Regional Consultation on the Status of Adolescent Health

Venue: Imphal, Manipur
Date: 15 Feb'19-16th Feb'19

Introduction:

Young people constitute about one third of India's population i.e. about 364 million but in reality, most young people in the age group of 10-24 years lack basic knowledge of nutrition, sexual well-being, family planning and contraceptive methods, HIV/AIDS and menstrual health.
Population Foundation of India (PFI) and The YP Foundation (TYPF) has partnered for development of adolescent and youth-friendly guidelines through an inclusive, evidence-based, rights-based, multi-stakeholder and participatory bottoms-up approach bringing together fragmented voices & efforts across and among young people, community.
Only 14% of young men & women had obtained information on contraception from a health care provider. Only about 15% of young men & women (15-24) reported having received sex education. In majority of the cases, youth and adolescents have not been involved in framing policies around SRHR and neither they are capacitated with skills and knowledge to contribute towards the policies. Also when we speak about contraceptive methods we speak from a perspective of heteronormative family and reproduction under marriage where we leave out a larger chunk of population unmarried and yet sexually active under the process in the Indian context.
Freedom to make SRH decisions free from coercion, discrimination and violence across geographies is the need of the hour if the nation and family demands productivity from the workforce i.e. the youth.

Working as the first step towards bringing a cross section of diverse voices the regional consultation aimed at developing a collective understanding of the present context of youth SRHR and Adolescent Health in the region. Further it aimed at developing national-level guidelines based on state-specific recommendations from youth, adolescents and CSOs to compliment state/national programmes and establishing long term and sustainable relationships that can be the focal point of AYSRHR engagement.

Ms. Philazan Shang Shimray, State RKSK Consultant, Manipur and Mala Lisham, Social Welfare Department attended the second half of the consultation. Dr Nilanjan Bhattacharjee, SNO, RKSK Tripura and Ms. Dipanjali Choudhury, SNO, RKSK Assam were present on skype during the second half of the session when recommendations were proposed.

Snapshot of the Participants:

The participants were representatives of 7 states covering majority of the North east region. The participants in the consultation were representing a diverse spectrum of experiences, there were school students and there were queer rights activist and doctorates sitting in the same table. However, for many of them the terms and discourse around SRHR was very new and many of them attended the dialogue around SRHR for the very first time in their region.

Among the 35 participants in the room:

- Only 5 participants knew about SABLA scheme
- 3 participants heard about MHM
- Only 9 participants heard about RKSK
- 13 participants never heard about the term SRHR or anything related to them before attending the session.

Day 1:

Session 1:

What is Sexual Reproductive Health and Rights (SRHR)

Summary of the activity:

Considering the diverse group and the experiences it was very important to come to a common understanding of SRHR. So the first session was to identify certain important parameters to be able to deconstruct SRHR in the simplest way. On a white chart paper a figure of an adolescent was drawn and the participants were asked to label few things:

a. Who is an adolescent (the characteristics)?
b. What are their (adolescents) needs from the outer world

Who is an adolescent	Need from the outer world
• They are Curious and eager to learn • Has an identity • Positive and enthusiastic to adopt changes • Undergo Puberty and Physical Changes • Age in between 10-19* • They are Confused • Prone to bullying • Starts developing Self-consciousness • Disturbed feelings where no one understands them (speaking from behalf of queer identities where they are made to feel shamed) • Context of freedom gets skewed • Prone to Substance abuse • Not aware of many things in reality and thinks misjudged • Feel: Mood swings, feels that they need to be understand	• Mental support • Positive support • Physical support • Lack of information: HIV/STI • Destigmatizing conversations around sex • Educating them about puberty/body before entering into this period • Need of change in syllabus in school: The NCERT books are too clinical and this needs to be changed. They are in binary and it needs inclusion • Actively involved in politics and giving them the agency • Guidance from parents to be able to have informed decisions • Counseling sessions for adolescents that includes parents also • Awareness around Substance abuse. • No entertainment: Recreation center is very important for adolescent and youth to have a healthy mindset. In Manipur there were hardly any spaces for that and there were no ways to express their energy and creativity hence the drugs. • Autonomy and agency in life. Many a times liberal people encouraging youth in institutions faces backlashes and there is no space for youth to express their views.

