2014:22 Sida Decentralised Evaluation

Bruce Dick
Renuka Motihar

Sexual Reproductive Rights for Youth in India - A Journey in Progress

Final Report

Sida

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MAMTA

Sida

Sexual Reproductive Rights for Youth in India: A Journey in Progress...

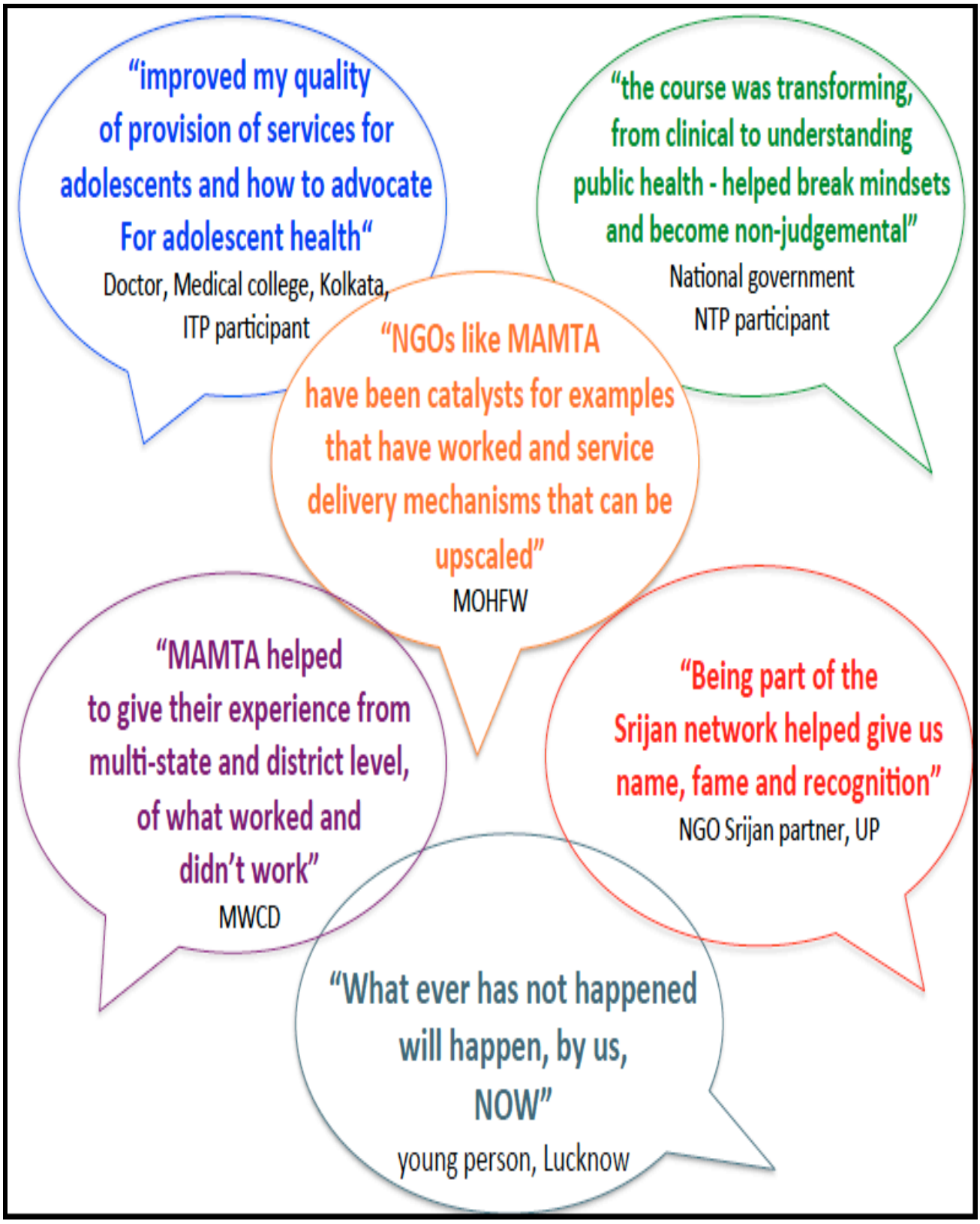
Impact Assessment of Adolescent Sexual and Reproductive Health and Rights and Youth Friendly Health Services in India (2000-2013)

Supported by
Swedish International Development Cooperation Agency (Sida), Sweden

Programmes Implemented by
MAMTA-Health Institute for Mother and Child (India) and Partners

Bruce Dick & Renuka Motihar

Table of Contents


"improved my quality of provision of services for adolescents and how to advocate For adolescent health"
Doctor, Medical college, Kolkata, ITP participant
"the course was transforming, from clinical to understanding public health - helped break mindsets and become non-judgemental"
National government NTP participant
"NGOs like MAMTA have been catalysts for examples that have worked and service delivery mechanisms that can be upscaled"
MOHFW
"MAMTA helped to give their experience from multi-state and district level, of what worked and didn't work"
MWCD
"Being part of the Srijan network helped give us name, fame and recognition"
NGO Srijan partner, UP
"What ever has not happened will happen, by us, NOW"
young person, Lucknow

Acknowledgements

Dr. Bruce Dick (independent international consultant) and Ms. Renuka Motihar (independent national consultant) planned and carried out the assessment from September-December 2013, and drafted this report.

This assessment would not have been possible without the guidance, insights and support of MAMTA staff, in particular Faiyaz Akhtar, Vandana Nair and Amitesh Sombanshi. Their energy, institutional memory, contacts, patience and good humour helped piece things together, and gain a clear understanding of what happened between 2000 and 2013. The guidance and inputs from the Sida team in New Delhi, notably Åsa Heijne and Yasmin Zaveri Roy, were also invaluable.

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We would also like to thank the many International Training Programme and National Training Programme alumni, the Srijan network members and young people in the states of UP, West Bengal and North East who travelled, often far, to meet with us and share their experiences and assessments of the program.

We very much hope that this report accurately reflects the ideas and perspectives provided by the many key informants that we met and the people who responded to the questionnaires that were sent out.

Acronyms/Abbreviations

ARSH	Adolescent Reproductive and Sexual Health
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual Reproductive Health and Rights
AFHS	Adolescent-friendly Health Services
CCRHTIT	China Centre for Reproductive Health Technical Instruction and Training
FGD	Focus Group discussion
GBV	Gender-based Violence
GFATM	Global Fund for AIDS, TB and Malaria
GOI	Government of India
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
ITP	International Training Programme
KII	Key Informant interviews
LGBT	Lesbian Gay Bisexual Transgender
LSE	Life Skills Education
MAMTA-HIMC	MAMTA Health Institute for Mother and Child
MoHFW	Ministry of Health and Family Welfare
MoYAS	Ministry of Youth Affairs and Sports
MWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organisation
NACP	National Aids Control Programme
NCDs	Non-communicable Diseases
NFHS	National Family Health Survey
NGO	Non-governmental Organisation
NIHFW	National Institute for Health and Family Welfare
NRHM	National Rural Health Mission
NTP	National Training Programme
PIP	Programme Implementation Plan
PGD	Shared Responsibility – Sweden's Policy for Global Development
RBSK	*Rashtriya Bal Swasthya Karyakram*
RGI	Registrar General of India
RCH	Reproductive and Child Health
RHIYA	Reproductive Health Initiative for Youth in Asia
RMNCH+A	Reproductive, maternal, newborn, child and adolescent Health
RFSU	*Riksförbundet för sexuell upplysning* - the Swedish Association for Sexuality Education
RKSK	*Rashtriya Kishor Swasthya Karyakram*
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRIJAN	Sexual and Reproductive Health Initiative for Joint Action Network
STIs	Sexually Transmitted Infections
TOT	Training of Trainers
UN	United Nations

UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
WB	West Bengal
WHO	World Health Organization
YFHS	Youth-friendly Health Services
YIC	Youth Information Centre
YRSHR	Young People's Reproductive and Sexual Health and Rights

Executive Summary

India has the largest population of adolescents of any country in the world. They constitute just over 20 percent of the total population, and their health and development is central to public health in India across the life-course, for the present and the future, for this generation and the next.

Adolescent sexual and reproductive health is an important aspect of adolescent health and development that has far reaching implications. A range of factors, such as lack of education and poverty, inadequate access to sexual and reproductive health information and services, and socio-cultural determinants combine to perpetuate child marriage, gender-based violence and sexual coercion; which in turn give rise to too early pregnancy, STIs and HIV, with all the long-term negative repercussions for adolescent girls and boys as well, for example ending their education, and for their children.

Improving adolescents' sexual and reproductive health is often not easy, because interventions touch on many sensitive social and cultural norms and values. In response to this challenge, in 2000, MAMTA, with the support of Swedish International Development Cooperation Agency (Sida), embarked on a project that aimed to contribute to national policies and programmes directed to improving adolescent sexual and reproductive health and rights in India.

The project involved many partners and included a range of training and programme support activities focusing on a number of intervention areas, such as adolescent friendly health services, gender and rights, STIs/HIV and AIDS, early marriage and sexuality education. It consisted of four phases: an Inception and Formulation Phase (2000-2003), the Implementation Phase (2003-2007), an Exit Phase (2008-2009) and a phase of Partnership Driven Cooperation (2010-2013).

This report contains the findings from an external assessment that was carried out of this adolescent sexual and reproductive health and rights project. The assessment was initiated in order to learn the lessons from the 13 years of work: what was the long-term impact on MAMTA and its partners in India and Sweden, and, most importantly, on SRH in the country as a whole? The assessment was based on a review of documents and reports relevant to the project; questionnaires and key informant interviews with a range of people who had been involved with or benefitted from the project; interviews with people from other organizations working in the field of adolescent sexual and reproductive health and rights in India; and young people who had contributed to and participated in the project activities.

The report starts by providing an overview of the adolescent sexual and reproductive health situation in India, including the policy and programme environment. It then synthesizes the findings from the questionnaires, key informant interviews and focus group discussions to provide an assessment of the impact of the project activities. While there are limitations to the assessment, all the findings indicate that the project made important long-lasting contributions to adolescent sexual and reproductive health policies and programmes; to the Swedish partners involved in the project; and to the capacity of MAMTA, both to continue contributing to the sexual and reproductive health

and rights of adolescents and also to tackle the new emerging issues that undermine adolescents health and public health in general, such as non-communicable diseases and mental health. Furthermore, the project not only had an impact on India, but also made important contributions regionally and globally.

From the key informant interviews and focus group discussions it was possible to identify a number of important lessons learned, to better understand the reasons for the project's success. These ranged from the respectful nature of the long-term technical and financial support that was provided by Sida; to the importance of strengthening both the technical and the organizational capacity of implementing partners, and of working with and through government systems. Several challenges were also identified, including the support and supervision of people who were trained through the project, and developing and sustaining networks.

The report additionally explores the MAMTA project within the broader context of current thinking about development assistance, and ends with a number of conclusions and implications of the findings of the assessment for MAMTA's future work; including the significant opportunities presented by the Ministry of Health and Family Welfare's new adolescent health strategy *Rashtriya Kishor Swasthya Karyakram*, and the contributions that MAMTA will be able to make to the roll-out of the strategy, building on the capacity and experiences gained from the 2000-2013 Sida supported work on adolescent sexual and reproductive health.

1. Background and Rationale

1.1 ASRH in India: situation and response

Young people (10–24 years) constitute about one-third of India's population[1]. Compared to earlier generations, the situation of young people has improved significantly in the country: they are healthier and better educated. However, many problems still exist including early marriage, early childbearing, HIV and sexually transmitted infections (STIs), gender-based violence, lack of information and choices, and lack of access to services.

