Knowledge. Voice. Democracy.

PRIA

SEPTEMBER 2021

National Consultation

"Our Health, Our Voice-institutionalizing adolescent participation for improving their health and wellbeing"

Organized by

PRIA,
Martha Farrell Foundation,
Gurugram University and
SHLC

Introduction

Rashtriya Kishor Swasthya Karyakram (RKSK) was launched on **7 January 2014** to ensure universal coverage to **adolescents** in the age group of **10-14 years and 15-19 years**. The scheme has provisions to enable establishment of **Adolescent Friendly Health Clinics (AFHCs)** to cater to diverse needs of adolescents, to ensure comprehensive and equitable access to adolescent-specific health needs. The RKSK scheme also comprises community-based engagement component with focus on **adolescent participation and leadership**. The community component involves adolescent groups, facilitated by **peer educators**, covering a broad range of adolescent related issues like nutrition, mental health, sexual and reproductive health, violence, drug and substance abuse and safety.

Society for Participatory Research in Asia (PRIA), together with **Centre for Sustainable, Healthy and Learning Cities (SHLC), University of Glasgow and Gurugram University** conducted a **Participatory Action Research (PAR)** study in **Gurugram** to understand the **prevalent situation of adolescent health in urban informal settlements as well as to explore the levels of engagement of urban adolescents with Adolescent Friendly Health Clinics (AFHCs).** The study reported poor health-seeking behaviour among adolescents and low levels of awareness among adolescents regarding AFHCs. The PRIA study even reported low preference among adolescents to seek treatment from Adolescent Friendly Health Clinics.

In recent decades, health policies and schemes have emphasized the importance of more participatory approaches in policy making that include views, knowledge, experiences and actions from those who are the intended beneficiaries. Although participatory approaches in adolescent health have been popularised through health policies, they differ in terms of explicit guidance on how to actually involve and engage youth in implementation. Considering the pandemic situation that has impaired health systems and taking into account poor health-seeking behaviour among adolescents, it is imperative to explore ways in which adolescent participation and engagement with AFHCs can be increased and strengthened, so that more beneficiaries become aware as well as benefit from the services. Implementing and strengthening facility-based interventions is an important step in the right direction that will ensure positive health-seeking behaviour among adolescents.

To have a discussion on this topic**, PRIA**, in collaboration with **SHLC (University of Glasgow), Gurugram University, Gurugram and Martha Farrell Foundation (MFF)** organized National Consultation on "***Our Health, Our Voice- institutionalizing adolescent participation for improving their health and wellbeing" in hybrid mode (both online as well as off-line) on September 03, 2021 from 10.00 am- 02.00 pm***. The national consultation was conducted to discuss the ways in which adolescent participation for their health and well-being can be enhanced and institutionalised through AFHCs to widen the outreach and penetration of services through active facilitation and involvement of civil society (refer annexure 1 for program design).

Session 1: Our Health, Our Voice: Participatory Action Research with Adolescents

The first session was conducted to provide an overview of PRIA and SHLC's participatory action research with adolescents in urban informal settlements in Gurugram. The panelist, **Ram Aravind from PRIA**, was joined by **adolescent champions from Gurugram, Jyoti and Manish** who presented a manifesto on improving health service delivery through Adolescent Friendly Health Clinics, also known as **Mitrata Clinic** in Haryana. The moderator for the session was Dr Anshuman Karol, Lead-Governance, PRIA who opened the floor with a presentation on PRIA and its work in knowledge democracy and governance.

- **Ram Aravind (RA)**, who lead the study in PRIA, began the session by introducing the participants to '***our health, our voice'*** study conducted with adolescents in urban informal settlements in Gurugram. The presentation was conducted to highlight the key participatory elements in the process, so as to provide a model for institutionalising adolescent participation in health policy making. Involving adolescents in health policy decision-making is expected to shape the design of AFHCs to better reflect the adolescent needs and demands on their health, as the experience of the study has shown.