There was a discussion in the group where they insisted that in Northeast, children grow old very quick. Even before they are 10 years old they are already taking care of the household and therefore the context specific cultural and social scenarios should also be considered before universally deciding on the age of adolescents. It was interesting how socio- culture. After identifying the needs from the outer world the second part of the discussion with the participants further explored:

a. What avenues adolescents' needs
b. Met and unmet needs based on the avenues

What avenues they need	Met and unmet needs
• Positive reinforcement: parents being helpful and understanding • State run Sports and culture Centers • Capacity building exercises on understanding choices and body rights • Accessibility of services around HIV AIDS • Counseling centers • Youth friendly Health services • Sex education • Contraception: Accessibility and awareness. Schools being the important sections on health • Free Sanitary pads should be part of policies • Awareness on mental and sexual health • People with Disability: Inclusion is an issues, without social worker, without infrastructure, fund and no support from guardian, it becomes problematic.	• There should be awareness and the message about adolescent health should be universally disseminated among the region. • Education is not designed in an inclusive way. The standard demarcations of education system don't fit in everyone including people with disability in it. • Education is met to a certain limit but it falls through as a majority of girls actually drop out and they join family and get pregnant. • Autonomy and representation for youth is limited. E.g. Only as Student Bodies in Universities but not in other places where youth is a primary stakeholder. • Accessibility of Sanitary pads is very limited, there are no vending machines. Even in government schools there is limited supply of sanitary pads and few schools collect pads in subsidized rates and when in stock gives students' one each during any emergency (if they stain in schools). However, students are always advised to keep sanitary pads with them. • Counseling services and Support systems for youth in general are limited. And if also there are counseling centers (infrastructure wise) there are no trained counselors who are functionally running the centers. • No process to curb teenage pregnancy as there are no awareness systems functional in the community. Parents themselves get their daughters married early and manipulate their age in front of doctors during pregnancy.

Few important points:

- Every discussion around Sex Education in the group hovered around contraception and information about STI/HIV only. To break the cycle, the facilitator introduced that Sex Education includes myriad of topics in it other than contraception and STI/ HIV information. It was shared that from consent to negotiation, puberty pleasure, sexuality and much more are included under Sex Education.
- While the participants were discussing adolescent needs and avenues none of them mentioned Abortion as a need. There was a mixed reaction in the group on the understanding of Abortion being illegal. The part of the discussion then included the concepts of safe abortion services.
- Also discussions on policies and their intervention in their regional context or mentioning ASHA/ANM, stories or experiences from PHC or local Health services were not mentioned at all.
- A participant shared that more than 80% of people residing in Kokrajhar, Assam are very poor, access to infrastructure like schools, hospital is very limited and they only had to travel for more than 4-5 kms. to reach Bongaigaon (Assam). Where the infrastructure and the medical services are so poor and where young girls and boys gets married as early as thirteen or fourteen policies doesn't matter. The common people in such remote areas believe that its legal to have a child as soon as one gets married and the age factor becomes secondary there. Such areas therefore become grey zones to talk about SRHR and policies. Hence speaking about recommendations as they shared seemed to be quite a distant task from the group where they even face challenges to hold conversations around SRHR.

Session 2:

Mapping out the challenges to meet these needs:

Summary of the Activity: The next activity was to identify the interconnection between the challenges met by the adolescents from the systems that were not in place. The group was asked to map out the reasons for the unavailability of the support system adolescents face in accessing the needs and services around Sexual and Reproductive Health from a Rights perspective. Seven small groups were made and the groups were given about half an hour to discuss about the challenges and present in the bigger group.

Group A:

- ASHA workers needs to be trained and should be provided clear role allocation. The majority of the ASHA workers in the community doesn't know their roles. They don't distribute it. The SABLA scheme is not working in the community and there is no monitoring also. The ASHA workers doesn't distribute any products or talk about services in the community.
- Lack of awareness of services and knowledge. Adolescents are curious and they want to explore their sexuality but in the community they are vulnerable when they become pregnant as they hardly know about their agencies.