Early marriage is a particularly important cause of poor health of girls in India, and despite being illegal before the age of 18 years, the National Family Health Survey (NFHS-3) indicates that nearly 50 percent of currently married women, aged 20–24 were married on or before the age of 18 years. Adolescent pregnancies are common as a result of early marriage: one in five young women aged 20–24 years have given birth at or before 18 years of age.

In addition to early marriage, lack of knowledge about sexual and reproductive health also undermines young people's sexual and reproductive health. A national study carried out in 2006-2007[2] indicated that only 15 percent of young men and women in the 15–24 age group had received family life or sex education, although the vast majority expressed the need for such education.

Many other factors contribute to poor reproductive health outcomes in adolescence. For example, findings from NFHS–3 indicated that as many as 56 percent of girls and 30 percent of boys in the 15–19 age group were anaemic. This has implications for morbidity and mortality rates of both mother and child, not to mention negatively affecting performance in school that keeps girls locked in a cycle of poverty.

Furthermore, other important health problems may be linked to poor sexual and reproductive health in terms of cause and effect, mental health problems for example. A review of deaths in India between 2001 and 2003 showed that 13 percent of suicide deaths in the country occurred in 15–29 year olds,[3] [4] and a more recent study reported that almost 14 percent of young men and women reported symptoms or behaviours indicative of mental health disorders[5].

An important proximal determinant affecting adolescent sexual and reproductive health and rights (ASRHR) is the policy environment. It was only in the late 1990's, when greater attention was directed to young people because of concerns about the transmission of HIV among this segment of the population, that there was greater

[1]Drawn from S.J Jejeebhoy and K.G. Santhya. *Sexual and reproductive health of young people in India: A review of policies, laws and programmes*, Population Council, 2011 and Draft Adolescent Health Strategy, MOHFW, GOI, 2013

[2] The study about Youth in India (2006–07)

[3] Registrar General of India (RGI)

[4]Patel et al. 2012

[5] Youth in India study (2006-07)

openness about addressing issues relating to sex among young people[6]. Of particular importance for ASRHR was the incorporation by Ministry of Health and Family Welfare (MoHFW) of a focus on adolescent friendly health services into the Reproductive and Child Health Programme (RCH2). In addition, the National AIDS Control Programme (NACO) developed an Adolescent Education Program that included modules for implementation in schools across the country. Despite these positive developments, a review of adolescent programs in 2011[7] showed that there remains a considerable gap between the commitments made in policies, the implementation of these commitments and the reality of young people's lives in India.

More recently, adolescents have been included in the MoHFW's Strategic approach to reproductive, maternal, newborn, child and adolescent health (RMNCH+A) and a number of programs have been developed for adolescents, such as *Rashtriya Bal Swasthya Karyakram* (RBSK) in schools, and programmes on menstrual hygiene and iron folate supplementation (MoHFW), and *Sabla* for adolescent girls by the Ministry of Women and Child Development (MWCD). In early 2014, the MoHFW launched an innovative comprehensive adolescent health strategy, *Rashtriya Kishor Swasthya Karyakram* (RKSK), based on the principles of participation, rights, inclusion, gender equity and strategic partnerships, and including a focus on nutrition, sexual and reproductive health (SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence, including gender-based violence (GBV) and mental health.

However, the situation was very different in 2000 when MAMTA started its Sida supported work on ASRHR.

1.2 MAMTA: AN OVERVIEW

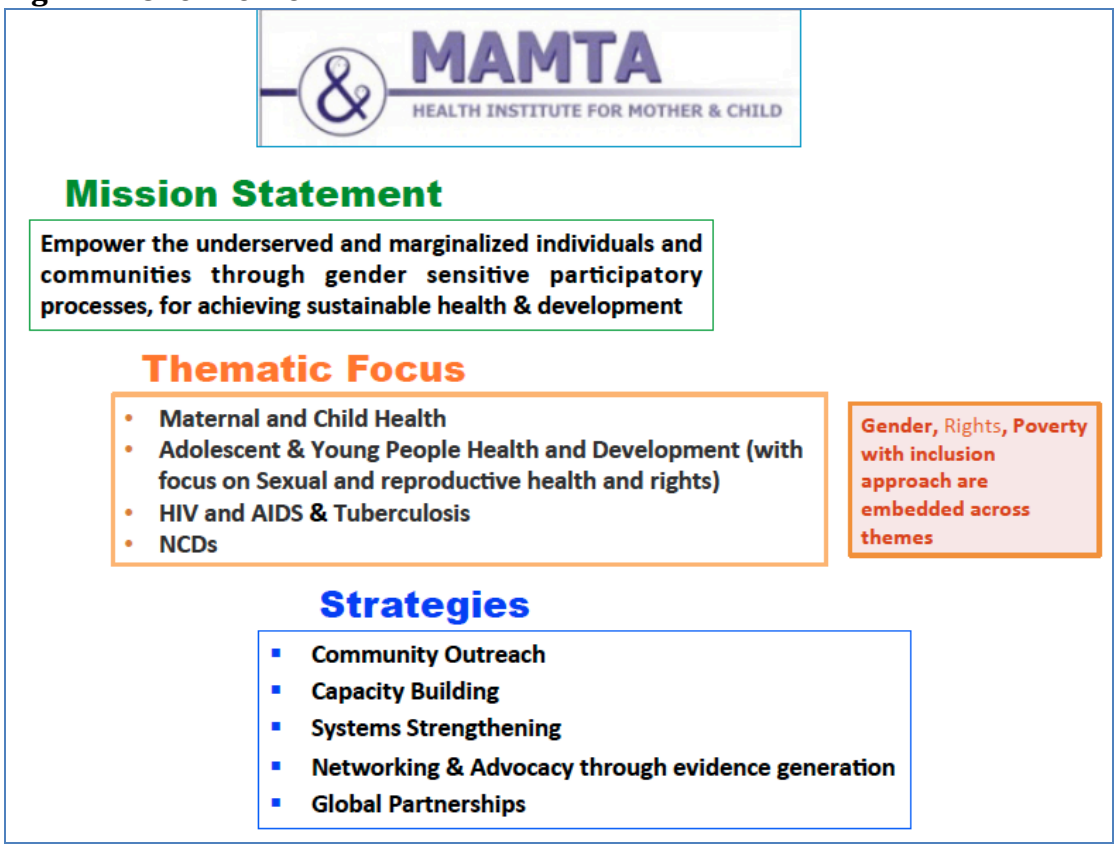
MAMTA Health Institute for Mother and Child (MAMTA) was started in 1990 to provide clinical services to women and children in a slum area of New Delhi, with the aim of enhancing their health status and improving pregnancy outcomes. From these small beginnings, over the past twenty years MAMTA has developed into an internationally known Indian non-governmental organisation (NGO) recognised for its technical expertise in maternal, child and adolescent health[8].

The mission statement of MAMTA is to "*empower the underserved and marginalized individuals and communities through gender sensitive participatory processes, for achieving sustainable health and development*". The thematic focus of the organization has evolved from its early work on maternal and child health in the 1990's to additionally working on adolescent and young people's health and development, with particular attention to sexual and reproductive health and rights, HIV/AIDS & Tuberculosis and NCDs. Gender, human rights, equity and inclusion are embedded across all of these themes. The organizational strategies include community outreach, capacity building, systems strengthening, networking and advocacy through evidence generation and the development of global partnerships (see Fig 1)

[6] National Population Policy 2000, the National AIDS Prevention and Control Policy 2002 and the National Youth Policy 2003
[7] Pop Council
[8] MAMTA Biennial Report 2009-11

From initially working in only one state in the 1990's, MAMTA has gained experience and developed strategies that have been taken to most parts of the country, and to other countries in the South Asian region. The work of MAMTA is based on a number of core activities, including: informatics, research and documentation, advocacy at state and national levels, and the development and support of partnerships and networks.

Fig 1: An Overview of MAMTA



1.3 Sida support to MAMTA

MAMTA has been working on ASRHR with support from Sida since 2000. This support included financial support, technical resources and organizational strengthening, and partnerships with Swedish institutions (RFSU, Lund University, Karolinska Institute, Uppsala University). RFSU was a key partner in MAMTA's initial growth, providing technical support and capacity building for MAMTA and its partner network members working in different states of India, and developing joint monitoring plans to assess progress.

Sida aimed to support MAMTA, in collaboration with its partners in India and Sweden, expand its work on creating an enabling environment where adolescents/young people can have access to information, have a voice in respect of life choices, and be able to protect themselves from risks to their health and development, such as child marriage, sexually transmitted infections and unwanted pregnancies.

The programme went through different phases from its start in 2000 to its end in 2013:

Phase I: Inception and Formulation Phase (2000-2003): This was a phase for exploration and learning and focused on young people living in vulnerable situations in both rural and urban areas in three states. This phase helped to develop and test strategies for adolescent girls and boys from poor and disadvantaged groups in different settings. In late 2002, an external mid-term evaluation of the first phase found that in a very short period of time the project had gained a very positive momentum and was being implemented effectively.

Phase II: Implementation Phase (2003-2007): The second phase of the project focused on six broad strategies: advocacy, research and documentation, informatics, networking, phased interventions and global partnerships in development. During this phase MAMTA partnered with RFSU to conduct an International Training Programme (ITP) on SRHR for participants from South and Southeast Asia. This facilitated a deeper understanding of the implementation of projects and training programmes focused on sexual and reproductive health in the region.

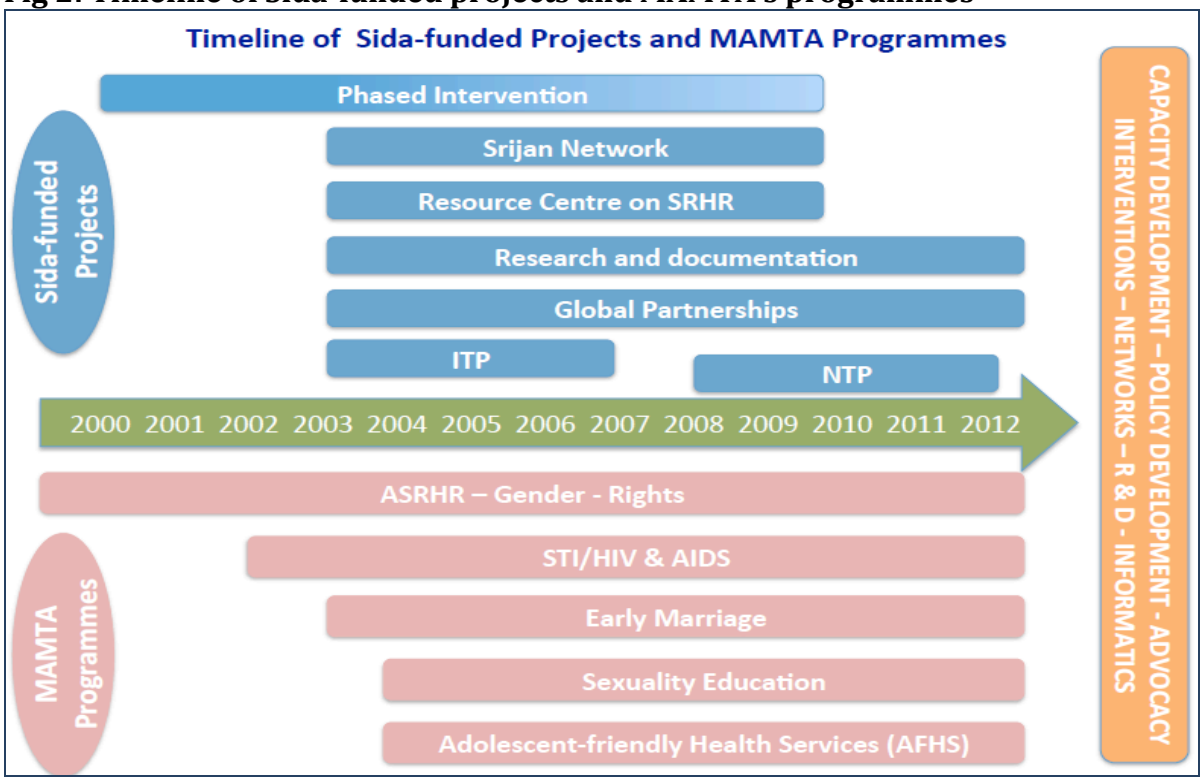
At the national level, MAMTA and RFSU built the capacities of SRIJAN (Sexual and Reproductive Health Initiative for Joint Action Network), a network of 136 NGO's across seven states, to create a supportive environment around issues of gender, sexuality and rights. Adolescents' access to health services was identified as an important gap in national responses to ASRHR, and the National Training Programme (NTP) on Youth Friendly Health Services (YFHS) was therefore developed to establish and strengthen YFHS. During this phase the geographic focus increased from three to ten states.