While talking about participation of adolescents in health policy making, it was important to understand the rationale behind advocating for participatory reforms.
When can the potential of adolescents to lead in health governance be realized?

- When adolescents are informed and aware
- When adolescents are organized
- When adolescents have voice and choice
- And finally, when adolescents have access to institutional spaces

The speaker further identified ways in which adolescent participation could be ensured:

- Developing, nurturing, and institutionalizing participatory mechanisms as envisaged through RKSK
- Regular information dissemination and consultations through participatory mechanisms to address information deficit in under-resourced communities
- Creating and promoting youth-led peer educator and referral models to emphasize on preventive model of health-seeking

- Incorporation of adolescent voices into urban planning process; should be considered as an opportunity to develop their capacity to govern

The model highlighted the potential of involving adolescents in taking over health decisions that affect their well-being. As part of the study, RA also shared the key LEARNINGS that would be useful for health researchers, participatory research practitioners, civil society as well as academia.

- ❑ Adolescent boys and girls have the potential to effect change if engaged through participatory methods.
- ❑ Confidential spaces for adolescents to talk about their health issues do not exist in urban spaces; hence it is important to create such spaces
- ❑ A top-down approach to design of adolescent 'friendly health systems' has served to further distance adolescents from seeking health-care.
- ❑ There is a need to work more closely, not just with adolescents, but also with their parents/ care-givers.

The adolescent champions, Jyoti and Manish on behalf of adolescent health champions who participated in the study with PRIA spoke about the participatory action research process that lead to the design of manifesto[1].
Jyoti and Manish presented their aspirations about living in a 'healthy city' and how the manifesto, designed from their vantage point, is expected to inform policy makers regarding inclusive practices in design of health systems that would make a difference in their health-seeking behaviour and health outcomes. **Some of the key demands presented by the adolescents[2]:**

- Given the adolescent population of Gurugram, increase number of AFHCs, especially catering to adolescents from informal settlements
- Need for male and female counsellors in each AFHC
- Sexual and Reproductive health education must be made available for boys as well
- Revive peer education component of RKSK scheme to increase use of AFHC services.
- AFHCs should be situated closer to the informal settlements to reduce cost of transportation
- Soft skills for AFHC support and medical staff, especially skills to engage with adolescents

[1] Refer https://www.pria.org/knowledge_resource/1630564004_Visioning_Workshop_for_Inclusive%20and_Adolescent_Friendly_Health_Facilities.pdf for the detailed report of 'visioning' workshop held at PRIA in August
[2] Refer https://www.pria.org/knowledge_resource/1629368044_Flyer_Manifesto_17_Aug_21_Eng.pdf for detailed manifesto prepared by adolescents in Gurugram

- Suitable, locally-relevant behaviour change communication material should be distributed to adolescents in the community
- Improve community outreach by Frontline Health Workers

The adolescents also spoke about their involvement in health policy advocacy, where they shared the manifesto before the city-health officials, including the Civil Surgeon, Gurugram and Deputy Civil Surgeon. Their participation has led to the health department, Gurugram reviving the peer educator model that was scrapped. Adolescents from urban informal settlements in Gurugram will be trained by the public health department.

Session 2: Institutionalizing and strengthening adolescent participation through AFHCs- experiences of implementors

The second session of the consultation explored the topic from the perspective of organizations working at the grassroots to implement RKSK scheme from three locations. Child-In-Need Institute (CINI) works with adolescents in different locations in West Bengal. Dr Rama Shyam, working with SNEHA, Mumbai spoke about her experience of working on adolescent health issues in urban informal settlements in Dharavi (Mumbai). Ekjut, working on generating evidence into a host of adolescent issues in Chhattisgarh and Jharkhand, was represented by Ms. Suchitra Rath.