- Availability of pads and condoms in the community is limited. If vending machines are installed then adolescents can avail the services whenever they want to, without depending on any leads.
- Schools avoids discussion around practical issues. Schools should adopt sexuality education from a very early age in order to bring a change.
- No community level interventions in order to facilitate behavioural changes.
- People end up googling information from social media which turns out to be half true mostly. Helpline, counselling centres and call centre for SRHR is the need of the hour to bridge the gap of information.
- Rather making Abortion illegal (as Manipur is a Christian dominated state and there is prevalence of religion that affects the practice on ground) the doctors needs to be made illegal who makes money out of the abortion illegally. In Manipur there is a center (the participant didn't want to share details) where doctor have been conducting abortion illegally.
- There should be systems on awareness on sexual abuse or molestation in place for youth to register complains. There is not much discussion about sexual abuse in the communities.

Group B:

- Lack of any form of support system to understand puberty, changes during adolescence and even pursuing important decisions in life. Voices of youth are never considered important in the community. The economic condition actually curtails a lot of aspirations of young people in this area and that leads to a lot of mental health problems.
- There are no functional behavioural and communication mechanisms in the community where there is a discussion around adolescence, vulnerability, puberty, relationships and sexuality etc. The cultural standpoint actually curtails a lot of information that the adolescents should be provided with.

Group C:

- The community is conservative and it's easy to talk about Life skill education than talk about sexuality. The gender roles are assigned to everyone.
- There has to be programs for teachers in schools to be able to speak about sexuality and SRHR with the children in the school. Adolescence cannot be treated in isolation, there is no serious program related to health in the community based on SRHR and adolescent health.
- In schools where there are counsellors' (CBSC schools) students are not aware of the importance of having a counsellor. In most of the cases the counsellors are used as substitute teachers. There needs to be accessibility and availability of the services in school.
- A majority of adolescents start working very early in their households and they also go to work for daily chores at other houses. This can be exploitative.

Group D:

- Religion and Customary Laws plays a big role in North Eastern States that supersedes all the laws and from experienced of Meghalaya and Mizoram (someone who worked in these regions only mentioned these regions) and hence talking about SRHR becomes a backlash in the community.
- In *Dobar* (a community gathering) system people are not allowed to talk about sex. In Mizoram there is an underline practice that one has to marry virgin and before marriage they have to undergo series of counselling. Having to deal with all these talking about SRHR becomes a problem.
- We never consider the role of infrastructure in making the services available to the last mile. Considering there are services available in hospitals there are many places where reaching to the centres can be a big issue for people majorly staying in the hill regions. Doctors and teachers don't have proper quarters in many places and hence there is no way that they can stay back and work in the communities. So services also need to be collaborated with agency available to avail those services.
- In Megahalya there is a room in PHC, counsellors are supposed to come but there is lack of information so even youth doesn't come.
- The HIV/AIDS issue is very vital in Mizoram and Manipur. During elections they would put up IECs talking about HIV/AIDS etc. but soon after the election they will take it down in pressure of the Religious Institutions as in a state where religion plays a big role, talking about sex and gender. And majorly in the Baptist Institutions they hardly talk about any other gender other than men and women and its very difficult to talk something beyond it. The new party currently is extremely conservative and religious.

Group E:

- Role of Mental health in SRHR: very less avenues and incentives for new energy to grow in North east hence youth has very less mental growth in these regions.
- Youth are not considered as sexual beings having pleasure and desire to explore sexuality.
- There is a lot of corruption lined up even down to the service provider level as there are frequent news that says diagnosis machines etc. disappears from the PHCs etc.
- There is an element of fear among youth for accessing SRHR services as there is lack of awareness on services.
- There are very less organisations working on feminism and patriarchy in North east regions that talks about narratives of feminist movements.
- The media and culture also tends to provide a gendered information to the adolescents. E.g. menstruation is treated as a woman's only issue and information is schools are provided separately to boys and girls.

Group F:

- Teachers in schools should start working with the parents also as parents would really agree to teachers supporting the cause.
- The urban and the rural context on SRHR should be seen separately.
- There are no areas to have dialogue around PCOS, vaginal discharge etc. with youth.