Phase III: Exit Phase (2008-2009): This was a phase for consolidating the network, empowering youth forums and integrating ARSHR in state institutions and policies. The NTP, implemented by MAMTA in collaboration with Lund University, was designed to develop the capacity of key health functionaries from the focused states and districts to improve young people's access to health services. Programme managers and service providers from the government system, nominated by the Government of India, were trained and their capacities enhanced in ASRHR and the provision of YFHS. As a part of the training programme, participants developed and implemented 'Change Projects', which included the establishment of several youth friendly health centres that were financed through the public health system.

Phase IV: Partnership Driven Cooperation (2010-2013): Following the initial pilot project, the NTP was scaled up in 2010 with support from Lund University and in partnership with the National Institute of Health and Family Welfare (NIHFW), a national apex training agency of the Government of India that was supported by Sida through its Partnership Driven Cooperation Strategy (PDC). This partnership was important because it strengthened the capacity of key personnel to deliver YFHS, scaled up the program and formalised the identification, selection and participation of government functionaries in the NTP.

A timeline of the components of the Sida-funded project elements is provided in Fig 2. This also includes an overview of MAMTA's main ASRHR programme areas and key strategies: developing capacity and policies, advocacy, developing and implement interventions, conducting research and documentation, informatics and the development of networks.

Fig 2: Timeline of Sida-funded projects and MAMTA's programmes



The journey from 2000, when Sida first started supporting MAMTA to 2013 when Sida withdrew its funding support from India, has been an experience of learning, sharing and growth for all the institutions involved in India and the partners in Sweden. This support facilitated work on policy and system strengthening, and created a pool of institutions and individuals across the country to carry forward the ASRHR agenda.

As a part of the process of phasing out programme support in India, Sida intends to share and showcase good practices, results and lessons learned through activities and cooperation in the area of sexual and reproductive health and rights (SRHR) in India This impact assessment is a contribution to this sharing of lessons learned.

2. Assessment objectives and methodology

Purpose of the assessment

The overall aim of the assessment was to better understand the impact that Sida's support for MAMTA has had on the SRHR of young people in India, and to assess how relevant and sustainable any long-term changes are within the larger country context.

The **specific objectives** of the assessment were to:

1. Understand how Sida support evolved to address SRHR over the period from 2000-2013 and track the contributions that MAMTA and its partners made to ARSH in India, including the evolution and current situation of laws, policies and programmes in the country;
2. Assess the role and impact of MAMTA and *Srijan* network partners in contributing to the SRHR agenda in the country, including their evolving capacities gained during project;
3. Understand the transfer of knowledge and capacities in the region (South and Southeast Asia) on SRHR through the ITP;
4. Study the impact of the NTP on ARSH programmes at state and national levels, including the impact on the provision of YFHS within the public health system;
5. Assess to what extent the programme was tailored to the needs of young people and how it responded to the priorities of the programme participants;
6. Highlight the nature and scope of different government and institutional collaborations developed through this project, and understand how the collaboration contributed to knowledge and skill transfer at institutional and individual levels, and the impact that this had at policy and implementation levels.

Methodology

Two external consultants, one national and the other international carried out the assessment[9].

A review of project documents

Documents produced during the course of the project were reviewed, including publications that synthesized good practice of project components; strategy documents, annual reports, and reviews and evaluations conducted during the project period (see Annex 3 for details).

Key Informant Interviews

Key Informant Interviews (KIIs) were conducted with a number of people who had been involved with the project (individually and in groups, face to face and through video-conferencing) to obtain feedback from a range of people involved with the Sida-funded project and with ASRHR in India (See Annex 4 and 5 for details). These included:

- ITP participants in India (Uttar Pradesh, Delhi and West Bengal)
- NTP participants (Delhi, Uttar Pradesh, West Bengal, Assam and North East)
- Srijan Network members in 2 states (Uttar Pradesh and West Bengal)

[9]MAMTA and Sida identified the national and international consultants through a bidding process and joint selection. The two consultants have experience in working on adolescent health issues, including ASRH assessments and YFHS, and an understanding of the context in India.

- Young people in 2 states (Uttar Pradesh and West Bengal)
- Government officials (MoHFW, MWCD, NACO) at national and state levels
- Sida staff in India and Sweden who had been associated with the project
- Other donors (MacArthur Foundation, Ford Foundation, European Union)
- UN organizations (UNFPA, WHO) and NGO (ICRW)
- Collaborators (RFSU, Lund University, Oregon State University, University of Melbourne)
- MAMTA staff (present and past)

Survey questionnaires

Questionnaires were sent to all the ITP and NTP participants who could be contacted and the active Srijan Network members and zonal coordinators in the seven states where this component of the project was implemented. The aim of these questionnaires was to explore the impressions of people who had benefitted from the project about how it had contributed to their work on ARSHR policies and programmes. The questions were predominantly closed, with possibilities for open-ended responses.

Limitations/Caveats

This report should be read in conjunction with the many reports and evaluations that have been carried out of the MAMTA activities that were developed and implemented with the support of Sida funding (see http://www.mamta-himc.org/pub.htm for details). One of the findings from the assessment was that significant efforts had been made during the course of the project to document and evaluate what was done. This assessment builds on but does not repeat what is already available (see Annex 3).

It was not possible in the time available to visit all of the states that had been included in the project. Uttar Pradesh, West Bengal and the North East were chosen for site visits and interviews. The selection was made through discussions between the external evaluators and MAMTA staff, using the following criteria: a state where MAMTA had had a long association and current involvement, including with the Srijan network partners (UP); a state where MAMTA did not have direct implementation and is not currently supporting the Srijan network (West Bengal); and states where there were NTP partners in a region that is relatively isolated (North East). The selection of key informants outside Delhi was therefore purposeful and pragmatic, with transparent selection criteria to ensure that they were representative of different conditions, if not randomly selected (see Annex 2 for details).

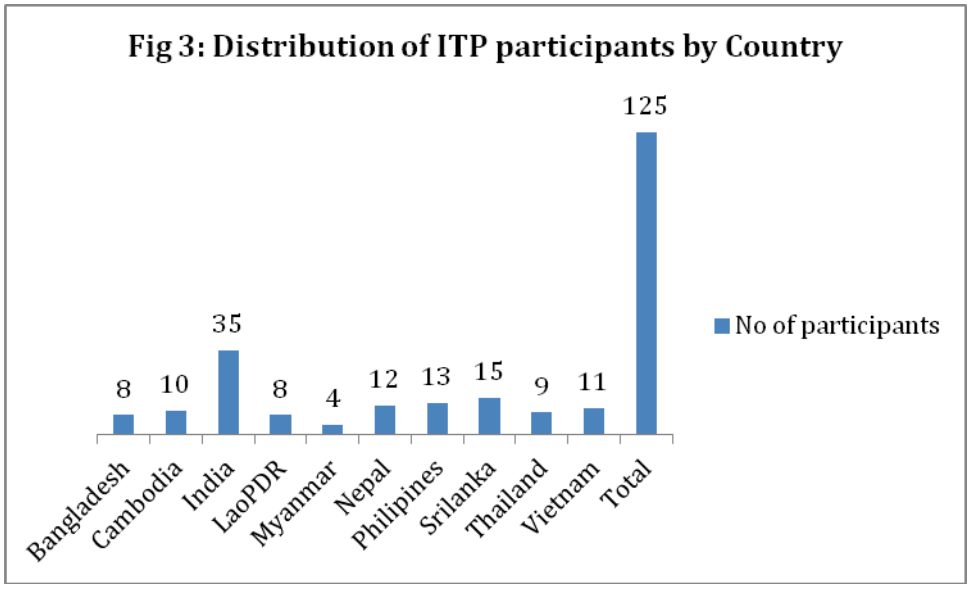
Finally, it needs to be stressed that this assessment was not intended to be an overall evaluation of the Sida-supported MAMTA project, nor was the aim to synthesize good practice from the thematic programmes areas that were the focus of the project (e.g. early marriage, AFHS, sexuality education, SRHR, young people and HIV/AIDS), much of which has already been done, globally, regionally and for India (by MAMTA and other organizations).

3. Results

3.1 An assessment of selected elements of the project

3.1.1 The International Training Programme (ITP)

The ITP was implemented from 2003-2008. 125 participants were trained from 10 counties in the South Asia and South East Asia region, selected from medical colleges, government facilities and NGOs (Fig 3).



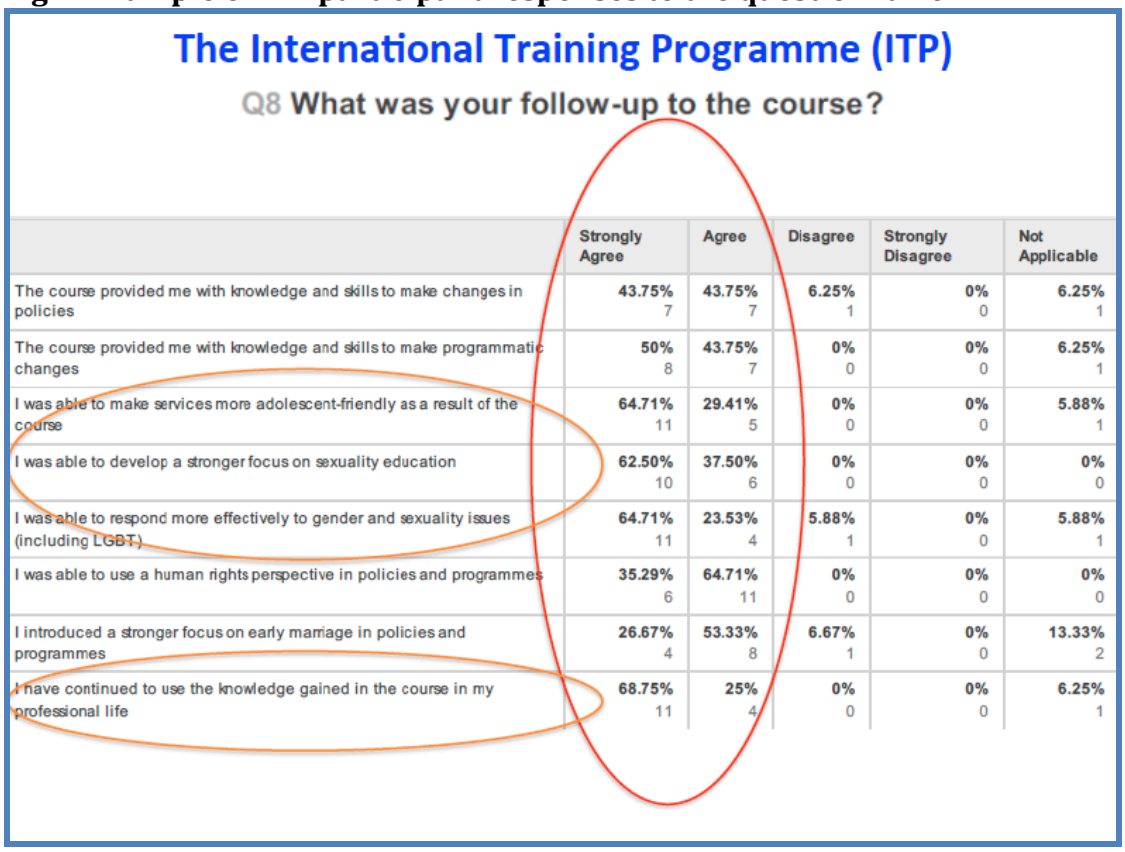
ITP Questionnaires

Only 18 of the 100 ITP participants who were sent an invitation to complete the questionnaire responded (18%). This is perhaps not surprising in view of the fact that the last training was in 2007, and many of the emails were no longer functional.