The following key questions were discussed by the participants:

- ❑ What is the present status of implementation of AFHCs in your state/city? How 'adolescent-friendly it really is?
- ❑ What are the challenges to effective implementation of AFHCs faced by you in your city/state? What policy level changes are required to integrate adolescent participation into RKSK scheme through AFHCs?
- ❑ Models of adolescent participation in designing health systems; case studies where youth participation has been used to strengthen the monitoring and evaluation of health systems(AFHC)
- ❑ What pro-active role can civil society play in strengthening and main-streaming adolescent participation through AFHC?

- **Dr. Indrani Bhattacharya, CEO, CINI,** while referring to the manifesto designed by adolescents, spoke about how the demands apply not only to Gurugram but also to other parts of India. IB enlightened the audience about AFHCs in West Bengal (***also known as Anwesha Clinics***) and remarked how the implementation of the clinics had started much before the RKSK guidelines came into effect. The clinics, established in both rural and urban areas, are confronted with the contextual challenges.

A key intervention by CINI with regard to AFHCs was the capacity building workshops for AFHC counsellors on how to sensitively handle the health issues faced by adolescents. Providing soft skills on conversation, adopting a non-judgemental

attitude are equally important as providing technical skills, which is under the purview of the health department. They also try to identify the challenges of counsellors, especially for female counsellors working with older adolescents, thus effectively moderating between the demand and supply-side challenges. They achieved this through extensive advocacy and partnership with the state health department.

There are 341 AFHCs in the state, but the health systems still fall short of addressing the health needs of the adolescents in the state, which constitute around one-fifth of the total population in West Bengal. As a technical support partner in RKSK to the state, **CINI's interventions** included **creating a safe space at the level of panchayats and municipalities**, so as to leverage participation of the community as well as the adolescents in knowledge and awareness generation, linking adolescents to health systems and health service providers and building capacity of adolescent community champions.

Creating a convergence platform with ICDS scheme and other health schemes in the state was also a strategy adopted by CINI to institutionalise youth participation in heath governance. Working with youth in schools and creating a cadre of teachers to increase awareness about health facilities , as well as about the phenomenon of adolescent health, was an intervention designed by CINI towards popularising adolescent friendly health clinics.

<u>Some other initiatives by CINI:</u>

- Developed Social and Behavioural Change Communication(SBCC)/IEC materials in local language and with simple and easy to understand text
- Peer leaders were trained to identify vulnerable adolescents in the community and to link them to health services
- Created a safe space for adolescents to talk about confidential health issues
- Linked AFHC counsellors to other health schemes, like SABLA

According to the speaker, even though convergence of schemes is essential ,it is important to not let the components of one scheme intersect with one another. Even though school counsellor programme is a component under Ayushman Bharat scheme, it ***should not be considered as an alternative to employing***

counsellors under the RKSK guidelines. Through these initiatives, CINI is actively pushing to integrate adolescent participation into the framework of RKSK in West Bengal in partnership with the Government.

- Narrating her experiences from **Mumbai's Dharavi, Dr Rama Shyam** spoke about how the organizational ethos promote and integrate adolescent participation in their framework and inform their work.

Nearly 30% of India's youth live in cities and this warrants the need for special attention to be paid towards enabling implementation of Adolescent Friendly Health Clinics across the country. Even though some states have implemented AFHCs with full vigour, some states have not kept pace with implementation according to the updates RKSK guidelines, even considering it as an extension to the pre-RKSK ARSH guidelines.

In order to provide further providing evidence about implementation of AFHCs across the country, the speaker quoted the work of another panellist, Dr KG Santhya, who enumerated the number of AFHCs in the country at 7459(as of 2019). For a population of nearly 254 million adolescents, the numbers point to acute shortage of health clinics. The limited success of implementation also owes itself to excessive weightage given to sexual and reproductive health, over a holistic RKSK mandate that includes five other components as well, like nutrition, mental health, drug and substance abuse, injury and safety. Studies or evaluation to assess implementation in the various tiers of health system in urban areas was also few in number pointing to lack of evidence regarding effectiveness of implementation and intervention.