Group G:

- There is very less knowledge that abortion is legal for married/unmarried women and girls irrespectively. Only in the case of minor there needs to be a guardian for this. People usually refrains from abortion in a government hospital due to lack of privacy as they are not aware that all hospitals are supposed to cases on abortion private.
- The health centres are not transgender friendly at all and while we talk about inclusion, in reality the discrimination prevails. The doctors are not trained on how to deal with transgender when they come for check-ups.
- On one side when we speak about Sustainable Menstrual Hygiene people in North East struggle to get a word on menstruation. There is no proper language in a word that talks about menstruation.
- In few hospitals there are proper rooms allotted with televisions and other IEC materials but youth has no idea of such services.
- In Meghalaya it is mentioned in paper that government is supposed to provide free sanitary pads etc. but the MHM scheme is not working properly at all.
- Sexual health/HIV: The medicines supplied in the North eastern region are very poor. Interestingly the only program to reach the LGBTIQ community in North east is through the HIV/AIDS program. So there is a clinical approach to the programs which the LGBTIQ community may not always be comfortable to reach out to.

No trans person reaches out for medicines for HIV/AIDS.

- Discussions around HIV/AIDS can be done in Manipur and Mizoram as the majority of funding has been around that however in Assam it is problematic to talk about HIV/AIDS as the entire discourse of movements around LGBTIQ community has been around the 377 issues towards rights based and it was not at all health based.
- The Sex Reassignment Surgery for trans people in North east is very difficult. One has to either go to Guwahati or Kolkata for any sort of operations.

A brief about RKSK

The next session was to introduce the Rastriya Kishor Swasth Karyakram (RKSK) to give the participants an overview of the policy. The idea was to help them get an overview of the policy and then start identifying gaps in between to frame recommendations. Few of the important points discussed were:

- RKSK is one of the National Adolescent Health Strategy developed focusing on the adolescent health care.
- It is an aspirational program and the strategy rolled out in approx. 231 districts in the country because the mandate that comes under RKSK is massive based on the components.
- Roughly three categories in which the interventions for RKSK can be pitched: Community based intervention in RKSK pushes through the curative and clinical approach introducing adolescent friendly health services in the community through sub centres, PHCs, district hospitals etc.
- The recommendations for RKSK and Adolescent Friendly Health Services (AFHS) can be looked through five simple principles. as per WHO's recommendations on Adolescent Friendly Health Clinics (AFHC): Adolescent Friendly, Accessible,

Equitable, Effective and Acceptable. The participants were also asked to focus on these while framing the recommendations.

- Not all districts have been able to roll out AFHCs in the best possible way.
- The peer educators were trained under RKSK to support the entire program but their retention in the program has been a challenge because the returns from the program is very less, there is no financial returns at all and mostly things are paid in kind at the end of the year e.g. t-shirts and bags.
- Adolescent Health Day is conducted quarterly as a part of Village Health Nutrition and Sanitation Day to reach out to adolescents and parents. So as a part of recommendation health checkups should come into this.
- As per the *Ayushman Bharat* program it is proposed that in schools there would be at least two teachers as health and wellness ambassadors trained on comprehensive sexuality education to be known as Health Education and they will be conveying that to the students of the school.
- RKSK aspires for a District Committee of Adolescent Health (DCAH) and State Committee of Adolescent Health (SCAH) that is supposed to have representation of doctors and NGOs and adolescents primarily in this context but this methodology didn't roll out good in the community in the implementation level.

Session 3:

Challenges and Recommendations

Post lunch, the participants were asked to identify the gaps in RKSK in relation to the health facilities available in their states as health is a state subject. They were shared that despite the centre provides guidelines on health its actually state's discretion to prioritise adolescent health but it ends up prioritising maternal and child health. The group through the discussion pointed out, mental health, sexual abuse, reproductive health, communicable and non-communicable diseases and violence as core issues. The group was then asked to ensure the changes that they would like to see in RKSK and bring it into the recommendation for ensuring adolescent and youth voices and representation of issues.

The participants in the group were asked to plan out the recommendations under four parameters that might work as alternative in regards to the current structures: Access to Information, Access to Services, Infrastructure, who is our target group.