There were more men than women respondents (65% and 35% respectively) with the majority currently in senior or mid-level management positions, working with Ministries of Health, other government ministries and NGOs. There was good representation across the years of the training (2003-2007) and reasonable geographical coverage, with responses from ITP participants from Cambodia, India (33%), Laos, Nepal, Philippines (33%) and Thailand.

Of those who did respond, there was remarkable consistency in the responses.
Participants were very positive about the course content and the teaching methods. They clearly benefitted in many ways. The vast majority indicated that they were able to make health services more adolescent-friendly as a result of the training, and were able to develop a stronger focus on sexuality education and respond more effectively to gender and sexuality issues, including specific issues related to LGBTs (see Fig. 4).

Fig 4: Example of ITP participant responses to the questionnaire



The International Training Programme (ITP)

Q8 What was your follow-up to the course?

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
The course provided me with knowledge and skills to make changes in policies	43.75% 7	43.75% 7	6.25% 1	0% 0	6.25% 1
The course provided me with knowledge and skills to make programmatic changes	50% 8	43.75% 7	0% 0	0% 0	6.25% 1
I was able to make services more adolescent-friendly as a result of the course	64.71% 11	29.41% 5	0% 0	0% 0	5.88% 1
I was able to develop a stronger focus on sexuality education	62.50% 10	37.50% 6	0% 0	0% 0	0% 0
I was able to respond more effectively to gender and sexuality issues (including LGBT)	64.71% 11	23.53% 4	5.88% 1	0% 0	5.88% 1
I was able to use a human rights perspective in policies and programmes	35.29% 6	64.71% 11	0% 0	0% 0	0% 0
I introduced a stronger focus on early marriage in policies and programmes	26.67% 4	53.33% 8	6.67% 1	0% 0	13.33% 2
I have continued to use the knowledge gained in the course in my professional life	68.75% 11	25% 4	0% 0	0% 0	6.25% 1

Over 90% of the respondents would have liked more technical support/guidance following the course and felt that they would have benefitted from access to additional resources.

ITP Key Informant Interviews

The interviews with ITP participants and people who had been involved with providing the training during the course overwhelmingly supported the findings from the questionnaires, and provided an opportunity to elaborate on certain issues.

The participants generally had a positive impression of the course: it was well designed, organized and facilitated; meticulously planned with useful field-visits and good reading materials. It provided "a great learning environment" and "happened at a time when very few people were talking about adolescent sexuality". In addition to ASRH, the issue of "rights" was well covered, including how to use a focus on rights to stimulate changes in social values and norms. A comment from one KII reflected the sentiments of many: "I left the course very motivated".

Participants liked the participatory techniques and the balance between classroom and field exposure, between theoretical knowledge and visits to a clinic in a slum area, where it was possible to interact with doctors and clients. This helped to make the connection between theory and practice.

Participants felt that there was a good balance between the trainers from RFSU and other external institutions, and the team of resource persons from India, which included MAMTA staff and other Indian experts. In addition to strengthening participants'

capacity in relation to ASRHR, they also benefitted from being involved in a participatory learning environment.

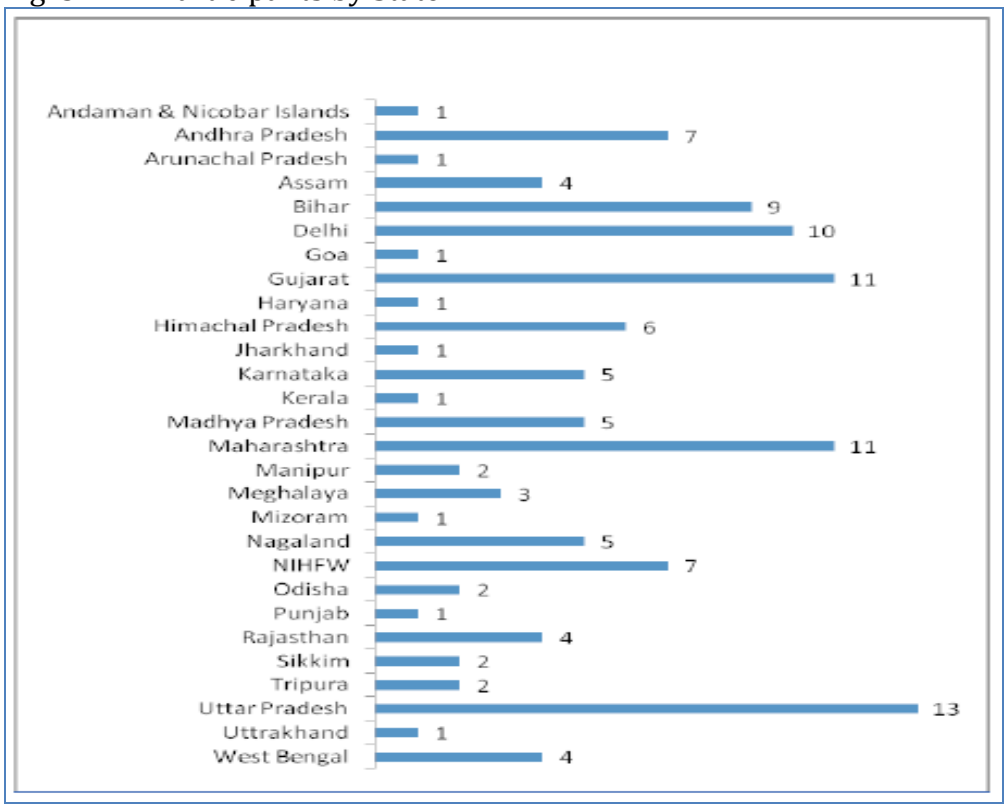
> *"The ITP helped me vis a vis other trainings. This is one of the major training programs that I remember from my career. It helped me conduct other trainings as well. The participants were from other countries in South and South East Asia region with different perspectives and experiences. There was complete ownership. The environment facilitated contribution by the participants. I have used the training in the programs I have managed over the years and tried to integrate SRH into HIV/AIDS programs. I brought in SRH and adolescents issues wherever I could."*
>
> Quote from ITP participant, India.

MAMTA had organized a follow up meeting for experience sharing, but other than that there was no formal networking between participants following the course. However, a number of participants had made the effort to keep in touch with each other informally.

3.1.2. The National Training Programme (NTP)

The NTP was implemented from 2008-2012 and had 122 participants from across the country, primarily ARSH nodal officers working within the government and medical colleges (see Fig.5). Seven participants were from the NIHFW, the government institute where the training course was in the process of being institutionalised.

Fig. 5: NTP Participants by State



NTP Questionnaires

There was a good response to the invitation to participate in the questionnaire from NTP participants, with a response rate of 34% percent (41/122). Respondents represented a cross-section of ages (35 - 60 years), a good gender balance (54% men and 46% women) and a representative spectrum across the years of the NTP [2008-25 participants,2009-27 participants, 2010-24 participants,2011-24 participants & 2012-22 participants].

The largest proportion of respondents was currently in senior and mid-level management, followed by academics and then practitioners (at the time of training the majority worked on adolescent reproductive health (ARH) at district or state level, or in medical colleges).

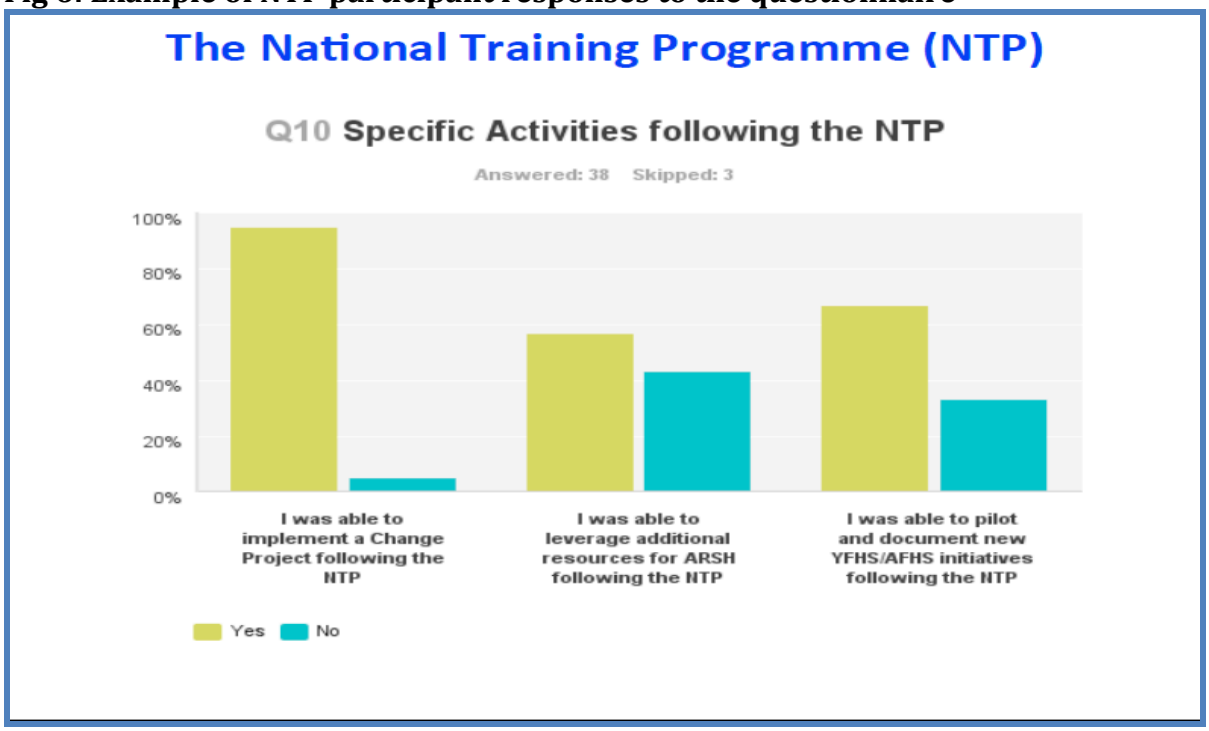
Participants clearly liked the training methods and nearly 80% strongly agreed with the statements: *The course gave me new ideas about adolescent/youth-friendly health services* and *I would recommend such a course to colleagues working with adolescents/youth*.

Visiting Sweden was an important component of the course and while over 30% of participants disagreed with the statement that *the opportunity for me to visit Sweden was a strong motivation to attend the NTP*, over 90% agreed/strongly agreed with the statements: *I found it motivating for developing ARSH interventions* and *I learned new approaches to solving policy and programme challenges*.