The implementation of the scheme, according to the speaker, has found success in rural areas. Hence, there is a need to explore the neglected aspects of RKSK in urban areas. SNEHA had worked closely with the Municipal Corporation of Mumbai (Brihanmumbai Municipal Corporation) to effect changes at the local level. Through SNEHA's EHSAS program, an effort was made to work with the adolescents through the broad spectrum of adolescent health as outlined in RKSK guidelines, like sexual and reproductive health, mental health, nutrition, domestic violence and abuse and safety. They had also coordinated with the Municipal Corporation schools and public health department to strengthen adolescent friendly health services.

World Health Organization(WHO) advocates for "**adolescent competency**" in public health. **Some key initiatives by SNEHA to operationalise adolescent participation:**

- Monitored adolescents accessing heath systems and availing health services through health posts (Public health system in Mumbai) through access visits
- Screened for anaemia

- Collaborated with local medical college (Sion Hospital) and Public Health Department to operationalise RKSK in Sion-Dharavi link
- Menstrual diary where adolescents were encouraged to note the challenges that they face during menstruation; also to keep tab of the distribution of sanitary napkins through Jan Oushadi centres and referrals

RS spoke about the need to recognise adolescents as 'citizens' first and to not relegate their voices to the periphery. That would be first step towards institutionalising adolescent participation in health policy.

- Talking about Ekjut's JIAH study designed by adolescents and conducted with community participation in Jharkhand, **Ms Suchitra Rath** spoke about the need to integrate other components of adolescent development , like education and livelihood, in community health projects. The focus of Ekjut's work with communities draws on the following principles:

- Facility and community-based activities
- Focus on adolescent participation and leadership
- Community adolescent groups facilitated by peer educators
- Leveraging the potential of peer interventions

Explaining the methodology being the Randomised Controlled Trial, SR spoke about the key learnings that the research team gained through their engagement with adolescents during the course of study.

- A strong consensus that any community intervention for adolescents should help them gain educational and vocational skills
- Groups should be fun and social
- Facilitators should be local and close in age group to the adolescents with engaging personalities

Session 3: Institutionalizing and strengthening adolescent participation through AFHCs- evidence

The third session was focussed on evidences from different parts of the country regarding adolescent health programmes and schemes, with a view on facilitating participation of adolescents.

The following key questions were discussed by the participants:

- ❑ What evidence exists to attest to the effectiveness of adolescent participation in improving design of AFHCs? How can NGOs and civil society use the evidence to further the agenda for institutionalising adolescent participation through AFHC/ present eco-system of adolescent participation through AFHCs?

- **Dr Alka Barua** had conducted extensive review of adolescent health programmes in India and enlightened the audience on the state of implementation of the schemes across the country. The speakers' research study is based on WHO mandate of evaluating the adolescent health programs at national as well as state level. **Some of the learnings shared by Dr Barua:**

- RKSK programme is not a priority at state and district levels
- Implementation experiences are not used for strengthening the programming.
- Vacancies in managerial and counsellor positions
- Unutilised funds and procurement issues
- Lack of capacity in reaching adolescents and location of the facilities
- Lack of mentoring support for staff
- Separate monitoring mechanism for the same programme
- Absence of formalised structure for engaging with adolescents
- Evidence is not used for programmatic decisions
- Adolescents excluded in monitoring and planning

She also spoke about the case of '***Yuva Mythri Kendra'*** designed with little engagement of adolescents to the effect that youth thought about the AFHC as a dating centre owing to the name that was given to the centre or clinic. This , she identified, was one of the many consequences of poor outreach among adolescents, quite rampant in implementation of RKSK. In order to tide over the problem, Laboratory districts were initiated in select priority states with UN partners to address the shortcomings that was based on evidence generated by the research team. It was aimed at supporting the state and district programme management units to design, implement and monitor a context-specific package of interventions aimed at achieving clearly defined outcomes rooted in evidence. **The initiative has been found to be effective in delivering context-specific interventions to improve health outcomes among adolescents**.