The recommendations were:

Problem: Lack of accessible counselling centers for adolescents and youth
Recommendation:

- There are several community halls in Mizoram called *Dobar* that can be used for AFHC/ Counselling centers where youth can be oriented to come and speak about their adolescent vulnerabilities, and express their views on gender and sexuality. This would be more accessible to the adolescents and even the drop out children attends

the *Dobar*. Hence would be a great move to introduce AFHCs with the community set up with *Dobar*. But government needs to send trained counsellors with updated information on youth and SRHR from a rights based perspective being secure and non-judgmental. These sessions should continue on a weekly basic. In order to take the sessions to the community- infrastructure, quality and mobilising them to access the services are the three key things that needs to be considered. There needs to be visible IECs or announcements in order to motivate and mobilise youth to access these services.

- State Mental Health Authority and District Mental Authority needs to be made functional as despite counsellors being in place the youth are not aware of the services and hence they don't avail these services. Also State Government needs to appoint counsellors in Sub centres or PHCs.

- CBSC schools has mandatory counsellors and under RTE it is mandatory that school should be having counsellor facilities, hence government needs to be pushed on that guidelines to introduce something similar in the government schools. Hence convergence among departments of Health services covering the mental health also and they have to ensure that the PHC should have at least one trained psychologist and the Education department needs to be pushed simultaneously to bring about changes around mental health.

- We need to think from a cost effective method, NALSA has funds allotted for the North East regions and through State Nodal Authority they conduct various sessions and awareness program. Linking up with them and including SRHR content in their sessions would be a great move.

- Having Counsellors in State Board schools and also having the the sessions compulsory.

- There counsellors should be trained over the time and there should be 6 counsellors in the PHC/Anganwadis- one talking to boys, one to girls and the other one experienced in queer issues. The rest three should be in back up. The counsellors should be young and they should be provided fixed salary.

- There should be a counsellor committee who should train parents too. There should be a monthly village counselling. Also its very important that counsellors from every community should speak the exact local language of that place.

- The counsellors should be young to be able to relate to the young people and their needs. Also the counsellors should be having regular refresher courses for the existing counsellors.

- A 24/7 toll free adolescent friendly number with counsellors on the other side speaking the local language. Speaking in local language will help in building the trust between the counsellor and the adolescent. Also toll free numbers can cater to talk

freely in an anonymous way about taboos, myths and stigma when adolescents hit puberty.

- The effective partnership between parents and stakeholders should be strengthened. If the Block Development Officer or the Village Head or Gram Panchayat in public addresses that there are clinics specifically meant for adolescent health i.e. AFHC then the stigma around the services can be catered. A healthy multi-stakeholder partnership is important to de-stigmatise the issue.
  The group discussed that if in general youth are accessing the clinics then people might think that they are sexually active or they have STDs but if the Gram Panchayat or other stakeholders' mentions about these services then it might challenge the stigma and parents might also be ready to send their children to the centres.

Problem: Lack of visible IEC materials on SRHR

Recommendation:

- The IEC materials should be done in a local language and is more context specific.
- The RKSK policy itself has a Hindi name to it which becomes extremely difficult to implement it in the fields in North east.
- Local television channels, newspapers and radio networks should be mobilised for showcasing the IEC materials.
- There should be proper monitoring in the Anganwadi centres for the services.
- The advertisement around Prohibition of Smoking run by governments in cinema halls or televisions are so scary and no youth wants to experience or watch that.

A participant shared that, 'Why are IECs made for awareness on health so clinically made Why can't there be some fun way of disseminating these concepts?'

Problem: Lack of sports and entertainment for adolescents

Recommendation:

- Schools should start incorporating sessions on health in the sports.

Problem: Lack of SRHR awareness and awareness on schemes

Recommendation:

- Making SRHR compulsory in schools. In schools the Value Education and Environmental Science classes can incorporate SRHR already into the set system. And these subjects are always used as token in schools as hardly there are specialised teachers for these subjects. The teachers however teaching SRHR under Values Education or Environmental Science should be a trained person.

- The B.Ed courses for teachers should have the subjects on SRHR education in it during their training so that once they pass the course they already are trained SRHR facilitators.

- Forming peer pressure groups in the community, and building a private-public partnership to talk about schemes. The peer pressure groups will be led by the youth.

