Regional Consultation on the Status of Adolescent Health

Venue: Mumbai, Maharasthra
Date: 28th Feb'19- 1st March

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. PFI through its program is working towards Family planning and making it a demand in India, and providing contraceptive choices for people in India, and prompting participating in the reproductive choices, and development of a youth strategy that is youth led.

The current consultation with representatives from Maharashtra, Goa Gujrat aimed at viewing the policies and programs around Sexual Reproductive Health and Rights in the region from a larger perspective and identifying policy level gaps and challenges. Further it aimed towards framing recommendations while including voices of youth and adolescents in the process of decision making. The needs for adolescents are different and varying so youth guidelines from different parts of the country needs to be framed in context specific ways. Hence the consultation was to understand context specific interventions around SRHR focusing on RKSK and frame doable recommendations around adolescent health.

Snapshots of the Participants:

There were 25 participants who attended the consultation from Gujrat, Goa and Maharasthra and more than 50% of the group has heard about or worked with the RKSK scheme. The group has participants working with Human Rights issues, Menstrual health educators, people working on communication tools around desi sex education, health and nutrition of woman, adolescent Programs in slums.
The group also had participants working around gender, sexuality and technology, transgender rights and gender-non conformist groups. Few representatives were from the Public Health organisations working around MSM, HIV/AIDS awareness, TG welfare schemes and more. Crisis intervention centres for survivors of human trafficking was one of the expertise a participant had.
Few of the participants worked on developing SRHR-inclusive perspectives around curriculum design on- masculinity, gender rights, sexuality on capacity building, gay community, content for adolescent boys-14-17 years old.
Participants also worked around ARSH training- 8-10th in slums, Gender Justice, Legal health-through art and games and in several youth collectives.
Bringing perspectives around education and community health for school, marginalised community and colleges, advocacy with BMC (Bombay Municipal Corporation) and forming resource centres were few of the expertise the group got into the room.
Few participants worked on democratised online portals to co-create new stuffs around woman empowerment and leadership, child rights, gender based violence, and LBGTIQ community through online and offline services.

Day 1

Session 1:

Health and Rights:

The health initiatives and policies is seen from a lens of welfare issue only, but beyond the welfare issue, development is also a rights based issue and health therefore needs to be perceived from a lens of a human rights perspective. On this context the participants were asked to identify adolescent needs, the cause of the unmet needs and the solutions to it.
The participants were provided a tool to write about:

- Adolescent needs in my community
- They need it because (the reason of the unmet need)
- But this can change (solutions identified)

The data from the tools collated into patterns are written below:
Adolescents in my community needs:
Proper education on health (mostly about sex)
They need it because:
My community cannot understand properly about their sexual needs because their parents can't discuss with them.
But this can change:
If parents can discuss about their sexual health in family just like father with son

Adolescents in my community needs:
Health education (including sex)
They need it because:
There is an inability to understand own sexual needs self-identify because of conversation at home.

Adolescents in my community needs:
Sexual health services
They need it because:
There is a lack of awareness around sexual health services specifically testing
But this can change:
e.g, programs around HIV/AIDS for LGBTIQ people tends to ignore HIV testing. In the Vidarbha region through a survey a participant surveyed that 8 out of 100 youth suffers from STI/STD and hence this needs to be channelized and in colleges HIV testing camps should be done.

Adolescents in my community needs:
Mental health care (3 people advocated for this)
They need it because:
It's important but affordability and accessibility is an issue

But this can change:
Schools and colleges should prioritise mental health care.
In order to curb affordability, Counsellors should be on a pro-bono/ minimum charges from non-profit.

Adolescents in my community needs:
Health benefits and government benefits
They need it because:
Because whatever they are getting they think that it's enough. It's satisfactory and hence nothing to ask beyond it, and the benefits tends to float as free and is a welfare subject rather than rights.
But this can change:
So the health professionals should have a mandate task for accountability. Communication of health as a right should be spoken about and the community should be made understand that government is not doing any favour to them by providing them services.

Adolescents in my community needs:
Health care services
They need it because:
Services availability doesn't align with adolescent daily schedule
But this can change:
Timings of the centre accommodating of school and college timing of adolescents
IEC materials for young people's use of contraceptives and disseminate through different mediums like WhatsApp, websites etc.
The Sathiya workers should also be trained in Human Rights along with SRH.