The speaker concluded by recommending the following plan of action to put youth-led accountability into practice.

- Adolescents be made aware of their rights and entitlements(so that they have ears and eyes)
- Adolescents be supported to engage in advocacy for these entitlements (so that they have voice)
- Adolescents be engaged in social accountability mechanisms(so that they have teeth)

- **Dr KG Santhya from Population Council** spoke about scaling up interventions to impact adolescent health. The speaker presented the case of **Project Udaan** implemented by IPE Global in partnership with local NGOs and Government of Rajasthan. It was a partnership with civil society and Government and she identified this partnership as one of the key elements impacting the ability of the project in scaling up. The project was devised as three streams-

- Promoting SRH with focus on reducing teenage pregnancy and improving SRH practices
- enrolling and retaining girls in school through scholarships
- Strengthening Government support in promoting family planning.

The uniqueness of the project was the integration of the component of adolescent participation in evaluation and monitoring of the project. The adolescents in many

states are involved in implementation, but not in design or monitoring and hence, the project sought to change the status quo with regard to institutionalising participation. The project started with a formative research phase where the objective was to understand attitude and practice among adolescents, parents teachers, community members. The stakeholder involvement was not restricted to the primary group and government, but also included other stakeholders like owners of beauty parlours with whom adolescent girls regularly interact.

The study findings pointed to lack of awareness among adolescents regarding sexual and reproductive health. SRH education mostly focuses on needs of married girls, the UDAAN study highlighted the need of bringing unmarried girls and boys into the fold of interventions.

In the co-creation phase, evidence was dissected and ideas were generated. It was also deliberated upon as to how adolescents could also be integrated into the study; not as participants alone but as an important knowledge co-creation agent. Consultations with Government and live prototyping of the interventions followed which evaluated its cost-effectiveness; the ones that was not found to cost-effective was discarded.

A school-based program was devised, following the live prototyping. The speaker identified the following means through which adolescent participation was incorporated into evaluation and monitoring.

- At the community level, young people were identified to see how attitudes and norms shifted among the adolescents and parents post the interventions
- Inclusion of adolescents was helpful is raising awareness as well as self-esteem and in bringing stakeholders to accountability

- **Nandika Kumari from Dasra,** spoke about the deficiencies in current program implementation of RKSK. Through her work with Government of Jharkhand, the speaker has initiated SoPs on institutionalising participation of adolescents through RKSK.

- Sustainable channels should be integrated into RKSK scheme for adolescent participation
- Communication should be channelised to reflect local realities through the insights from adolescents
- Funders adopting a participatory approach to grant-making will make a difference to bring forth the voices of adolescents

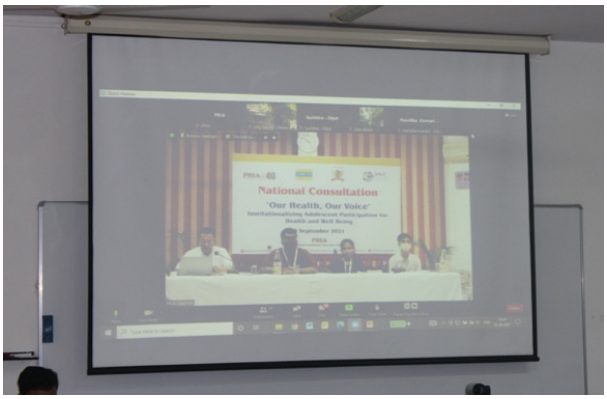
- **Mr Binoy Acharya, founder-director of Unnati,** lamented as to how the legacy of 'participation' was lost in the recent decade, as opposed to 90s and the

beginning of the millennium. The speaker prescribed the formula for institutionalising adolescent participation in health programmes like RKSK; government should work in partnership with Civil Society that is closer to the people. Implementation of schemes with active engagement and participation cannot be achieved by the government in isolation. A programme can only be successful if the operations is in the hands of the user group. Instead the country follows an approach where programs are designed in 'Delhi' (centralised planning) and then dispatched to various parts of the country and in the process, paying scant regard to cultural diversity and behavioural patterns of various communities.

