Regional Consultation on the Status of Adolescent Health

Date: 18th & 19th March 2019
Venue: New Delhi

Background and Context

Young people constitute about one third of India's population making their health and development central to public health in India. Compared to earlier generations, young people today are healthier and better educated. However, issues such as gender-based violence, diminished access to sexual and reproductive health information, services and choices, forced marriage and early childbearing, etc. continue to exist.

A range of factors such as poverty, lack of education, inadequate knowledge and limited or no access to basic healthcare services (including SRH), and socio-cultural determinants contribute to these issues. Moreover, national-level policies in India are not tailored to the varied the socio-economic situations of states and of diverse communities; often failing to address the specific needs of young people in these contexts. Evidence-based advocacy and ground-up policy recommendations, therefore, become a vital need in enhancing the understanding of key decision makers and draw their attention towards the emerging needs of young people.

Keeping this in mind, Population Foundation of India (PFI) and The YP Foundation (TYPF) have come together to develop adolescent and youth-friendly guidelines using an inclusive, evidence and rights-based, multi-stakeholder, participatory approach. They have sought to bring together fragmented voices & efforts by young people, community members, civil society members, donor agencies, frontline service providers as well as the government, to define guidelines, which can address the current gaps and barriers.

It is in this context a regional level consultation was held on **18th and 19th March 2019** on **Adolescent Health and SRHR Issues in New Delhi. Participants from Delhi, Rajasthan, Haryana and Punjab joined the consultation.**

This report captures and summarizes the discussions held during this regional level consultation.

Objectives of the Consultations

The consultation aimed to:

- Develop a collective understanding of the present context of youth SRHR and Adolescent Health across different regions.
- Explore the strengths, challenges and opportunities for convergences between various active SRHR and Adolescent Health Interventions across different regions
- Frame recommendations for different stakeholders towards advancing Adolescent Health and SRHR of young people in the country.

Participants:

The participants were from Delhi, Rajasthan, Haryana and Punjab. There were a total of 31 participants present at the consultation.

- 11 from Delhi
- 4 from Haryana
- 4 from Punjab
- 8 from Rajasthan
- 4 from Chandigarh

Day One – 18th March 2019

Sessions Brief

The broad agenda of the consultation included:

- Introduction
- Issues, needs and challenges faced by adolescents
- Existing policies, gaps and recommendations
- Multi-stakeholder interaction
- Strengthening youth participation

The first session started with an icebreaker and introduction of the participants as well as the facilitators. Edwin from PFI and Souvik from TYPF kicked off the consultation by presenting a brief on the background and intent of the consultation, an overview of previous consultations as well as the context to the larger initiative. They mentioned that the consultation in Delhi is the sixth in a series of consultations across the country. The objective, they explained, is to take the insights and learnings from these consultations to the national consultation, which will be held in Delhi later in the month.

They also pointed out that reason for inviting the participants present in the room was to provide a platform to those working on the ground. While bigger NGOs often make up a big presence in the space of adolescent health, the aim of the consultation is to make sure that the youth working on the ground is heard and given the chance to share their own challenges and thoughts. As a listening

and learning platform for everyone, the hope is that those present at the event can take this conversation forward in the future.

Session One:
The first activity (15 minutes) was an individual activity where the participants were given templates to fill out. They were asked to think through the issues, challenges and needs faced by adolescents in their respective communities; as well as the reasons and possible solutions for these.

Following this, the participants were asked to share their individual thoughts and concerns with members of their respective groups. These groups were divided based on the regions that the participants came from. There were:

- 2 groups from Delhi
- 2 groups from Rajasthan
- 1 group from Haryana
- 1 group from Punjab
- 1 group from Chandigarh

The groups were, then, asked to prioritise their top three concerns to share in plenary.
The facilitators, then, clustered the issues put up by the participants as a way to identify key needs.

