Child Welfare Committees (CWCs)
- 24-hour Drop-in Shelters for Street Children
- CHILDLINE Service

This scheme provides a gamut of options to reach out to children in conflict with law and children in need of care and protection in which HIV can be readily integrated.

Activities

An interface between the MWCD and Department of AIDS/NACO needs to happen, at the national level, to understand the extent and nature of actual reach and level of implementation of their individual programmes and identify potential for integration and work out mechanisms for the same.

Ministry of Youth Affairs and Sports (MOYAS)

NACO has collaborated extensively with MOYAS for implementation of its programmes to reach out to the young and this need to be consolidated. Details of its programmes and areas of integration need to be worked out. MOYAS programmes presents an opportunity to reach out to youth out of school.

Ministry of Human Resource Development (MHRD) was one of the ministries with which NACO collaborated for its programmes for school children and there are many experiences to share and learn from. NACP IV shall seek to address the gaps identified in NACP III and continue to reach out to students in school and out of school. A greater political advocacy and rebranding of existing AEP needs to be done in NACP IV to increase its acceptability and improve coverage.

Ministry of Social Justice and Empowerment (MSJE)-

The drug and alcohol programs and Social Defense Division of MSJE are already reaching out to people who inject drugs or those with problems of alcohol. Its programmes can support NACO to extend its coverage and areas of reach.

The details with respect to specific activities to be undertaken with each Ministry/ Department are being finalised and will be submitted for members feedback in the next working group meeting.

GENERAL RECOMMENDATIONS

1. Collect of data to inform national HIV programming, monitoring and evaluation. age and sex disaggregated data and indicators on young people made an integral part of the national monitoring and evaluation system
2. Develop national strategies and action plans which addresses the identified issues and gaps
3. Identify needs, forge partnerships and generate commitment at National and district levels for young people programmes;
4. Establish convergence of RCH (RCH-II ARSH strategy) and HIV Services for meeting the needs of Young People.
5. Train service providers so that they are better able to meet the specific needs of young people.
6. Make effective linkages between services and communities (parents, schools, civil societies, religious and community leaders and others).
7. Demonstrate the feasibility through successful approaches that could be taken to scale for providing information, counseling and service to young people;
8. Share information and knowledge and use them for action to promote young people programmes;
9. Monitor, evaluate and conduct operations research for programme improvement and community action.
10. Involve adolescents at all stages of the programme development and implementation,
11. Generate political commitment including resources to develop and sustain the programme.
12. Legal provision that guarantees adolescents right to the full range of information and services to protect themselves (and their partners) against infection.