The speaker prescribed some principles for institutionalising participation:

- There is a participation ladder; a process involved in starting from passive participation towards achieving complete participation and it starts with mobilisation and organization
- Adopt a Paulo-Freirean understanding of information; don't dump IEC material on people, instead enable the communities to develop a critical understanding of the phenomenon and develop action based on local realities
- "*In India, even a block has multiple contexts*", hence adolescents had to be engaged around the living environment
- Decentralised planning would enable convergence of relevant programmes

Dr Nilesh Deshpande, UNFPA summarised the discussions by agreeing on the role of civil society if implementation of RKSK scheme is to be strengthened. The points shared by the speaker are as follows:



- Peer educator models sounds simple but implementation is tough; ensuring that there is support of parents and reducing the level of drop-out would be critical.
- Guidance and mentoring post training was important to build their skills
- PE models should not be sustained with just monetary incentives, they also deserve recognition; give additional marks for those volunteering. Such initiatives trigger curiosity in adolescents to continue their role as peer educators
- Designing SBCC material in compliance with suggestions from adolescents
- Finding ways to engage parents
- Infotainment has proved to be effective if adolescents want to inculcate healthy behaviour
- There is a need to mindfully allocate resources based on evidence; identify what is the return on investment

Dr Rajesh Tandon, President PRIA, recalled the Alma Ata declaration of 1978 that emphasized on adopting a preventive, promotive and curative approach to health-seeking.

The speaker identified the following challenges to policy making in India:

- Rigid design based in Delhi; no flexibility
- Inadequate investment
- Inadequate training of officials responsible for implementing welfare schemes

In the past decade, the vocabulary of programs has changed. In 80s, participation was not a key feature of any policy document. Today, phraseology like people's movement have found its way into policy documents.

Rajesh Tandon noted that as the language became more participatory, collaboration with civil society has receded. There was an inherent assumption that Government officials at block, district and state-level would catalyse people' participation but that has not happened. 'Participation' in such cases has remained confined to 'paper'. Hence, it is important to explicitly acknowledge that vertical structures of governance are not equipped to initiate participation. Only organizations rooted in the grassroots and community could achieve this. If this realisation happened, more partnerships would emerge making it possible to achieve scale.

In contravention to Government figures that stipulates that 30% of adolescents lived in urban areas, the speaker feels that nearly 70% of them now inhabit urban spaces. Private health facilities are increasingly being preferred in urban areas and this mindset was driving health policy making in urban areas; that private services would complement public services.

"***Teachers can be injurious to learning; doctors could be injurious to primary health care***" privatised health services are leading people to not take responsibility of their health. Adolescents are dismissed as being ignorant of health and hence, unable to exercise agency over health matters. It is important to empower adolescents to organize as a group and take responsibility for their health; they are the future and they will drive the progress towards achieving SDG 30.

Key take-aways from the national consultation

Annexure 1

Program Design

Friday, 03 September 2021	
09.30-10.00	Registration
10.00- 10.10 10.10- 10.45	Welcome and Agenda Setting Our Health, Our Voice PAR study with adolescents in Gurugram – Ram Aravind, Research Associate, PRIA – Jyoti and Manish, Adolescent champions, Gurugram
10.45-11.45	**Panel discussion** Institutionalising and strengthening adolescent participation through AFHCs- experiences of implementors – Dr Indrani Bhattacharya, CINI – Dr Suchitra Rath, EKJUT – Dr Rama Shyam, SNEHA Open Discussion
11:45- 12:00	Health break
12.00-01.00	**Panel discussion** Institutionalising and strengthening adolescent participation through AFHCs- evidence – Dr Alka Barua, Independent Researcher – Dr KG Santhya, Population Council – Nandika Kumari, Dasra – Dr Binoy Acharya, Unnati Open Discussion
01.00- 01.40	**Key Takeaways and Ways Forward** – Dr Nilesh Deshpande, UNFPA – Dr Rajesh Tandon, Founder President, PRIA
01.40- 01.45	Vote of thanks- Ms. Samiksha Jha, Martha Farrell Foundation
01.45 onwards	**Lunch**