The needs/ themes that emerged from this clustering were:

- Youth friendly spaces
- Conducive environment to talk about SRHR
- Mental health awareness
- Substance misuse
- Access to SRHR services
- Comprehensive sexuality education

Session Two:
In this session, Dr. Yogesh, Program Officer, RKSK Punjab shared information about the structure and functioning of the RKSK program, to ensure that everyone had a shared understanding of the policies that exist for adolescents.

Started in 2012, the RKSK program initially focused only on SRHR. When it was launched, however, it was felt that other factors also ought to be included within the ambit of the program. Five more themes were, therefore, added and the name was changed from ARSH to RKSK. The themes that now fall under the program are:

- SRHR
- Nutrition
- Mental health
- Non- communicable diseases
- Gender based violence
- Substance misuse

The program has a three pronged strategy including facility based, community based and schools/ Aanganwadi based interventions.

1) **Facility based interventions** – Parents are often uncomfortable sending adolescents to regular clinics for their issues. AFHCs were, therefore, introduced to tackle this problem. The mandate is for these clinics to be placed away from the OPDs to ensure discretion. These clinics are available throughout all CHCs and DHs everyday of the week and are also run out of PHCs every once a week. Moreover, all the States have been given the freedom to choose a catchy name for state specific clinics. Counselors have been introduced, alongside medical officers to ensure that adolescent issues are dealt in ways that are not over-medicalized. The service providers meant to deal with adolescents undergo modular training, based on each theme. Counselors receive six days of training, ANMs receive five days and medical officers go through four days of training. These providers are instructed to maintain optimal privacy.

2) **Community based interventions** – To ensure that information about these clinics reaches a maximum number of adolescents; counselors go into the community every week to hold awareness building events. Counselors, ANMs, ASHAs, peer educators and teachers also organize Adolescent Health Days. The adolescents decide the venue and the six thematic areas under RKSK are discussed along with conversation on how the adolescents perceive their own health through *nukkad naatak*, poster making, etc.

Moreover, peer educators have been enlisted so that adolescents feel comfortable talking about these issues at the community level. There are four peer educators for a population of 1000. The average distribution is two males and two females, as well as two in-school and two out of school peer educators. Boys hold meetings with male adolescents and girls have meetings with female adolescents. These peer educators have the ability to discuss context/ community specific issues, which differ from one region to another. Peer educators have monthly meetings to discuss the issues faced by adolescents in their particular communities. In some states, they also have their own identity, i.e. a bag and a green coat and are given Rs.50/- month as a non-monetary incentives.

3) **School based interventions** – As a way to reach the maximum number of in-school adolescents, the third prong of the RKSK program entails the in-school interventions. In collaboration with the Rashtriya Bal Swasthya Karyakram, RKSK ensures that lectures on health & wellbeing are regularly held in all schools across the community to increase awareness and address adolescent issues.

The RKSK program is currently in the pilot mode, and is available in 25-30% of the states, in different high priority districts. Some districts, however, still have ARSH clinics.

Some of the questions that came up during this session were:

Q: Is the Child Protection Policy taken into account as part of the RKSK program?

- No, it is currently not included under the guidelines but all those who interact with children are extensively trained on 'what to say' and 'how to say it'.

Q: Has the RKSK program planned for long-term curriculum development as part of formal education?

- This is the new mandate in Punjab and Haryana. Two teachers in each school, one male- one female, are trained to include SRH as a part of formal education.
- However, often service providers and teachers themselves are not comfortable talking about SRH openly. This is a challenge that still needs to be addressed.

Q. Have any NGOs or CSOs been instated in monitoring or training capacities?

- The program itself it tweaked and modified in different states. The government designs the module and the states can tweak these according to their own differences.
- While the government primarily runs the program, some states have outsourced peer educator trainings to NGOs.
- There is no monitoring body as such; the department itself monitors the program.

Session Three:

Following this, the participants were divided into groups according to the six themes identified in session one, to work through solutions and recommendations on the issues that were identified by different regional groups.