Adolescents in my community needs:
Social dignity and Inclusion
They need it because:
LGBTQI community not treated equally:

- Respect and Equality
- Education, health and housing has no access.
- As they don't have as many options to choose for they end up choosing something that they do not want themselves.

But this can change:
Government should monitor all schemes to include inclusivity and should not operate in binary.

Adolescents in my community needs:
Adolescent girls need mobility
They need it because:
Parents don't allow them to travel with autonomy because its unsafe in the community
But this can change:
Policy makers should increase grassroots level approaches to ensure safety of girls which will decline the number of school drop outs through stronger on ground campaigning.

Adolescents in my community needs:
Services on Safe abortion
They need it because:
There is a conflict between MTP and POCSO because of mandatory reporting for teenage pregnancy below eighteen. So social workers and doctors tend to be in dilemma and doesn't provide young girls services through government hospitals/health centres.
But this can change:
If the clause is reconsidered for the adolescents.

Thematic areas of intervention

From the needs, unmet needs and the solutions identified by the participants a pattern of thematic areas were drawn.
The group identified several thematic areas around which there is a gap in adolescent health initiatives and the services adolescents would need for them:

- The Lack of Policy Awareness of Health Scheme
- SRH- Services and Product: Availability and Accessibility
- Substance Abuse
- Mental Health Services: Affordability and Provisions
- Safe Space to hold conversations around SRH: Lack of Social Structures, Institutions and in Government program, Non Judgmental space shared with parents
- Nutrition
- Education/ Livelihood: Quality of education, Employment, these are other determinants of health
- Sanitation and Hygiene: This only focuses on menstruation and not beyond it.
- Violence: This was a key theme, no safety brackets for non-binaries, trafficking, violence based on gender identity.
- Access to Technology: Making accessibility for Technology is also a youth issue, lack of policy awareness can also be linked to less accessibility of technology and autonomy for adolescents. In a country like India where there is a lack of sexuality education, technology has a link with menstrual health, reproductive health, gender etc. when it comes to awareness. Hence technology becomes a safe space to talk online and also look out for relevant information. Also for trans, queer and for people with disability the online space becomes a community to refer to the gaps of accessibility of awareness.

But the use of technology is not equal for boys and girls and hence having equal access to technology is also a health issue and needs to be framed under the policy recommendation. In Gujrat and Tamil Nadu, government provides tablets in a subsided rate but they don't provide necessary software, Wi-Fi connections in colleges, proper processing methodology for using those.

Session 2:

Identifying the existing policies:

Post the discussions on thematic area, the dialogue involved the existing policies and to understand the existing policies better to be able to leverage for better recommendations. Hence RKSK and its existing structure was discussed in order to identify where can the needs and the gaps be addressed. More than 50% of the group has heard about or worked with the RKSK scheme.

RKSK is a Comprehensive Sexuality Education Program launched on 6th Jan, 2014.

Post the National Adolescent Health Program which was very objective and was more like guidelines but with limited accountability or implementation plans, RKSK was then launched which is still like guidelines but RKSK has six objectives and has six priority themes based on adolescent health these and the objectives are pretty comprehensive. The themes are substance abuse, mental health, violence, non-communicable diseases, SRHR and Nutrition. It's a holistic program that even recognises community interventions for social barriers, it has a peer support module also. ARSH is a very important component under RKSK which further includes the WIFS and the MHM programme under health and sanitation. In sub centres there are walking clinic as per provisions of RKSK and further in District Hospitals there is supposed to be mandatory counsellors in the AFHCs. RKSK is functional in few high priority districts in India and is implemented there with mandatory Adolescent Health Day being celebrated quarterly also which includes screening, deworming, menstrual hygiene services etc. Under the Sathiya model there is the *Sathiya Salah* Mobile app which answers questions around adolescent health. There is a peer educator model where in every village four trained Peer educators are technically assigned to conduct groups and talk about SRHR to adolescents for in-school and out of school population.