Annexure 2

Profile of speakers

1. **Ram Aravind** is **research associate working with PRIA**. He has trained as a professional social worker from Tata Institute of Social Sciences, Mumbai and has worked on research and advocacy on issues surrounding disability, public health, maternal and reproductive health and adolescent health. He is currently undertaking a participatory action research study with adolescent in urban informal settlements in Gurugram, with support from SHLC, University of Glasgow. Recently, he was awarded EIT-Health fellowship to undergo training on 'Data-Driven Prevention Policy' from University of Groningen, Netherlands

2. **Dr Indrani Bhattacharyya** is a social scientist working in the development sector for last 21 years. She has done her PhD in social anthropology and led many programmes on child, adolescent and women health and nutrition issues as well as participatory governance and community partnerships. She is currently the CEO of CINI, which she joined in August 2001. she has been trained on child, adolescent and women rights, participatory governance, community mobilisation, reproductive and child health, adolescent sexual reproductive health and rights, leadership development issues from reputed organisations in India, including DASRA, supported by Harvard Management School.

3. **Rama Shyam** is the **Director of SNEHA's Adolescent Health and Sexuality Education programme.** She holds a doctoral degree in Social Sciences from the Tata Institute of Social Sciences, Mumbai, and has over 15 years of experience in both grassroots and international organisations, working in the development sector. In her most recent stint, she headed the Education and Citizenship programme with Apnalaya, Mumbai, working on developing a high-impact community engagement programme. Earlier, Rama co-founded SAHER (Society for Awareness, Harmony and Equal Rights), a youth-led organization, working on peace education, sexual and reproductive rights, leadership and citizenship in Mumbai. She has implemented programs to scale in partnership with organisations such as USAID, United Nations Alliance of Civilisations, Tata Trusts, Magic Bus, US Consulate and many others. Prior to her engagement with SAHER, Rama had stints in academia and in training and capacity building and community development across themes such as peace-education, primary education, governance and youth development. She was awarded the Martii Ahistari Peacebuilder Award in 2012, for her peace-education activities in Mumbai, the Dasra Social Impact Village Capital Award in 2010, the Youth Action Net Fellowship in 2007 and Ashoka's Changelooms Award in 2017.

3. **Ms. Suchitra Rath** is the **Program Lead in Ekjut**. She has worked on the design, training and implementation of the Participatory Learning and Action (PLA) process for more than 15 years. for various interventions, like – Maternal and New-born Health; Child Health; Maternal and Child Nutrition; Water, Sanitation and Hygiene; Linking Agriculture, Nutrition and Natural Resource Management; Adolescent Health, Nutrition and Well-being, and Gender based Violence.

4. **Dr. Alka Barua** is a **Paediatrician with a PhD in Sociology from Tata Institute of Social Sciences.** She has 30 years of experience in public health research. She has been involved in formative and implementation research in the health sector, particularly in the area of reproductive and child health, safe abortion and adolescent health in various states of India. For last ten years she has been associated with evaluation of adolescent and youth friendly services and programmes.

5. **KG Santhya** is a **Senior Associate at the Population Council**. She is a demographer and economist with more than two decades of experience in designing and conducting rigorous large-scale cross-sectional and longitudinal cohort studies and mixed-methods process and impact evaluations in the field of education, vocational skill building, promotion of livelihoods, violence prevention and sexual and reproductive health of young people

6. **Mr. Binoy Acharya is the Founder Director of UNNATI – Organisation for Development Education.** He has been working as a researcher and public educator to promote social inclusion and democratic local governance. Over the last twenty-three years, he has been associated with movements, networks and government forums relating to Dalit rights, gender issues and decentralized governance. Based on his field experience, he has been writing articles and issue papers in different academic and NGO journals.
   He holds an M.Phil. degree in Social Sciences from the Jawaharlal Nehru University, Delhi. He is currently based in Ahmedabad, Gujarat and work primarily in Rajasthan and Gujarat.