Nearly 100% of the respondents agreed/strongly agreed with the statements: *I was able to make services more adolescent-friendly as a result of the course*; *I was able to develop a stronger focus on sexuality education*; *I was able to respond more effectively to gender and sexuality issues (including LGBT)*; *I was able to use a human rights perspective in policies and programmes*; and *I have continued to use the knowledge gained in the course in my professional life*

Following the course over 90% of respondents were able to implement a variety of Change Projects, nearly 80% were able to pilot and document new YFHS/AFHS initiatives, and just under 60% were able to leverage additional resources for ARSH (see Fig 6). Over 90% of participants would have liked more technical support/guidance following the course, and felt that they would have benefitted from more access to additional resources following the course (e.g. regular technical updates, examples of successful ARSHR projects).

Fig 6: Example of NTP participant responses to the questionnaire



Many of the respondents clearly felt very positive about the training and indicated that they would have benefitted from more ongoing networking and opportunities to share experiences.

NTP Key Informant Interviews

The KIIs with NTP participants confirmed and elaborated the findings from the questionnaires. The NTP experience was clearly transformative for many of the participants and had a significant impact on their perspectives about young people and how to meet their rights to SRH.

Participants were overwhelmingly positive about their participation in the course: *inspirational*, *thought provoking*, *transformative (both individually and professionally)*; *developed a passion for adolescents*, *learned how to think and talk about sensitive issues (sex, sexuality, LGBT)*, *to be non-judgmental*, *to focus on adolescents as clients not patients*; *didn't realize that pre-marital sex happened in India until the course*.

Feedback about the course was consistently positive: participants thought that the course was well planned and organized, that there was a good balance between academic/policy/programme focus, between inputs from Sweden and inputs from India, and they enjoyed and benefitted from the interactive teaching methods, and from having opportunities to share experiences with the other participants, and learn from them.

Participants were almost unanimous in their positive assessments of the benefits of the time spent in Sweden during the NTP. While they were clear that Sweden and India have many important differences, and that much of what they experienced in Sweden could not easily be replicated in India, the experience was "inspiring", "aspirational" and "motivating", and gave participants a vision of what to aim for. It provided them with a

sense that the issues that confront them *could* be overcome (even if not immediately) and examples of strategies for doing this ("what can be done"), including the importance of developing collaboration with a range of partners beyond health workers. Two of the participants interviewed felt that some of the presentations were rather academic and were perhaps not so relevant to the situation in India, but the vast majority gained enormously from seeing ASRHR ideas being put into practice.

The overall impressions from the KIIs were that the training had brought about long-term change in the participants (knowledge, attitudes, and actions) and in their programmes, all of which contributed to the growing focus on ARSHR in the country. It improved the quality of proposals for ASRHR interventions in the Programme Implementation Plans (PIPs). It left adolescent champions in important positions in national and state government who were, and still are able to be resource persons in their own states and, in other states.

The KIIs indicated that the NTP provided inputs for the NIHFW to strengthen the existing training on ARSHR for health workers through the Orientation Programme (the current plan is to extend this training from 3 days to 6) and contributed to the development of the new Adolescent Strategy. Being involved with the training also significantly strengthened the capacity of MAMTA to carry out such training, which it was able to use in many other contexts and for many other target groups. Additionally, being involved in the training had a positive impact on the Swedish partners (Lund University and RFSU).

According to the participants, the training helped them understand AFHS in practical terms, including issues such as confidentiality, being non-judgmental, avoiding stigma, having effective referral systems, standards, the types of services that need to be provided (including contraception, abortion for unmarried and married adolescents), and staffing of facilities, including non-medical staff such as social workers and counselors. They also realized the importance of behavior change communication and interpersonal communication for adolescents, and helped break mind-sets on pre-marital sex and LGBT issues. As one technical officer said, "*I didn't know that this existed before. It helped me get more exposure, deal with my biases and become non-judgmental*."

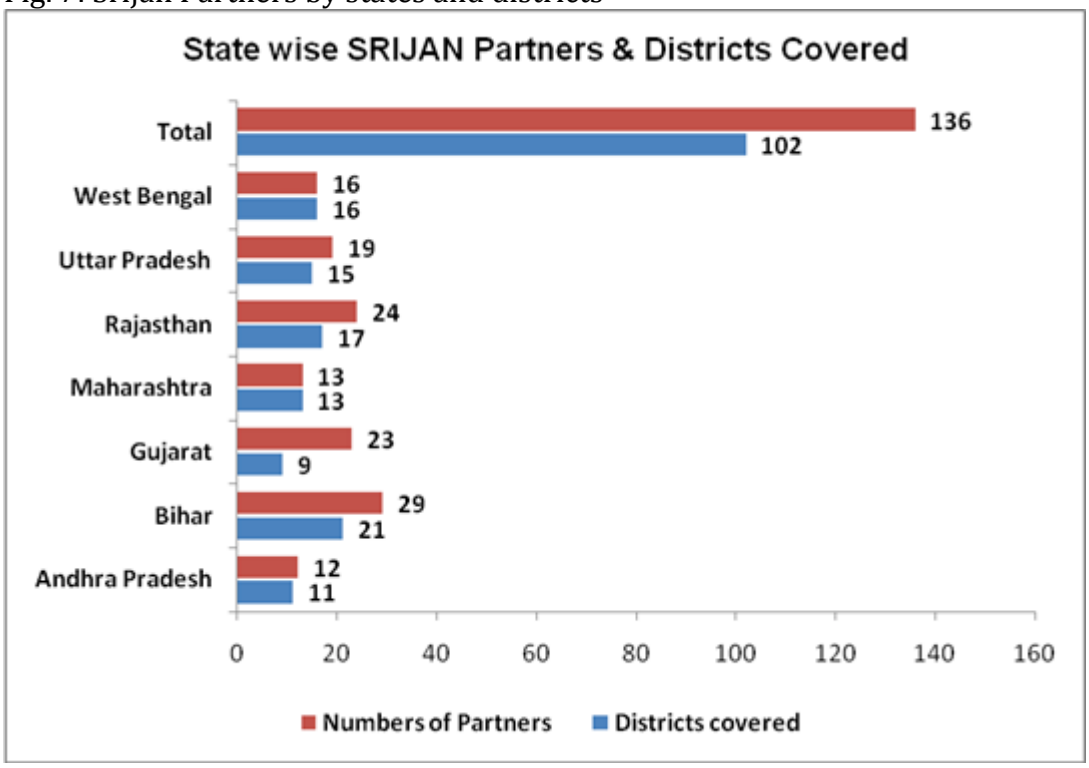
The Change Projects were both organizationally and individually important, as was the post-6 month's meeting to review and discuss the projects that had been implemented. These change projects helped the participants use the training in concrete ways in their work, and a number of them have since become "demonstration projects" that stimulated statewide replication: they provided concrete examples of "doing what needs to be done" and some resulted in publications in peer-reviewed journals.

Participant selection was important and the tripartite agreement that was developed between MAMTA, Lund and the NIHFW (2010) clearly helped to ensure that the "right" people were selected. Of course, with government staff rotations it is not possible to ensure that the people trained do not remain in positions where they can focus on adolescent health, nor that all people trained would retain the fire for adolescents. However, a number of people interviewed were in important positions to strengthen the national or state response to ASRHR, and all the people interviewed "had the adolescent bug"!

3.1.3 The Srijan Network

The Srijan network was developed from 2000-2009 and had 136 partner NGOs in 102 districts in 7 states of India (see Fig. 7).

Fig. 7: Srijan Partners by states and districts



Srijan Questionnaires

Responses were received from 35% of the Srijan partners to whom questionnaires were sent (29/80), a good response in view of the limited Internet connectivity and ability to communicate in English of some of the partners. There was a good spectrum of responses across the years that the project was run and responses were received from partners in all seven states. In terms of the focus of their work, the largest numbers are focusing on yong people and HIV and YFHS, followed by sexuality education and women's empowerment (the latter two both less than 20%). None of the respondents' organizations were focusing on early marriage.

The main reasons given for joining the network were to strengthen the organization's capacity to work with young people, followed by a desire to strengthen the organization's capacity to work on SRHR. Additional important reasons for joining included the desire to work with other organizations to improve young people's access to SRH services, and to advocate with other organizations for SRHR policy changes.

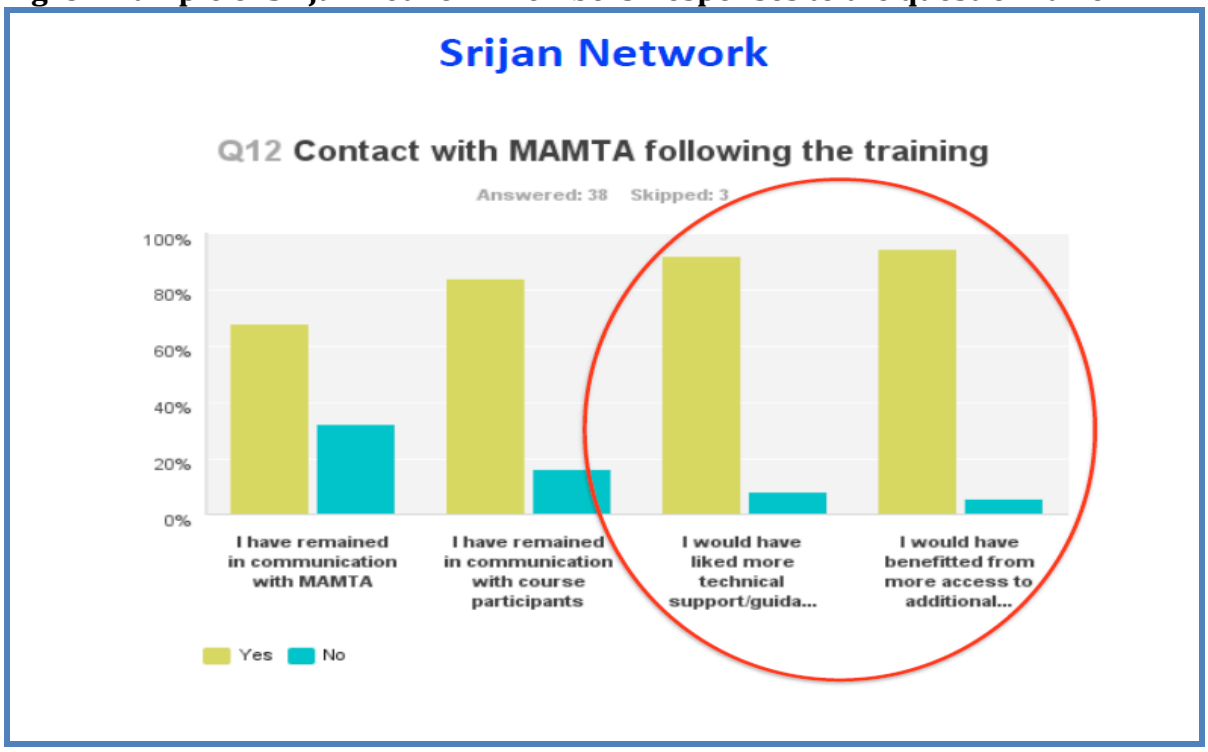
The main gains that respondents perceived from joining the network were information and experience sharing and capacity building on YSRHR, gender and sexuality; mobilizing and empowering young people; and gaining recognition and visibility. The most important ways in which the organizations were influenced by the network were: mainstreaming SRHR into other programmes, and strengthened networks for advocacy in relation to ASRHR.