One of the participants shared that, 'Until and unless we make the community understand not a single scheme will actually work out. It is also very problematic to talk about SRHR'. She shared that a majority of the polices designed by the centre is not prepared keeping in consideration the needs from North East so when the policies reaches the ground in North east it loses the value because implementation becomes a problem as schemes are not contextual enough.

A participant from Mizoram shared that for a majority of policies that are designed centrally the State Government and Church denies the implementation in the community. The religious leaders are in the power recently. So despite the NALSA or the Supreme Court judgements taken time and again around Trans Bills or scrapping of 377 may not have a ripple effect in Mizoram. Church is the last resort to help bring about any changes related to youth and their health and gender in the communities, they are very orthodox but only they have capacity to bring a change in the community in a larger perspective.

Problem: Not enough sanitary pads distributed in schools and not enough dialogue around menstruation.

Recommendation:

- Local sustainable products should be promoted. The organisations working on the sustainable menstrual hygiene products in the ground should be identified and should be promoted by the government to create own products and distribute it in the community. This already has been done in places like Maharashtra and the same model can be replicated in North east to ensure social entrepreneurship.

- Mostly the government projects on MHM has budgets for producing the materials but not for sales and marketing and therefore a small entrepreneur cannot reach to larger group of customers. The budget allocation for sales and marketing should also be taken into consideration while planning MHM programs. Moreover, the projects are all for three years and five years based on targeted approach, to break a pattern of stereotype there should be sustainable plans made in the community versus the target approach set currently.

- Installing vending machines is not the answer as places where machines are installed doesn't function properly or the community doesn't use them at all. There can be an alternative of girls learning to make their own pads as a sustainable skill.

- To start the dialogue on menstruation there should be materials and tools prepared in local language. These local tools and IECs on menstruation should be then showcased in local media. There are already tools and IEC materials made for promoting that

smoking is injurious to health so similarly in prime television channels awareness around MHM should be provided.

One of the government officers said that, 'Under the Beti Bachao Beti Padhao Abhiyan inaugurated by Prime Minister of India, one of the component is too have separate toilets for girls and boys. This scheme is also rolled out for few districts and not all. Haryana, Delhi and Manipur has such stark unbalanced male-female ratio and women are not allowed to be born. We talk about menstrual hygiene but we need to know what needs to be prioritised, as women should be respected as women first before even she finds the schemes helpful for her in the community.'

Problem: Not aware of Abortion Rights

Recommendation:

- A lot of people in the community thinks that abortion is illegal. They hardly have any knowledge on their rights and hence a functional Adolescent Health Day should be using the opportunity to talk about Abortion Rights to the adolescence as a part of awareness of SRHR issues.
- There is a lack of awareness and discussions around contraception in the community which leads into the teenage pregnancy. If the aim to decrease abortion rates is the aim then the awareness around contraception needs to be more functional and widespread.
- The ANM and ASHA workers should be trained in a way that they can disseminate in the community about Abortion being a legal right and they can speak from a rights based perspective.

- The Church Leaders should also be sensitised in a manner about Abortion that they are able to bring a behavioural change. The information should be disseminated in a manner that it should be from a rights based framework.

Problem: Lack of Infrastructure

Recommendation:

- Mizoram has eight Observation Homes where Manipur has only five. And a majority of the juvenile delinquents at the Observation Homes who have conducted sexual violence. We still struggle with a language for sexuality education however we hardly pay attention to these adolescents. Sexuality education even needs to be taken to these delinquents.

- There is extreme corruption in the grassroots where teachers if posted in rural areas usually send some other local representative to teach in the schools where they

themselves doesn't teach them. If there is no proper infrastructure in place for monitoring of the teachers, then the intersections of schemes would not fall in place.

- The AFHC should be creative and fun with visual and youth friendly IEC components. The AFHC should not be gendered, the information should not be disseminated in binary for boys or girls only but should include the third gender also into it. The counsellors should be available in the centres, these centres should have sanitary pads and other educative booklets for youth and adolescents to choose from.

Closing remarks of the day:

Ms. Philazan Shang Shimray, State RKSK Consultant, Manipur

'Family should be the first stakeholder to be able to bring about a change. The first discussions on puberty from girls should start from the kitchen where every morning they are spoken about gender and puberty.'