7. **Nandika Kumari works with the 10to19: Dasra Adolescents Collaborative** where she is looks at bolstering engagement with the government, youth and civil society in order to create a greater positive impact on the lives of adolescents. In the past, she has worked with the Government of India's Ministry of Women and Child Development on planning and implementation of women-centric policies and programmes. Nandika has a post-graduate degree in Human Rights from the London School of Economics.

8. **Dr Nilesh Deshpande is National Technical Specialist -Adolescent & Youth, UNFPA** , New Delhi where he ensures engagement of adolescent and youth peer educators in COVID-19 response work in rural area in RKSK districts and Advocacy with MoHFW to initiate technology-based monitoring and reporting system for school health program.

Annexure 3

List of participants

S. No	Name	Organization
1.	Anshuman Karol	PRIA-New Delhi
2.	Binoy Acharya	UNNATI-Gujrat
3.	Indrani Bhattacharyya	CINI-Kolkata
4.	Jagadananda	CYSD-Bhubaneshwar
5.	Kaustuv Kanti Bandyopadhyay	PRIA-New Delhi
6.	Nandita Bhatt	MFF-New Delhi
7.	Rajesh Tandon	PRIA-New Delhi
8.	Rama Shyam	SNEHA
9.	Ridhima Rathi	MFF-New Delhi
10.	Prerna Barua	MFF-New Delhi
11.	Nitya Sriram	MFF-New Delhi
12.	Darvi Joneja	MFF-New Delhi
13.	Samiksha Jha	MFF-New Delhi
14.	S. Ram Aravind	PRIA-New Delhi
15.	Yogesh Kumar	Samarthan-Bhopal
16.	Suman Nag	Healthy Cities for Adolescents Fondation Botnar
17.	Elizabeth	Community for Social Change and Development
18.	Archana	Community for Social Change and Development
19.	Jyoti	Adolescents from Gurugram
20.	Manish	Adolescent champion, Gurugram
21.	Shruti Arora	PRIA-New Delhi
22.	Shivani	Adolescent champion, Gurugram
23.	Gudiya	Adolescent champion, Gurugram
24.	Linu Rachel Chacko	PRIA-New Delhi
25.	Bindu Baby	PRIA-New Delhi
26.	Dr Amarjeet Kaur	Gurugram University
27.	Rooplata Sahu	Healthy Cities for Adolescents, Ennovent and Fondation Botnar
28.	Alok Vajpeyi	Population Foundation of India
29.	Niharika Kaul	PRIA
30.	Sumitra Srinivasan	PRIA
31.	Nikita Rakhyani	PRIA
32.	Yashvi Sharma	PRIA
33.	Linu Rachel Chacko	PRIA

34.	Anushka	Ekjut
35.	Riya Thakur	Population Foundation of India
36.	Suchitra Rath	Ekjut
37.	Alka Barua	Independent researcher
38.	Prairna Koul	UNICEF
39.	Yogita Hiranandani	Martha Farrell Foundation
40.	Samiha Umbralkar	Dasra
41.	Nandika Kumari	Dasra
42.	KG Santhya	Population Council
43.	SH Ali	UNICEF
44.	Subhashree	Ekjut
45.	Surjeet Singh	PRIA
46.	Bindu Baby	PRIA
47.	Dhanasri Bagal	Ekjut
48.	Rajkumar	Ekjut
49.	Vedika Gupta	Dasra
50.	Swapnodipa B	UNICEF
51.	Rebati	Ekjut
52.	Pooja Rao	Dasra
53.	Nilesh Deshpande	UNFPA
54.	Anupama Kashyap	Dasra

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