The participants were asked to decide on a problem statement.

- They had to start with deciding one need as well as the reason for it.
- They were asked to then identify whether their problem statement fit in any one program or policy.
- Following this, they were told to think through and identify a solution or a recommendation for their respective problem statements.

Towards the end of this session, participants further refined their solutions/ recommendations and rated these based on their feasibility, scalability, cost effectiveness and any other criteria. This activity was undertaken towards determining the on-ground policy level barriers to achieve their recommendations and interventions.

Session Four:
In this session, the participants shared their discussions with the larger group. The group also included government stakeholders, who responded to the recommendations shared. The government representatives had been briefed on the activities that had been covered since morning. The representatives present during the discussion were:

Dr. Gautam – State Nodal Officer for Adolescent Health, Delhi
Dr. Rameshwari
Dr. Pushpa
Dr. Yogesh – Program Officer RKSK, Punjab

The group-wise recommendations shared during the interaction were:

Youth Friendly Spaces

Problem Statement – There are no safe spaces for adolescents to openly speak about SRHR.

Existing Policy/ Program – The RKSK program

Recommendations
- The RKSK program is currently not functional in all regions, this should be amended and these services should be available to adolescents in all parts of the country.
- There is limited awareness around the RKSK program. Visibility should be increased akin to the Polio prevention program.
- While the Government and NGOs are working on community empowerment, there is no common network between them; a link should be created to facilitate collaboration.

Potential Challenges
- Families don't support discussion around adolescent SRHR, therefore, even if these are spaces exist families don't let adolescents access them.
- Communities don't support girls and boys visiting the same spaces, beliefs like '*ladkiyan bigad jaaengi*' contribute to the rampant gender discrimination in the community.
- Caste and religion could pose major challenges; the strong value placed on 'tradition' and the discomfort around discussing topics like mental health, sexual health, etc. make it difficult for adolescents to reach out to AFHCs.

Comments from government representatives
- Safe spaces are extremely important, be it to talk about our issues openly or to comfortably deal with menstrual hygiene. It is necessary, however, to recognise our rights to claim our spaces. One has to be ready for conflict, when claiming our spaces. To do this, we should first feel an inherent need for the space.
- Reproductive and Child Health (RCH2) was introduced in 2006 to reduce maternal and infant mortality. Following this, anaemia was found to be the

leading reason for maternal death. Adolescent health, therefore, came back into focus in 2006. However, back then, the concept was limited to opening AFHCs and expect adolescents to walk-in. This was not the case since there was a high rate of denial regarding issues faced by adolescents. While many of these spaces were available, adolescents did not feel at ease in them. The presence of these spaces, therefore, doesn't guarantee that the needs of adolescents will be met.

- Awareness is definitely one important aspect. However, another reason for adolescents not availing these services are the preconceived notions and ideas associated with certain kinds of clinics, hospitals, and service providers. It is, hence, important that adolescents claim these spaces.

Conducive Environment to Talk about SRHR

Problem Statement - 'Sex' is an extremely taboo subject in all arenas and ASHAs, ANMs and teachers are unable to openly and sensitively talk about SRHR issues.

Existing Policy/ Program – The RKSK program, The National Health Policy, Gram Panchayat Development Program

Recommendations

- ASHAs, ANMs, teachers etc. are influential members of a community. It is, therefore, important that their capacities are built to enable them to openly speak about SRHR issues.
- Data collection and monitoring indicators need to be modified. Both baseline and end-line monitoring should take place to estimate the changes that take place over time; and the results from these studies should be utilised to establish realistic indicators of change.
- The mandate for Sarpanch's role on social issues should be monitored and rewarded/ reprimanded accordingly.
- An external, third party, to ensure an unbiased output, should conduct the evaluation of these programs.
- While sufficient funding already exists within different government programs, a certain amount of funding should be dedicated to the capacity building of service providers and community leaders.