But there is no sequence or monitoring done regarding the components as to what the counsellors or peer educators should talk about and hence the sanitised topics like, nutrition, early marriage, substance issues are spoken which are easy to handle but the rest are never prioritised. The counsellors are also given a very short course before they start their roles which should be extended because a mental health professional should be well equipped with all forms of methods to deal with adolescent vulnerabilities. Under the program like MHM and other initiatives around RKSK, there are times when ASHA workers doesn't have a clear role allocation and monitoring mechanism ensured. Also for ASHA her major job role is towards functional maternal health system in the community and her priorities for adolescent health

Important Discussion:

- **Is Trans men/woman also included in the interventions of RKSK**

[?] RKSK operates in the binary. Under the Ayushman Bharat program there are plans to include gender reassignment surgeries and providing surgeries in subsidised rates but currently the RKSK functions in binary and doesn't include trans voices.

- **The curriculum on SRHR**

- The curriculum under the the School Health Program has removed majority of the components around SRHR program and has government has made it mostly around HIV mentioning that other components are covered in the school text books. This was therefore an area of recommendation.

- **For whom are the services:**

- There are only 2 AFHC centres in Mumbai and for a huge number of population it is very problematic to avail those services there.

- **Construction sites and Migrant rights**

- In Goa a lot of people migrate to construction sites. There are no health facilities available for the children of the workers. It is assumed that they leave in six months hence not a permanent resident and requires no services.

- **Contraception and Abortion:**

- Its problematic to talk about using condoms as one of the safest methods of contraception better than Copper-T because its every hard to keep a check as to the community actually using those.
- For a majority of women from the community comes back to take their copper-t out from their body when they are pulled into the process by the health workers to fulfill the target.
- At times women wants to get Copper-T but the family members don't allow her to avail the services as they need children. Here should be some sort of helpline for such situations.

- **Privacy and Clinical Services:**

- There needs to be less stigmas in the services available in the centre.
- No safe space to talk about SRHR, if youth visits the AFHC the community thinks that they must be having HIV/AIDS.
- In West Bengal the clinics had library making it more youth friendly and certain things need to be adopted.

- **Inclusion and Agency:**

- Interventions are there but there is a lack of support system, there are rights that are in policies but the support system in the community is not compatible enough where the adolescents can exercise the rights.

- **Vocabularies:**

- Vocabularies are not contextualised, so the terminologies and the meanings and messages that reaches the community when it comes to sexuality and sexual reproductive rights also differs and a lot of them are influenced by popular culture and media.

Session 3:

Challenges and Recommendations

Problem:

- The Lack of Policy Awareness of Health Scheme

Recommendations:

- We know about Pradhan Mantri Sadak Yojana and have seen their boards and banners everywhere, but for Health Schemes like RKSK or Ayushman Bharat people doesn't even know about it to even ask for the rights. Awareness of RKSK through TV advertisements or print media including some celebrity brand ambassadors for mass appeal. This needs to be done in schools too.

- The Sathiya mobile app should be in regional languages with audio- visual aids for people who cannot read. The current app is in Hindi and half the country might not be able to access it.

- NSS programme at school and colleges should be used to spread awareness on the six objectives of RKSK

- State-wise RKSK helplines in regional languages. This has already been implemented in Rajasthan and this can be replicated.

- **Making IEC material context appropriate:** IEC materials must be translated into local languages with usage of local words/terms for various medical terms. This material must be finalised and disseminated only after testing with the target audience.

- Post de-criminalisation of the 377, a public sensitisation of this Act needs to be done across population. Also LGBTIQ issues should be prioritised under RKSK and other health schemes.

- During the framing of the policy, there should be members included in the process whom the policy effects directly and only then can we ensure awareness and implementation.

Problem:

- The Lack of SRH services and products

Recommendations:

- Clarity of roles in implementing RKSK at the level of Health Posts, with trainings on the RKSK module. They are neither accountable nor they have a monitoring mechanism. Most of the ground level awareness are to be dealt by ASHA workers and school teachers but they have priorities other than adolescent health and they are not experts in every avenue.

- ASHA workers should be provided with capacity building trainings on SRHR. As soon as we increase the post and roles of ASHA workers we also need to appoint more ASHA workers and increase the budget around appointing health workers. Also ASHAs should also go through proper evaluation mechanism and the monitoring mechanism of RKSK needs to be strengthened. And these monitoring reports should be made public to people. A partnership with NGOs needs to be made where they can evaluate part of it.

- The ASHA workers should be appointed proportional to the number of youth available in the community.