Concerning young people, peer educator training, the youth advocacy activities and the youth information/drop-in centres were considered to be the most important activities for strengthening young people's participation and engagement.

In terms of long-term impact, over 80% of respondent strongly agreed with the statement: "*the capacity that we developed has made us a stronger and more effective organization*" and 75% with the statement "*we still have a strong sense of solidarity on SRHR issues at state level*", both important considerations for sustainability.

Many of the respondents would like to continue with the network, for advocacy, sharing ideas and information, confronting new issues, developing joint finding proposals and providing a platform for young people in the state (see Fig. 8).

Fig. 8: Example of Srijan Network members' responses to the questionnaire



Srijan Key Informant Interviews

The KIIs with the Srijan network partners confirmed many of the issues highlighted in the questionnaire, including a strong desire to continue networking (which some were doing without support from MAMTA).

Overall, the network partners spoke of how their organizations had benefitted from the network, and how the network had helped them develop their technical capacity on ARSH issues and sharing with others.

Training on technical issues and the availability of technical support (from MAMTA) for responding to ARSHR("*even being able to talk openly about sex and sexuality, condoms was an important change*") helped members of the network strengthen AFHS (including training service providers) and focus more effectively on a range of issues such as child marriage, anaemia and menstrual hygiene. They had also benefitted from training and support for organizational development, including accounting and proposal writing (and

were subsequently able to be linked with other sources of funding). It was the first time for many of them that there was a focus on young people with consistent and deep engagement.

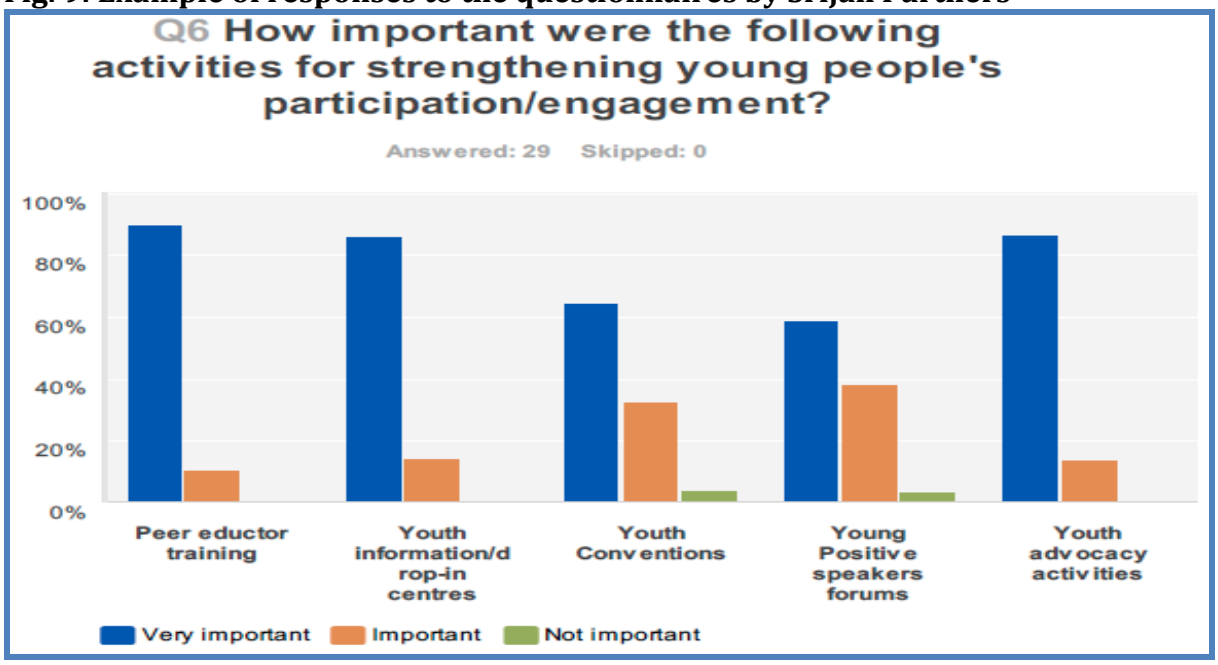
Members learned how to work in a more planned and systematic way, and together they were better able to advocate for young people more effectively. The Srijan network provided a platform/movement for ARSHR, through which members could share experiences and contribute to programme and policy changes at state level – the government recognized the value of the NGO members. The network helped to link different ARSH components and strategies and mainstreamed a focus on young people into other programmes.

Being members of the network gave them visibility, recognition and strength, and the ability to have dialogue with senior government people in the community/district/block. The members of the network gained "*name, fame and recognition*" by state and district government officials and by young people, and through their involvement with the network they became resource people at the state level, including participation in state and district level committees dealing with different aspect of ASRHR.

The members of the Srijan network were unanimously positive about the benefits of being members of the network, and how it created a platform for advocacy and sharing experiences ("*it brought people together from different locations and organizations working on different issues around common goals working in partnership with a common understanding*") and developed a common understanding, despite the different perspectives of the members, and developed a solidarity and ways to work together for young people.

The young people who were involved in the network were also very positive about their involvement. It was clear during the interviews that the network had supported the creation of a group of powerful self-confident young people ("*whatever has never happened will happen, by us, now*!") and young activists, advocates and leaders ("*young people need to be informed if society is to change*"). They benefitted from a range of network activities, for example the peer educator training at state and national level, which they found useful and effective for their work, and the youth forum, which enabled them to learn from each other. The exchange and exposure visits, and the youth forums at district, state and national levels clearly made important contributions. In some cases, the peer educators had become master trainers in the organizations (see Fig. 9).

Fig. 9: Example of responses to the questionnaires by Srijan Partners



3.1.4 Research and Documentation, the Resource Centre and Global Partnerships

This review focused primarily on the ITP, the NTP and the Srijan Network. However, as can be seen from Fig.2, these activities were supported by the other components of the project, namely the Phased Interventions, during which strategies were developed and tested; the Research and Documentation, which ensured a strong on-going institutional memory for the project elements and opportunities for sharing (see Annex); the Resource Centre, which provided participants in training programme and members of the Srijan network with easy access to a range of programme support materials; and the Global Partnerships, in which global partners could both contribute to and benefit from the ARSH interventions that were at the heart of the MAMTA-Sida collaboration.

Although these components were not explicitly assessed, it was clear from the KIIs that they played an important role in supporting and facilitating the project elements that were included in the assessment.

3.2 An assessment of the impact of the Sida support for MAMTA

3.2.1 General

Capacity building took place in many ways during the Sida-funded project. Through the international and national training programmes, through the Srijan network, but also through the training of MAMTA staff: staff responsible for setting the direction of MAMTA, people responsible for the ITP and NTP, and the people who were developing and implementing programmes during the phased intervention. This capacity has lived on in many ways, in the individuals and organizations that were involved and, through the partnership with NIHFW, in the development of other training programmes in India. The fact that government functionaries were selected for the training programmes, from national, state and district level, and from medical colleges, also ensured that the

training continues to have an impact, in terms of policies and programmes and also in terms of advocacy for young people in general and for ASRHR in specific.

In addition to the state-level networks that were developed and nurtured through the Srijan component of the project, there was also more informal networking that took place as a result of the NTP and ITP components of the project. It is often not easy initiating and supporting networks that include a diverse range of partners in terms of focus and ability. The role that MAMTA played in coordinating the networks differed in the different states (e.g. UP and WB), this role varying depending on the availability of other NGOs who could play this coordinating role. The networks have clearly been important for the members, particularly for the smaller NGOs, and it is interesting that despite the formal "end" to the Srijan network, much indigenous networking continues.

There was extensive advocacy as a result of the project at national, state and district levels, in many different settings and focused on the range of ARSHR issues: directly through MAMTA, through the people trained, through the networks, and significantly through young people themselves.

The young people who were involved in the project benefitted extensively through their participation, through the fora for young people, through the training programmes for peer educators, through the information centres and the advocacy activities (see Annex 1 – success stories).

Gender and equity issues were key issues that were addressed in the project over the years. This was reflected in a number of findings from the assessment, including the feedback from the KIIs that stressed the importance of the gender dimension in relation to both the training programmes and the programme support. The questionnaires to NTP and ITP participants showed an almost equal number of female and male respondents, and the young people met during the FGD's included both girls and boys from poor communities across diverse religious backgrounds, equally empowered and committed.

The global partnerships that were a component of the project provided MAMTA with important links to academic institutions and research organizations internationally, with mutual benefit.

Over the years there has been extensive global and regional synthesis of good practice, guidance and programme support tools in relation to the core thematic areas of the project: early marriage; ASRHR; YFHS; sexuality education and young people and HIV. Through this Sida-funded project, MAMTA has both benefitted and contributed to this body of knowledge,

3.2.2 Impact on MAMTA

MAMTA has benefited in many ways from the support provided by Sida and the technical and organizational developments that this facilitated. A consistent message from the KIIs was that MAMTA is responsive, technically strong, and has evidence, facts and figures to support its positions on ASRHR and brings perspectives based on multi-location field experience and an understanding of the diversity in the country. As a result of the activities that it was able to implement during the period 2000 to 2013 MAMTA has gained national, regional and global respect, credibility and visibility. This

has enabled it to be a strong and effective champion for ASRHR, in terms of advocacy, technical assistance, capacity building and policy and programme development, with significant capacity for implementation support and wide national coverage (see Fig 10).

In addition to strengthening MAMTA technically, the support from Sida contributed to MAMTA's organizational development, including sound financial management systems, accountability and human resource management.

The support from Sida provided financial security, which, among other things, allowed MAMTA to take the risks necessary for growth. The foundations that were laid through the Sida supported project have provided MAMTA with capacity to respond to many health problems in the country, enabled MAMTA to take on other projects, to secure other sources of funding (see Fig 11) and to work in other states in India and in other countries, within Asia and outside the region.