Comments from government representatives

- The government releases monthly reports on the RKSK program. It is important to have a look at these when trying to assess its progress.
- All the data that is collected, as part of the monitoring program, needs to be analysed properly. Unless this happens, this exercise will be futile. It is, therefore, important that only workable data is collected because too much data will always have an element of error.
- The government does undertake coverage evaluation and surveys, which are carried out by a third party.
- Supportive supervision and awareness are the weakest components of all public health programs. While there is a need to identify the non-performers, one must also be aware that this may have to do with health-

seeking behaviours in our community, rather than the be a shortcoming of service providers alone.
- The government can pump in resources but the community also has a role to play in improving the current status quo; teachers, CSOs etc. should play an active role in mobilisation and increasing awareness.

Mental Health Awareness

Problem Statement – Adolescents in my community find it difficult to express and address mental health issues due to the stigma associated with it.

Existing Policy/ Program – Health and Wellness Centres and School Health Programs under Ayushmann Bharat.

Recommendations
- A linkage between the education and health departments is vital. Teachers should be trained to be the first point of contact and to make the first diagnosis for mental illnesses like ADHD etc.
- While some teachers are being trained there is no set time for referrals, at the moment. A specific time window and a referral follow up system with proper accountability should be set up under this program.
- There should be a mandatory module around mental health, as part of the formal school curriculum, to engage and educate school children around emotional intelligence and positive psychology.

Potential Challenges
- The targets of these policies are usually government schools, which lead to out-of-school children getting left out.

Comments from government representatives
- Instead of training all teachers, why not focus on one teacher from each school, who the students trust and feel comfortable with?
- As per the GoI norms, each school will have 2 trained teachers; they will be the health and wellness ambassadors. This program is going to be implemented in selected regions.
- We, however, cannot leave the job of counselling to teachers. Counselling is a very specialised job and health is not that simple a subject; mental health least so. Our suggestions to GoI, therefore, should be very practical. Experts should be doing experts' job.
- In many schools where counsellors are present, children often hesitate to go to them since other students make fun of them. Teachers should have some awareness around mental health so they can become mediators between counsellors and students who seem to be facing issues but are unable to address them.
- Teachers should definitely be sensitised around these issues at large. Acceptance amongst peers, however, also plays a very significant role. For instance, it reduces absenteeism amongst girls who start menstruating. It takes time, but once peers are sensitised, they become a big source of support.

Substance Abuse

Problem Statement – Adolescents get involved with substance abuse due to peer pressure, stress, depression and a lack of positive role models.

Existing Policy/ Program – Peer Educators as part of The RKSK Program, the National Narcotics Act and the National Mental Health Policy.

Recommendations

- The issue of substance abuse should be included in the formal school curriculum and the teacher responsible for teaching this subject should be sensitised so students feel comfortable discussing these topics with them.
- More de-addiction centres should be created. These should be more accessible with an easy referral policy in PHCs, CHCs, AFHCs, etc.
- Substance abuse should be prioritised under the National Mental Health Policy.
- Counsellors should be sensitised on how to identify and deal with cases of substance abuse.
- Substance abuse should be a chapter in the medicine course so doctors know how to deal with these cases.
- The taboo around seeking help for mental health should be addressed by increasing sensitisation within the community.

Access to SRHR Services

Problem statement – Health infrastructure is lacking in SRHR related services preventing them from reaching the relevant audiences.

Policy: The RKSK Program

Recommendations

- Currently AWWs, ASHAs, and ANMs should only provide SRHR services to married couple due to the taboo and stigma around talking to adolescents about these issues. There is a need therefore, to strengthen the youth based focus of these service providers.
- Primary Health Care centres need to be strengthened with proper doctors and services available at these centres.
- Peer educators in RKSK don't have a lot of incentive to motivate them to continue working in the long-term. There is a need to change this so that RKSK services reach more adolescents.
- The government cannot use traditional ways to target the youth. There is a need to have youth oriented volunteer programs and a network of youth, in every block, who can talk about particular issues. This can be done in partnership with CBOs.
- Patriarchy and traditional beliefs don't allow for easy access to SRHR services. People may know about policies but don't know how to avail of them, others don't know about them at all. Increasing knowledge and awareness within the community is, therefore, important.