- Any counsellor, recruited under the National Health Mission, working with adolescents should:

  A) undergo mandatory initial training

  B) Attend a minimum of 3 refresher course/training every year conducted by:

  (i) a government or a NGO on: SRHR, LGBTQ+ Issues, Gender Sensitisation, Issues at the intersection of Caste, religion, gender and violence, Substance Abuse.

  (ii) National Psychology and psychiatric institutes.

  C) Continuous feedback loop should be created. We can ask Local NGOs to monitor and evaluate the counsellors. Similar process for counsellors to attend seminars and conferences like doctors who needs to represent themselves in conferences/ seminars to be up dated about current medicines/ research etc. should be made mandatory.

  D) Should know ethics of privacy

- Ensure that the Bharatiya Janata Ayushudhi Yojna carries the necessary medications.

- Counsellor training under RKSK programme must incorporate components related to gender, GBV, human rights and sexual and reproductive rights.

- Schools across boards should introduce mental health and sex education under Moral Science/ Social studies to have this discussion started under Right to Education.

- NALSA recommendations must be incorporated in drafting of the Transgender Bill

- *Maa card* (in Gujrat) providing insurance only to men and women should be compulsorily available to transgender (all genders)

- **Facilitating access to safe abortions:** HCP must be sensitised to provide non-judgmental services to adolescents seeking SRH services. There must be greater awareness-raising of the MTP Act through the usage of mass media and IEC material, which must also be displayed in hospitals as there is often an incorrect notion about this act which dissuades HCP from providing abortion services.

- **Improving access to menstrual hygiene products:** There can be liaising with NGOs where possible to improve the supply of sanitary napkins. Schools and Anganwadis which offer these products must have a signage displayed outside which states the same, as many girls are unaware that such sanitary napkins can be got from there.

- **Inclusion of Saathiya or peer educators/adolescent community representatives in the programme development process:** Peer educators and Sathiyas working directly with adolescents must be involved in the programme development process as they not only understand the needs of the target population and the context, but also the issues which may arise in implementation.

- In the last four years there has been no evaluation done for the RKSK scheme and that needs to be done, which needs to be done.

- SABLA had specific 9 models under it however RKSK is flexible and is more like a guideline. RKSK should also have categorized modules or curriculum under it for better functional approach of the scheme on ground.

- Raise awareness about MTP and Contraception from a Rights Based Approach. Information and IEC materials in schools and in areas frequented by the adolescents should be increased like that in hospitals, parks etc.

- **Budget**: There are already budget assigned for the RKSK program and IEC but hardly there is knowledge and awareness about the program or IECs available with the community. The Gram Sabha should know the budget of RKSK and the Panchayat Bhavan should also get these posters and visual tools made for awareness. Gram Sabha can then also mould the budget accordingly. The recommendation to government can be that the budget for SRHR awareness should be increased and the utilisation of the budget should be prioritised.

- RKSK mentions mental health but it is not very clear, it doesn't provide what exactly comes under mental health services and awareness. The Bharatiya Jan Yojna which is entitled to provide low cost medicines doesn't have the required medicines stored in health clinics. The doses for mental illness are specific and not any form of generic medicines can be provided for the patients which there by remains unavailable. Hence the mental health services and availability of resources needs to be prioritised under the RKSK or it would be problematic for doctors to provide services to everybody in urban and rural discourse.

- Rehabilitation centres should be having mandatory counsellors for youth/ adolescents under substance abuse and they should be treated with care and ethics.

- The topics that are discussed under SRHR are sanitised. So discussions around sex and other taboo topics are usually not prioritised or are important enough that is even asked in term papers, so usually students and teachers skips this. There should be campaigning and outreach done on these topics including boys and girls both in the school.

- Digital literacy programs for both boys and girls equally to ensure technology as a safe and equal space for all. The current Ayushman Bharat scheme has the addiction part of internet covered in it but it should emphasis more on the positive parts too.

- The RKSK website should have a list of state and district wise services provided under the scheme and also the places the services are supposed to be available. This would help in accessibility of services in a structured form.

Problem:

- Limited Safe Spaces to hold conversations around SRH

Recommendations:

- Establish community youth spaces at the Zila Parishad Levels as safe spaces with WiFi for the local youth to gather for recreational & educational purposes. And these spaces should be gender neutral with boys and girls both coming together. But there should be avenues where girls should be provided separate platforms to share their issues and have a safe space.

- Integration of Mental Health, Sex Education and other topics in school curriculum. Government can initiate a private-public partnership with NGOs to conduct these workshops.