Fig. 10: MAMTA's expanding national coverage between 1997 and 2013

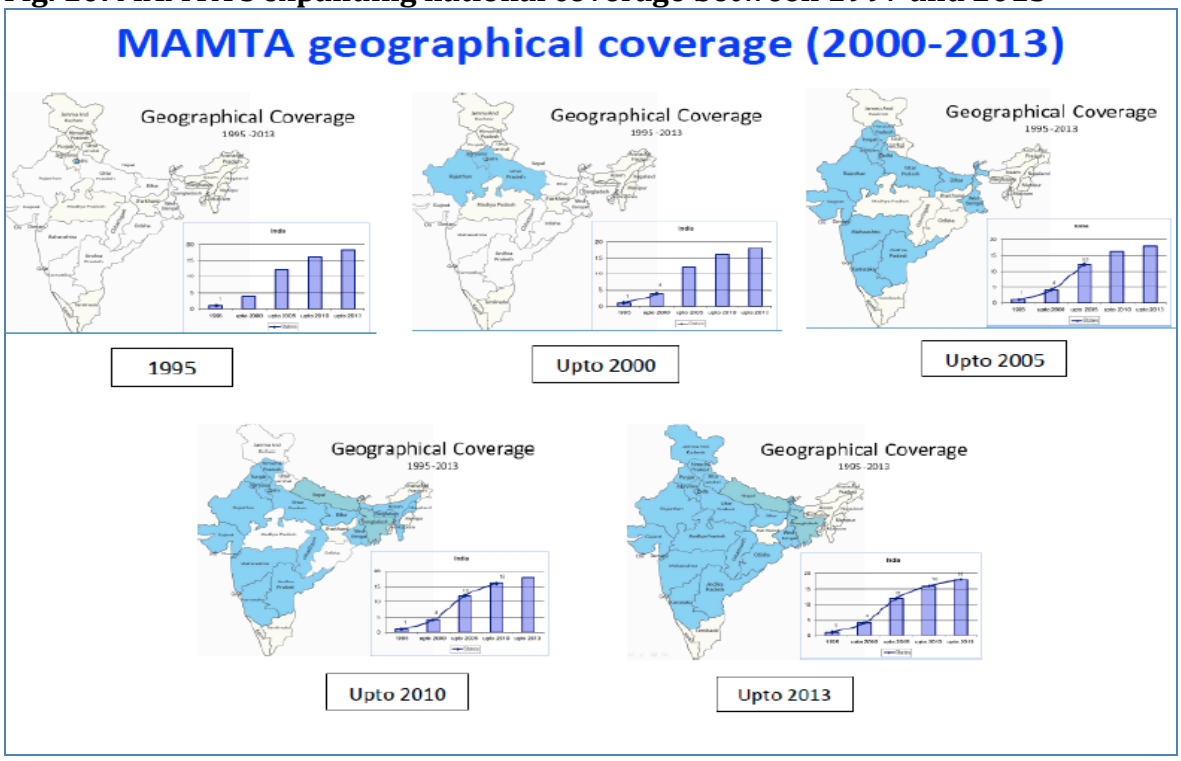
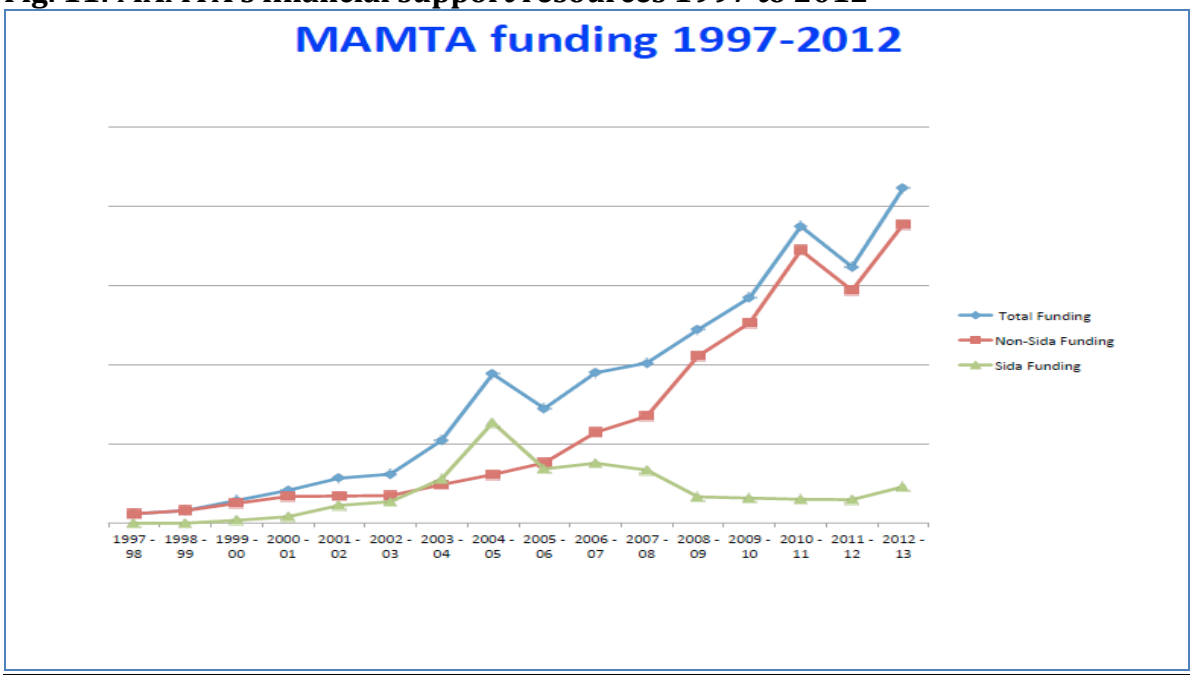


Fig. 11: MAMTA's financial support resources 1997 to 2012



3.2.3 Impact on Swedish Partners

The feedback from KIIs with members of the Swedish institutions [RFSU, Stockholm, Lund University & University of Karolinska] that had provided support to MAMTA's during the period of the Sida funded project indicated a number of ways in which they had also benefitted from this involvement.

It provided them with an opportunity to support action in India, and to share their expertize in the country with the largest number of adolescents. It strengthened their capacity and sensitivity for working in different cultures and contexts and collaborate with different organizations, which involved "de-learning and learning". It developed competencies that facilitated subsequent work in other countries, and strengthened their systems for monitoring and documentation, and their training programmes in Sweden.

3.2.4 Impact on national ASRH policies and programmes

The Sida support helped strengthen MAMTA's capacity to contribute to national/state policy and strategy formulation in a number of ways: through participation in government committees, the development of national guidelines for the government, inputs for the development of national strategies and programmes (e.g. RKSK), and the training of staff in key positions within the government and in academic and training institutions and NGOs.

In this way it way, MAMTA was able to make a sustainable contribution to moving the ASRHR agenda in India, through ideas, people, programme support materials, strengthened NGOs, programme examples, collaboration and funding. Specific examples include:

Inputs into policy/strategy/action plan development:

- MoHFW (e.g. Adolescent Health Strategy, Technical Resource Group (Adolescent Health, RCH 2)
- MWCD (e.g. Early Marriage, Child Sex Ratio)
- Planning Commission (e.g. National 10th and 11th 5 year plans)
- NACO (e.g. Sub-group on child, youth, women and gender of NACP 3 and sub-group on youth and link-workers NACP 4)
- MOYAS (e.g. Advisory Board, RGNIYD)

Technical assistance, capacity development and programme support tools/guidelines

- Training materials for NACO link-workers
- Materials for "Adolescent Education" programmes
- Peer Education training materials
- Inputs for the planned NIHFW training materials/programme
- Trained people in key positions at national and state levels through NTP, ITP, Srijan network and MAMTA staff
- Implementation of ASRHR interventions in 9 states and 136-plus NGOs active on ASRH-related issues

Specific technical inputs included:

- Member of the National Technical Committee on Child Health, MoHFW, to guide the effort towards achieving the National Population Policy Goals [2001]
- Member of the Core Committee for Midterm appraisal of 10thFive Year Plan for Health Sector, Planning Commission, Government of India [2003]
- Convenor and professional designate for subgroup on children, adolescents, women and gender in National AIDS Control Programme (NACP)-III [2005]
- Lead consultant organization for preparation of operational guidelines for Link Worker Scheme under NACP-III, HOHFW. [2006-07]
- Member of the Committee for 11th&12th Five Year Plan as a lead organization for Health- HIV and Nutrition (2007 – 11 & 2012-17)

3.2.5 Regional and Global Impact

In addition to strengthening MAMTA's contribution at national level, the Sida supported project also increased MAMTA's capacity and credibility to contribute to regional and global activities

Regional activities included:

- Development of human resource development plans and guidelines for Capacity Development of Reproductive Health Initiative for Youth in Asia (RHIYA) partners in Bangladesh [2005, UNFPA]
- Preparation of a standardized culturally appropriate clinical service delivery package and 'Developing Sustainability Strategies' for phasing out procedures for RHIYA partner NGOs in Bangladesh[2005, Marie Stopes Clinic Society]
- Collaboration with International Federation for Red Cross and Red Crescent Societies to provide technical support to multiple stakeholders (2007), including: contributing to the training during Bangladesh Red Crescent

Regional Meeting on life skills education (LSE) and HIV; advocacy skills building training for the Sri Lanka Red Cross meeting; customized training on LSE and RH for Afghanistan Red Crescent Peer leaders
- Development of Peer Education Manual & Adolescent Parenting Manual and Conduct TOT for Strengthening Adolescent Reproductive Health in Dhaka, Bangladesh [2009, Plan International, Bangladesh]
- Development of Advocacy Training Module for the Stakeholders for India and Bangladesh on HIV-SRH Convergence in Dhaka, Bangladesh [2010, International HIV/AIDS Alliance, UK]
- Development of Peer Module on Gender transformative Approach for implementing Partners in Nepal, 2010
- Advanced Training on Young people's Sexual and Reproductive Health and Rights for CSOs & policy makers through collaboration with CCRHTIT (China Centre for Reproductive Health Technical Instruction and Training) in Shanghai, China [2005,UNFPA]
- Technical Support to South East Asia and Pacific Hub Partners of Khana, Cambodia, on SRH-HIV Convergence [2010, International HIV/AIDS Alliance, UK]

Global activities included:
- Technical Steering Committee of WHO, Geneva, on Child and Adolescent Health [2003 – 05]
- Regional Technical Steering Committee of WHO, SEARO, on Child and Adolescent Health [2005]
- Scientific committee for 4th Asia Pacific Conference on Sexual and Reproductive Health [2006-07]
- Expert for finalisation of GFTAM Round Six proposal for CCM approval [2006]
- Co-Chair (Officiating Chair) for 4th Asia Pacific Conference on Sexual and Reproductive Health [2007]
- Strategic and Technical Advisory Committee for HIV/AIDS (STAC-HIV), Department of HIV/AIDS, WHO, Geneva [2007-09]
- Prevention Reference Group on HIV/AIDS, UNAIDS [2009]

4. Lessons Learned

4.1 What made the project achieve what it could?

Creating and taking opportunities

The support from Sida helped MAMTA grow as an organisation. From modest beginnings, the organisation was able to make strategic choices and evolve with the changing context. MAMTA was able to take opportunities when they presented themselves and take risks when it was necessary: it was able to be in the right place at the right time with the right mind-set.

Long-term support and safety to take risks

Sida provided long-term commitment and support for MAMTA, which was very important because changing ideas and focus takes time, and the seeds of sustainable development do not grow overnight. In addition, Sida support helped to create a space

to learn and experiment. There was not only a willingness by all involved to take risks and be innovative, but the failures that are inherent in risk taking were responded to in a positive, problem solving way.

Preparing and sustaining the project

Sida spent time making a good initial assessment of MAMTA's strengths and weaknesses (capacity, connections, courage) and had a deep understanding of the context of India. At the same time, MAMTA had made an assessment of Sida as a potential partner, and subsequently assessed the capacity of the collaborating organizations in Sweden to strengthen those aspects of MAMTA's capacity that needed to be strengthened. The collaboration therefore met all parties' interests, and was further strengthened by being clear about roles and responsibilities, ensuring sensitivity and respect, and optimizing the two-way influence and benefits for MAMTA and the Swedish institutions invovled. Having an exit strategy and clear expectations when the funding came to a close was also important.

Adequate technical capacity

MAMTA was responsive as an organisation and keen to build its technical capacity. It was therefore able to benefit from the external support that was provided, and was able to ensure that the strengthened capacity benefitted all levels of the organization. The technical support especially in the areas of gender, sexuality and rights, was crucial for MAMTA to play the subsequent role that it played nationally and regionally. The project highlights the importance of being clear about training needs (when to train, who to train, what to train?), and the training that was carried out had long-term impacts on MAMTA staff, strategic government staff (key influencers), and NGO staff at different levels, in different states and countries in the region. This will likely leave a long-term legacy for the future on ARSHR issues.

Adequate organizational capacity

An important aspect of the project was the early recognition of the need to strengthen aspects of MAMTA's financial and organizational management, and Sida invested funds in developing these aspects of MAMTA. This had many knock-on effects over and above their contribution to an effective project: MAMTA was able to share this capacity with members of the Srijan network. In addition, the reputation that MAMTA had for good financial accountability benefitted subsequent requests for funding from other sources.