We should create platforms to talk about SRHR with adolescents and youth. There are very less platforms to have discussion on SRHR with parents, it's important but the routes to discuss about SRHR are not planned. The IECs should be made in local language and there are 260 local languages in North east using only one language may not be a wise decision.
It's important to talk about puberty, body and menstruation to young girls before the on sight of puberty. The discussion around good touch and bad touch should be delivered confidently to adolescents and children since early years.

Church would be one of the allies to work on SRHR if the issues to work with them can start from family counseling, parents' consultation, talking about relationships and family and life skills and later talk about gender and sexuality and reproductive rights. Talking about love and relationships can be the first steps to start with discussions and later talk about gender.

Mala Lisham, Social Welfare Department

'POCSO is a gender neutral law that is overriding any other law in the country when it comes to sexual offence for children. Hence abortion cannot be legal and a right for people who are below 18 years. As per POCSO nobody below 18 years can be pregnant, hence there is no way we can even think about lobbying to government and talk about accepting abortion as a discussion for young people or lobby about getting abortion legalised for young people below 18. There are certain reasons why children get sexually active and that needs to be worked on. It's rather important to understand why adolescents are getting sexually active, is it because of western influence or is it because of fashion or sexual trauma. There are certain reasons of teenage pregnancy that happens in interiors of Churachandpur and that needs to be understood.
Instead of talking about MHM and Abortion we need to talk about certain things that has gone wrong in North east like female infanticide and foeticide. Girls are killed at an early age and there is no respect for girls, in such situations talking about menstrual health and other health topics may not be helpful or important.'

In the communities of North East, there are no funds that organisations have received to conduct welfare and right based projects. The session ended with youth pointing out that the avenues for growth is extremely low and this leads to dysfunctional ecosystem. The participants also showed extreme concern on being unable to take dialogues around SRHR to the communities with ease.

Day 2:

Few important points:

The day started with the facilitator taking an account of the reflections from the previous day and they were asked to list out:

- There expectations from the consultation
- What could have been done differently in the agenda of the consultation
- The takeaways from the first day of the consultation

However, the regional coordinator for the consultation went ahead with an agenda to understand state wise issues the participants would like to concentrate on and work ahead. The next one hour the groups were divided state wise and they brainstormed on ideate they would love to contribute towards.

The paragraphs below mention the state specific issues they would like to work upon and solutions identified on that by the participants. Few of the participants also mentioned reflections from their day one experience.

Meghalaya

- **Issues:**
    - Intensive awareness program on menstrual hygiene in schools, especially in girls
    - Advocacy with women's groups for SRHR - because it's a matrilineal society
    - Linkage with concerned authority for MHM

- **Solutions:**
    - Community based events - to raise awareness
    - One to one interactions to have more effective communication
    - School based interventions

- **Reflections from Day 1:**
    - The whole discussion was about sex education and youth health
    - There are several issues as HIV, mental health, drug abuse, and cancer problems which are only specific to the North East and that needs to be worked out.
    - The organising committee should talk to the locals first and get the context before organising consultation or events.

- All 7 states should not be clubbed together and instead 2 to 3 states at a time should be dealt with during any consultation.
- There should be adolescent representatives from school/ community and parents in the consultation instead of involving more social workers
- Expectations - more receptive attitude to the opinions being offered. People came with their own ideas and then wanted to express their opinions and then come to the agenda.

Manipur

- **Issues:**
  - Discussions around health in the community is around female health only, but in North East boys are more vulnerable and trans genders too but their viewpoints and perspectives are neglected. Hence one area of focus would be need for group counselling for boys.
  - Concentrate on substance abuse. Substance abuse traits can be genetic and there is a politically a grey area - expensive drugs are cheaper in Manipur