- De-stigmatisation of SRHR related issues through government campaigns - through media- mainstream and social along with collaboration with NGOs.

- Digital literacy programs to ensure rights based and secure usage of technology for all genders.

- Expand Saathiya Salaah app to include queer and trans sexual health. Translate the information to more languages than just Hindi.

- Reaching out to health centres can be problematic, if RKSK is implemented in schools then it might have better impact. There is an organisation named *Vacha* in Mumbai that works with the government schools and they work on gender and sexuality. So in already registered government spaces trusted organisations should be given space to conduct long term interventions around adolescent health. And currently BMC has started providing schools on rent, so in that way schools can also have a sustainable income on one hand and on the other hand the issues around trusted infrastructure can be dealt with ease.

- Celebration of *Adolescent Week* dedicating one day for all of the six objectives of RKSK in all government schools and colleges. This should be declared and made mandatory to be done once a year. And these programs can be run in the interest with both. Also these should be prioritising in SRH issues and not anaemia or malnourishment only.

- For out of school adolescents, day camps in villages should be introduced that talks about health facilities. And the *Adolescent Week* should also be celebrated in the village.

- **Helpline for feedback:** There should be a toll free number to report to the centre on unavailability of SRH services e.g. If girls approach such a facility and there are no sanitary pads available, then there must be a phone number they can call to inform about the same. This helpline number can be used for various purpose as a direct monitoring mechanism by collecting data and feedback about the availability and quality of various adolescent-health related services.

- Under POSCO the mandatory reporting turns out to be a problematic for social workers. There is a dilemma to either support the adolescents and keep confidentiality when they share their personal information and provide them a rights based approach or report the incident. Hence this aspect of POCSO should be considered.

- Naming the spaces as ‘Adolescent Centres’ and not clinics to first take away the clinical aspect from the centres and then actually working on it from a perspective which is inclusive and have necessary language to talk about gender and sexuality.

- Establishing a Community Youth Space at the Zila Parishad level as a government assigned space with WiFi and library for local youth to gather for recreational purposes. This would act as a medium for youth that acts towards their mental health.

Problem:

- Lack of Nutrition and policies around it for adolescents

Recommendations:

- Under the ICDS mid-day meal schemes, children and adolescents until standard 8th are only benefitted. This scheme should be extended till standard 12th for adolescents.

- If we integrate the Nutritional aspects and awareness in all the existing policies like under National Skill Development programmes, because there is a clear link with nutrition and the health/wellbeing required for youth to produce skills.

- Ensure that alternative ration cards are provided to migrant workers and other marginalised communities.

- A tool kit or a curriculum that includes basic understanding on nutrition for youth and adolescents in schools and colleges. This should be age specific e.g. when adolescents reach puberty etc. and regional specific also depending upon need for adolescents.

- Along with counsellors there should be dieticians and nutrition experts in schools and similarly for Anganwadis.

- There is a successful model in Kerala that includes a *Chawanprash* named as Amrutham Nutrimix Consortium distributed to adolescent girls and pregnant/lactating mothers in Kerala. The products are local which has nutritious value, this is made by SHG groups and are funded by CSR groups and it is hosted by the ICDS. So these kind of model can be replicated in other states too.

- The current nutrition schemes like providing *Chikki* to girls failed in ICDS. So sustainable plans need to be framed and those plans and schemes should include boys in it as currently its only for girls.

- Under the Takeaway Home Ration (THR) in Gujarat people are supposed to get oil, rice and daal. But there is irregularity in the supply and people end up getting only one thing a month either daal, rice or oil. The regularity of the supply of products and a monitoring of the schemes needs to be in place.

Day 2

Agenda:
The two major agendas for the second day were:

- To discuss around Meaningful Youth participation
- Introducing the Policy Making group

Session 1:

Roger Hart: Ladder of Participation

What: The first session of the day included discussions around understanding of youth and their meaningful participation. Roger Hart's ladder of participation was introduced in order to start the discussion where the participants were asked to recollect cases/events from their lives where they have worked in any leadership position.

How: The seven stages of the ladders were written in a paper and placed in the floor. The participants were then given time to think and place their views and thoughts based on their position during any particular event in their life in any of the stages of the ladder.