- The stigma around this topic leads to fears around lack of confidentiality and anonymity. This fear should be addressed to ensure that adolescents don't worry about this.
- Service providers themselves hold many biases against adolescents using SRH services. They should be sensitised to provide judgment free services to all adolescents.

Comments from government representatives

- All these points are important but the behaviour of police and junior service providers should also be dealt with properly, since they are the ones who hold the maximum biases against the use of SRHR services by adolescents.

Comprehensive Sexuality Education

Problem Statement: The word 'sexuality' induces discomfort within the community due to the taboo around the subject.

Policies: The RKSK program.

Recommendations

- We cannot emulate the same syllabus in every region. Every community's sexuality education should be specifically designed for them so it is relevant and easier to talk about.
- It is also important to have staff that understand and can focus on specific community needs, changes, module revision, etc. These should people with expertise in psychology, gender studies, etc. who are preferably from within the community.
- We cannot jump directly into sexuality education due to the discomfort around the topic. Rapport formation around other, more approachable issues first is important to build trust, and then move to these issues.

Multi-stakeholder interaction

CSO involvement

- We are trying to improve the conditions of the adolescents in the country, yet those most responsible for this (peer educators) are paid a mere Rs. 50/-. There are no selfless services in India yet and this is one of the reasons these services are not spreading.
- In Delhi, we have a AFH clinic in Dr. Baba Sahib Ambedkar Hospital in Rohini. There we are starting a new initiative to provide free of cost HPV vaccination. Only girls between the ages of 6 to 14, that are residents of Delhi, are eligible. However, not a lot of people know about this. It is important for CSOs to collaborate with the government in its initiatives. They could adopt one particular clinic and help with awareness building around it. We have resources and trainers, but awareness and mobilisation is a problem. Government has its mandate but it is not 'the pill for all ills'.

- Often the attitude of service providers isn't good. We understand this and are working on this. We even call beneficiaries and ask them how they feel about the services. But the change will take time. We cannot cater to adolescents without the help of CSOs.
- We are planning to add more clinics, but are not getting enough footfall. We are losing the battle to anaemia and the NFHS data shows that the situation getting worse. So we need help from CSO urgently since we are losing out on time and won't be a 'young country' after 20-30 years.

How to ensure a feedback loop?

- The state can sign a MoU with CSOs. We have done many meetings under the peer education program. Roles and responsibilities of the government and the CSOs etc. are clearly demarcated. CSOs expertise can be used to the benefit of the government; it has its strength but lacks in mobilisation etc. and the two can help each other.
- This work cannot happen in silos. But we also need to justify the need for resources. So CSOs should come forth with their expertise.
- Maximum adolescent health links with education department. If we speak to teachers directly they say they have not received any such guidelines. The department on the other hand claims that they have sent these out. So there is a need to have a meeting with the education department, at the head quarters.
- CSOs have good associations with many newspapers. Yet, very little is written about adolescent health in these sources. This can be a good avenue to speak about these issues and move beyond sensational news. It is important to write about their health and wellbeing.
- There is scope for improvement but if CSOs and the government work together, a lot more can be done. We need to come together and work towards synergetic action. An MoU is a feasible and easy mode through which we can all get going.

How can we create further community involvement?