- **Solutions:**
  - Ground realities should be understood – there was a case in North east where 400 youth were caught for drug abuse by the local youth organisation and surrendered to the police with no counselling - attitudes of the youth also need to change
  - If we plan interventions, we must consider the ground reality. In rural areas - they have to earn a living - they do not have time for their community or any form of health related discussion.
  - Youth club leaders are not educated
  - We should ensure early childhood education on SRHR
  - Radio is an effective platform - for both literate and non-literate audiences
  - Consultations should be state wise - and involve locals and should be in the local language
  - No viable health centres in hard to reach rural areas - policies only on paper
  - Health education is always relegated and need to be prioritised.
  - In rural areas there is no infrastructure for education and no schools.
  - When people are living in extreme conditions - agrarian workers go from drugs and this scenario needs to be changed.
  - Some organisations are working in Manipur to combat this but not accessible for women and girls

- **Reflections from Day 1:**

  - It was almost a half day consultation (to draft the recommendations) and facilitators should have done their homework regarding the situation of SRHR in the community. There should be one day just for recommendation
  - There should not be a definite agenda
  - The participants should already know a bit about the context before sharing recommendation.

Arunachal Pradesh

- **Issues**
  - To work on Adolescent Health and understand the schemes and policies to take it to the community.
- **Solutions**
  - Channel for collaborations and networking

- **Reflections from Day 1:**
  - Since the consultation was about adolescents - there should have been more adolescent participants
  - More parents and healthcare workers should also have participated in the program.

Darjeeling

- **Issues**
  - Safe spaces for de-stigmatising sex and sexuality and raising awareness for LGBT community - online - social media, local TV channels, offline spaces - training, counsellors, spaces where it is not all serious, picnics, self-sustaining support group
  - Reaching out to parents around issues of SRHR giving them a clear understanding

- **Solutions**
  - Informal meet in the main town
  - Mobilise people to take them to other districts
  - Push for mental health helpline
  - Need support for budget from organisations like The YP and PFI

- **Reflections from Day 1:**

  - Attitude was dismissal - made to feel like they were dumb and not spoken to as equal
  - However, this is just the very first step towards working on core issues around SRHR in the North eastern community.

Sikkim

- **Issues**
  - Still has protection - to protect its customs - the *Zunsa* system prevents government systems from working. To start with, door to door sensitisation session is required.
  - Sex education and normalisation of SRHR
  - Transformation of mainstream education system – stop forcing adolescents to make choices which they do not enjoy

    - Career options for humanities should be made available and children should be made aware
    - Normalisation of LGBTQ issues - should be included in syllabus - nothing in syllabus right now

- **Solutions**
    - Hard to convince people to join and to get collaborations from government - approach fellow students and teachers
    - Approach state government for events around SRHR
    - Approach CM's daughter's studio for collaboration
    - There should be Government run forum for reporting sexual abuse and violence
    - Drug abuse is a problem due to sharing borders with Bhutan, West Bengal, China - the laws should be made stringent

Mizoram

- **Issues and Solutions**

- Abortion - more than 80% of Mizoram are conservative Christian - abortion is murder to them - so information about its legality should be made more widely available
- Substance abuse is a problem – discussion around safe adolescence should start from a very early age.

Assam

- **Issues**

- Sexual health – The research and data on sexual health is not relevant to women in the queer community – there is no data from the ground
- Sex reassignment surgery - specific to whole of North East - people from all over the North East are brought to the regional mental Health Institute in Tejpur - the conditions are horrific. There is no confidentiality and facing stigma
- Early marriage, which is still a prevalent part of the system and needs to be worked upon.
- Highest rate of anaemic women population in Assam
- Due to lifestyle changes - PCOS is getting more rampant

- **Solutions**

- Train more mental health practitioners
- Mental health is a big issue for the queer community - not specific to the queer community. Hence, more inclusive curriculum for queer people
- Formation of self-help groups to cater to the issues
- Focus group discussions to spreading the message

- Working across Assam and reaching out to all of Assam is hard - restricted to Guwahati, hence more collaborations needed

Comment:

Day 1: The group collectively denied to place any of the recommendations from the consultation in front of the ministry.

Day 2: After the discussion on the second day the regional facilitator announced that 'Ya_All is giving seed grants for Rs. 5000 to organisations, and this funds are given to a representative from each state to organise events. Funding is a big problem in North East and there are very less safe spaces to hold meetings and consultations hence this seed grant is one of the kinds of initiative. There was no discussion around Policy Working Group on the Second day at all.