The seven stages:
The group was asked to identify from the stages of the ladder they could identify themselves while while discussing any of the life events. Further they went into a detailed reflection of the process and understanding of why the group felt the way they felt in identifying with the leadership process of the event. The group identified themselves in different stages of the ladder from being manipulated to explaining events when they felt confident and heard. Below are the experiences of the participants with few of the examples:

Manipulation:
In Goa a lot of government colleges announced that they will provide computers after enrolment in the colleges so a lot of students got excited to get themselves enrolled. But after the enrolment the authorities didn't bother to live up to the announcements. For two months the Student Association along with the students protested to get their rights and finally they received.

Tokenism:

- The Internal Quality Assurance Cells in Medical Institutions and the University Counsel asked students to be a part of the Board of Studies as student nominees however students were just called for decoration as the members of the Counsel fought with each other and students were just asked to sit.
- A participant who identified himself as non-binary shared that he was often asked to wear a sari and come for donor meetings to represent the transgender community and he found it extremely offensive.

Assigned and Informed:

- In college days a participant was given a random position in college to maintain the crowd.
- Though asked to work voluntary based a participant was forced to manage group of girls during college events. Another participant was forced to manage a marathon event in the college.
- There used to be cricket courses in college where none of the participant from her class used to participate and the class was threatened to be banned from any extracurricular activity. So the participant was asked to take a lead that our class shouldn't get banned. This was totally assigned and informed where the participant was not interested in taking up the task.
- Assigned roles in social entrepreneurship

Consulted and Informed:

- Blood donation camp in girls' hostel. One of the participant met girls and told them to eat and not get scared etc. before the camp. As the participant shared that she felt good about this.
- There is not much health awareness program in Vidharwa region, there is a Martha family (group of MSM people) where one of the participants took lead and consulted with the youth and shared information about SRH.

Adult Initiated:

- Under the syllabus of Bio-ethics college partnered with UNESCO and wanted students' organisation to make campaigns. These campaigns were then organised by students which the teachers initiated.
- Being a part of mandatory activity to have fund raising in schools that were initiated by teachers.

Youth people lead and Initiate Action:

- Church based activity which allowed young people space to do something and it was an outlet for youth to showcase their talent in the cultural fest.
- Hosting an inter-college youth festival involving 13 colleges.
- Made a Red Ribbon Club where youth took initiative to talk about sex and sexuality with students but later students started having problems because teachers were not okay to talk about sex education.
- There were lot of misconception among students in college about trans people and a participant selected some videos and in an open forum organised a session to talk about trans people to everyone.

Young People and Adults Share Decision Making

- A participant from Gujrat shared that she started her activism quite early in her hostel. When she was in her 7th standard she led a strike in her hostel as the food quality was so bad. The strike went for few days where she was a class leader and let the strike by not eating any food. Finally, the teachers agreed to have a conversation with the students and their demands were met. The news of this strike went to the regional level hostels and since then a board of members monitoring the food quality was set in all government hostels in the region and it had students representing it.

Session 2:

Introducing the Policy making Group:

The second session and the last session of the day was about introducing the Policy Making Group to the participants. Linking it with the Roger Hart's ladder of participation the participants were then introduced to the different ways youth can ensure meaningful participation and how the Policy Making Group was one of the platforms initiated by a group of youth in order to bring a change in the narrative of SRH Rights and Policies.

It was introduced that this group is supposed to be beyond any organisation and will tend to work as an independent youth group. The participants were given a brief about the Youth Insight in the year 2018 where about 170 youth came forward for a two-day program and the idea of the policy making group was materialised. The agenda of the group was to have youth from different regions come forward and speak about their issues related to health and reproductive rights which can then work on to a policy development platform.
The values and the procedure of framing the group was discussed in details in the participants and further discussion on core committee formation was discussed.

The participants were the asked to join the group voluntarily with Accountability and Ownership on the group being the two leading components to run the group. More than 70 percent of the participants signed up for the group.

AFHC: Adolescent Friendly Health Clinic
IEC: Information Education and Communication
IFA: Iron Folic Acid
HIV: Human Immunodeficiency Virus
HSC: Health Sub Center
PFI: Population Foundation of India
PHC: Public Health Centre
RKSK: Rashtriya Kishor Swasth Karyakram
SRHR: Sexual Reproductive Health Rights
WIFS: Weekly Iron and Folic Acid Supplementation