- Discussions around SRH need to start at home. PRI members can facilitate this but cannot start the conversation. We have documented success stories and shared them in the community at a later point, which helps a lot in increasing awareness. Fruitful results should be documented and used as case studies to be present positive stories.
- The menstrual hygiene scheme under RKSK is running in a number of districts. This involves the distribution of sanitary napkins at the rate of Rs. 6 for a packet of 6 napkins, which is a subsidised rate. These schemes exist but not everyone knows about them. RKSK is a very vast scheme. There is a need to also put yourself in the place of the government and give recommendations accordingly.
- Many initiatives are not health related but are being rolled out under the health department. It is important that in cases like those of drop outs the WCD also gets involved.
- The Aanganwadi centres under the ICDS scheme are not ideal but they have done a lot. Under the given budget one cannot expect better than

this. Our expectations might be higher but one has to understand the constraints as well. Credit must be given where it is due.

Day One was concluded with the facilitators asking the participants to think through the role of the youth in Youth Based Policies as well as how this can be improved.

Day Two – 19th March 2019

Session One

The second day started with a feedback session regarding the activities that took place on the previous day. Some of the feedback that came through was:

- The sessions were very engaging. We had the space to explore ideas and the facilitators acted as good guides through the entire day. We felt free and not bounded; it felt very natural.
- The people coming together from different organisations and NGOs were very helpful. Everyone got one platform to speak about this topic, which does not happen often.
- We learnt a lot during the course of the day.
- We wish that there had been more conversation in Hindi; it would be better as it would have helped us understand better.
- The structure of the day could be improved. If the Government panelists had come before lunch the policy brief would have been more comprehensive.
- The agenda setting in the beginning of the day could have been more comprehensive. There could have more documentaries, videos, etc. to explain the current context and scenario of SRHR.

- Adolescent needs should have been discussed region-wise since different regions have different challenges.
- If the regions were mixed right in the beginning, we would have been able to have a better, more comprehensive approach.
- We should have had more energisers.
- The closing of the day could have been more interesting. We could have revised/ summarised what we did through the day.
- The worksheets were helpful. Rating on different criteria helped with identifying barriers.

- The Government panelists' feedback wasn't helpful. It was too top level and they spoke too much about what the government is doing and how the civil society is falling short.
- There were gaps between the information they were sharing and what we know through on-ground experiences. We wish we could have asked them more questions.
- They didn't seem open to our suggestions and were criticising them too much. They seemed too rigid.

- Maybe it's important to also recognise the positive aspects in government programs and only then add on our suggestions in the way we present our recommendations to the panelists. It is also important for facilitators to play this mediating role for this.

- We could have had better assistance in one direction, to help with narrowing down the group discussions, which often went all over the place.
- We aren't working for government policies and their improvement; our focus is to improve the status of adolescents.
- It seemed like we only spoke about improving government policies and not enough about the mental models of the community.
- We should have had more interaction time with government panelists.

- It is beneficial to limit and prioritise challenges so we are able to think through one or two challenges in depth rather than pick up multiple challenges. We cannot speak productively about each issue.
- We should have focused more on discussions around contraception and STDs.
- Time allotment was fine across all activities.

Session Two

Following the feedback session, the participants were asked to think through, either in groups or individually, the role of the youth in the formation of youth centric policies like RKSK and how this role can be strengthened.

The participants were then asked to share their discussions and thoughts in plenary, with the larger group.

- I found out about RKSK for the first time yesterday. The work happening from the side of the government does not reach rural areas. Grassroots implementation is severely flawed.
  How to improve this? Those working on ground should be heard, their challenges should be acknowledged. There should be 2-3 people monitoring and reporting on the work happening at the grassroots.
- There should be a monthly meeting where we can speak to adolescents about what their needs are. While this is a provision in the RKSK policy, it is not happening at the grassroots. Programs should be held in the community to improve the situation.

- A lot of things exist at the policy level but implementation is flawed. Policies should be designed alongside the youth representative of each state (every region is different).
- Adolescents of 40 years ago were very different from those today. They have access to different technology, different thoughts and ideas. We need to keep up and utilise the avenues they are familiar with.
- We could use games to talk about health and wellbeing.
- Youth Parliament is a good way to reach adolescents. Youth needs to be made aware of their responsibility, their stake in different policies. If they feel ownership towards it, they will also buy into it.

- These policies should be promoted using advertising, possibly on the Internet.
- Youth should participate in the creation of policies that are directed towards them to ensure that their points of view are incorporated. This participation should be of people from diverse backgrounds to ensure representation.

- Those leading the programs should be youth themselves.
- Suggestions given by the youth should be incorporated into the policies and programs.
- Why are those responsible for implementation (ASHAs, ANMs) only women? Men should be involved.
- Those meant to prevent and deal with sexual harassment are themselves uncomfortable talking about these issues. This needs to be addressed.
- Are people from the LGBTQI community given the same space in these programs? There is barely any awareness around their needs, and even their existence in certain communities. They could be given government positions like ASHAs, ANMs to increase their opportunities and visibility.
- There should be extensive advertising, akin to the Polio program, to spread the word.
- Adolescent issues should be incorporated into the school curriculum.

- Currently there is only an indirect role for the youth. Data collection and surveys are carried out on them, but they don't have an actual role.
- We could organise conferences where the youth can present their points of view, challenges, and problems to policy makers; who can then gauge their feasibility.
- There should be an anonymous helpline to call and discuss their problems. One already exists but there is no awareness around it.

Session Three

In the next session the participants were introduced to the 'participation ladder'. The different levels talked about were:

1) Manipulation
2) Tokenism
3) Young people are assigned roles and informed
4) Young people consulted and informed
5) Adult led, decision shared with young people
6) Youth led initiative

They were then asked to share examples from their personal or professional lives that correspond with any of the categories in the ladder. Some of the experiences they shared were:

- Number six, Youth led initiative - I used to work in a company 2-3 years ago. Most people were young and we used to speak about holding a seminar and put forth our opinions. Some people would get interested. I spoke to my 'sir' and took permission to hold a seminar on sexual

harassment in the company because I felt the need for it. In this way, the youth got together to organise this seminar.

- Number six, Youth led initiative – As part of our project, we speak to children between 10 to 19 years of age, on SRH. Those who talk to these children are young people themselves. Earlier we did not know about these programs but after the training we found out about them. We are able to talk about these issues because we have been through the same ourselves. Moreover, we appoint class monitors who take these conversations forward and play their part.
- Number six, Youth led initiative – We hold sessions for out of school children. On speaking to them about why they don't go to school, they asked us whether we could teach them. So we took on the responsibility to teach them every Sunday.
- Number two, Tokenism – We have an Internal quality assurance cell in college. I'm part of this cell. And while we are invited to all the meetings, the college committee members make all the final decisions.
- Number one, Manipulation – I was working with an NGO during my graduation. A lot of my friends joined this NGO as they spoke a lot about social issues, poverty, etc. But after a few months we realised that it was all show and that the work we did was only for the sake of being presented on social media.
- Number six, Youth led initiative – Whenever we work in the village, we do a safety assessment with the youth group who make recommendations after having internal discussions. Whatever recommendation we get from them are taken to the village leaders and presented during a meeting. They, then, also ask for their suggestions to be incorporated.
- Number one, Manipulation – Where I live, Christian missionaries attract young children saying they will provide free tuition and stationary. Many children end up going but their main motive is to convert them to Christianity.

Following this, the Policy Working Group was discussed with the participants. It was explained that this group works on health issues of young people. There are no organisational representatives and everyone is part of it as an individual to ensure that there are no power imbalances. They were asked if they were interested in joining this group and requested to sign, if so.

Nikita from Restless Development talked about the Youth Insight that took place in October. The idea to start this Policy Working Group was incepted during this time, since the majority of policies don't reflect the needs of the youth. In November, a structure, objectives, and vision statement for this group was discussed. There are currently around 20-25 members from different parts of this country, with representation from different states.