The importance of being evidence-informed

MAMTA put significant effort into being evidence based. It was able to develop programme strategies through the Phased Intervention phase of the project that could then be replicated and adapted in other places. This field-based evidence was clearly welcomed and appreciated by many people. At the same time, MAMTA made a serious effort to document what was taking place and captured the lessons learned over time. The on-going evaluations helped to make mid-term corrections and strengthen the program as it evolved.

The importance of adequate knowledge management

During the project, significant attention was given to Knowledge Management on ASRHR and related issues, documenting experiences and collecting, collating and disseminating programme support materials. MAMTA was thus able to share the technical knowledge gained, including training materials and programme guidance, in areas such as

Information Education Communication (IEC) and Behaviour Change Communication Change (BCC), to a range of audiences nationally and regionally.

The importance of working with/through the government and existing systems
MAMTA expressly worked to strengthen government systems, and found ways to balance innovation with working through government structures. MAMTA also recognized the importance of working through existing NGOs, by building their capacity to reach young people in different contexts (rural, urban and semi-urban) in different states.

Working strategically with young people
Listening to young people's perspectives and finding ways to empower them was important for the project, and a number of strategies were developed to facilitate this: spaces and forums where they could freely express themselves, grow and participate, and access the information and advice that they needed.

Balancing advocacy and activism
Advocacy is much more powerful when it is based on experiences of action on the ground, and MAMTA was able to support its advocacy in this way. At the same time, MAMTA was able to find a productive balance for itself in terms of having sufficient credibility to have a seat at the policy table and also being able to contribute to advocacy on ARSHR issues that were often politically and culturally sensitive.

4.2 Challenges for the project

In addition to the many positive lessons that were learned during the project about the factors that contributed to its success and positive impact, there were also a number of challenges.

Developing and sustaining networks
Although MAMTA had previous experience of collaborating with other partners, it had not had a great deal of experience of initiating, coordinating and sustaining networks. Bringing together a diverse group of NGOs posed a number of challenges, including meeting different needs/expectations and finding suitable roles for those NGOs already actively involved with ASRHR advocacy and programmes. However, despite the difficulties encountered with some of the coordination mechanisms, it was clear from the KIIs and the questionnaires that the NGOs involved with Srijan benefitted in many ways from the experience - their main area of complaint was that it had stopped.

Supporting and supervising people who are trained
Training people is in many ways the easy part of a training programme. How the people trained are subsequently supported, motivated and supervised is also important for turning the content of the training into action. From the interviews and the questionnaires it was clear that although the Change Projects and the on-line Resource Centre made important contributions to the people trained, there was a general feeling that the ITP and NTP participants would have benefitted from additional support and access to technical resources, and more on-going opportunities to share experiences following the training.

Capturing the longer term positive changes in the lives of young people and their communities

The investments in this project aimed to have an impact on the lives of young people and the communities in which they live. While there was significant documentation of the different components of the project between 2000 and 2013, the longer-term impact on young people and their communities was not systematically assessed. Although challenging, it is important for advocacy and possible replication to be able to demonstrate these longer-term effects.

Finding a balance:

In any project it is important to find a balance between competing needs and requirements. These include:

- Developing staff and retaining them
- Having high expectations/scaling-up and ensuring that quality is maintained.
- Supporting government programmes and finding the space to be an innovative NGO
- Having strong leaders with vision and credibility and ensuring that it is the organization that is recognized for its capacity and potential to contribute.

4.3 Impact and the challenges of development assistance

The feedback from the questionnaires and the KIIs complement each other. They all confirm that the international and national training programmes and the Srijan network were positively assessed, and that the three initiatives had an important impact on the past and current thinking and work of individuals and organizations, and on the country as a whole. However, there are some general issues that require further consideration, issues that place the current assessment in the broader context of external support for national programmes.

First, what do we know about the sustainability of the project? All of the discussions with KIIs indicated that the project *has* had a sustainable impact. This has resulted from many factors, in particular: the focus on strengthening MAMTA as an organization (both technically and organizationally); the involvement of the government in the selection of participants for training and the focus on supporting government programmes through the development of programme support materials and staff capacity development; and the focus on contributing to the development of policies, which, while they often take a long time to develop, once developed they have a long-term impact. Furthermore, the project laid the foundations for MAMTA to respond to new challenges, such as NCDs and mental health, and contribute to the development of the new National Strategy on Adolescent Health.

The second question relates to value for money: was the project a good use of the available resources? Certainly there was a sense from both the questionnaires and the KIIs that the project was effective in achieving what it set out to achieve. Whether or not this outcome could have been achieved through using the resources in a different way was more difficult to assess. To answer this question it is necessary to take into consideration the ARSHR context in which the project started; the need for a long-term perspective in developing national responses to ARSHR; and the importance of trust and respect for taking the risks that were essential for the development of new initiatives and approaches in what was, and in some ways still is, a politically sensitive area of

work. Overall, it appears that Sida found an enterprising and effective partner in MAMTA, and MAMTA found a responsible and responsive partner in Sida to do what needed to be done.

A third issue relates to attribution: how much was the project responsible for the changes that took place in MAMTA, in the Swedish partners and in national policies and programmes? Clearly, not all ARSH developments in the country were the result of MAMTA and not all the developments that took place in MAMTA during the period 2000 to 2012 were the result of Sida support. However, there was wide consensus from government functionaries, donors and UN organizations that MAMTA has made important contributions to ARSH policy and programme developments in India during the 2000's, a time when there was relatively little focus on ARSHR in the country; and all the KIIs with MAMTA, Sida and the Swedish partners stressed how important the project had been for the development of ideas, capacity and activities.

Fourth, there is the question of scale: what was the coverage (and quality) of the impact of the project? To begin with, the project was not national, and furthermore, for a country such as India, the training programmes that were initiated reached a relatively small number of people. However, the people included in the NTP were strategically selected, and despite the inevitable rotation of government functionaries, a number of participants have remained in important positions at national and state levels, in the MOHFW and Medical Colleges, where their ideas and experiences continue to be felt. At the same time, the capacity within MAMTA that was developed through the project has not only continued in the project areas, but as the coverage of MAMTA programmes has increased in the country, these have been replicated and expanded throughout the country.

Fifth, how much was the project in line with current thinking about development assistance – did the project comply with recommended approaches for external support for national interventions? During the period that the project was implemented, there were a number of global meetings that attempted to develop consensus about key issues related to development assistance. The 2005 Paris Declaration spelled out five key principles of aid effectiveness— ownership, alignment, harmonization, results, and mutual accountability, and these received further support through meetings in Accra (2008) and Busan (2011), and through the International Health Partnership (IHP+) (2007) that encouraged development partners to align assistance with national health plans[10]. Whilst these principles are primarily directed towards governments, it is important that they also influence the activities of NGOs and their relationships with development partners. In general, these principles were well reflected in the project, with MAMTA clearly being in the driver's seat and consistent efforts being made to align what was done with existing government policies and programmes.

There is no universally applicable mechanisms through which official agencies can provide funding to NGOs. However, over the years certain principles have emerged[11]

[10]Stierman E et al (2013): *Aid alignment: a longer-term lens on trends in development assistance for health in Uganda*, Globalization and Health 2013, 9:7
http://www.globalizationandhealth.com/content/9/1/7

[11]Pratt B et al (2006): *Official Agency Funding of NGOs in Seven Countries: Mechanisms, Trends and Implications*, INTRAC Occasional Papers Series No: 46

that should be taken into consideration: clarity in the criteria used to determine funding decisions and to choose NGOs for funding; the need for an organisational assessment; rationalizations of financial management; advice from resource centres/consultants to complement capacity constraints; and clear indicators of success around an NGO's overall performance and specific outcomes, with appropriate and effective monitoring and evaluation systems. In general, again, the project reflected these principles of good practice.

5. Conclusions and implications for the future

MAMTA with Sida support has made a sustainable contribution to moving the ASRHR agenda in India, in terms of ideas, trained professionals, empowered young people, materials developed, strengthened NGOs, programme examples, collaboration, government policies and programs and increased funding to ASRHR. It has done this through hard work and commitment, innovative and sometimes high-risk decisions, long-term support and systematic development, and flexibility with monitoring and accountability.

The project has contributed to MAMTA becoming a strong national technically and organizationally sound NGO, with wide coverage, that has respect and credibility, and a seat at the top table in terms of policy developments. It is in a good position to not only help with the unfinished agendas (e.g. ARSHR) but also, perhaps more importantly, to support the new agendas (e.g. NCDs).

At the same time, the collaboration with Swedish partners not only benefitted MAMTA but also helped the partners expand their international work, and strengthen their capacity to work in different cultures/contexts and collaborate with different organizations.

The context in India is very different from what it was 15 years ago in terms of the thinking about ARSHR and the role that the government is, and should be playing in terms of ARSHR, and more generally in terms of adolescent health. There is now much more attention being paid to ARSHR and YFHS. An Adolescent Health Strategy (RKSK) has recently been launched, and there are many vertical programmes focusing on adolescent health, either being implemented or in the pipeline. For example from the MOHFW: Iron folate/deworming, menstrual hygiene and RBSK; and from the MWCD *Sabla* (for adolescent girls) and *Saksham* (proposed for boys).

The new national Adolescent Health Strategy (RKSK) includes six strategic priority (programme) areas that should provide the focus for work in the health sector in the coming years in India: nutrition, sexual and reproductive health (SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence, including gender-based violence (GBV), and mental health. These priorities should clearly influence MAMTA's future work.

RKSK is innovative in *many* ways. Three in particular stand out:

- The focus on adolescent health, putting together the package of health problems and linking multiple risk behaviours

- The fact that the MOHFW is taking responsibility for filling the gap between health facilities and adolescents, including developing new cadres (i.e. peers, "barefoot counselors" and adolescents counselors working in facilities) and strategies (e.g. adolescent health days), that will be part of the "health system" - important for a sustainable focus on prevention
- The explicit intention not to develop pilot projects, but to go to scale, with equity.

All of these will require significant NGO support, for capacity development; for the convergence at community level of a range of programme elements; for the use of new technologies, such as m-health; and for monitoring and evaluation, to complement and support the growing attention being paid to adolescents by the MOHFW, MWCD and others. MAMTA will have an important role to play, building on its expertise developed through the support from Sida.

As these new and innovative programmes move from words to action, there will be a need for implementation research, to test the feasibility of different strategies and to understand what is working on the ground and why, so that this can be fed into the doing-learning-refining cycle. There will also be a need for intervention research, in particular to develop interventions that reach beyond information/skills/services. Such interventions will be important for the prevention of many risk-behaviours that start during the second decade of life, and will likely contribute to the effectiveness of the core elements of RKSK (for example supporting parents). Again, MAMTA will have an important role to play, building on its expertise developed through the support from Sida.

In order to maximize Sida's investments, it is likely that MAMTA will need to be ready to take on new and expanded roles: technical (e.g. a consortium for operations research, knowledge management, m-health), organizational (e.g. new collaborations and partnerships) and strategic (e.g. linking the Information Centres with the new Adolescent Counselors).

There will be many opportunities to build on the capacity developed and the lessons learned from the project, including: supporting better screening of adolescents by adolescent counselors and front-line health workers; creating jobaids that are appropriate to the context of India; supporting the role of parents; helping the states prioritize; and demonstrating how all the different strands can come together at community level, including through the involvement of the peers and barefoot counselors incorporated in RKSK. These opportunities will require some re-tooling and strong leadership within MAMTA.

In the era of "big data", MAMTA should also consider re-energizing its previous and existing roles that have provided an impressive footprint and an extensive address book: strengthening and updating the YRSHR resource centre and the networking with a range of NGOs (this is something that they want and that has provided MAMTA with significant credibility in the past); and reassessing its support for networks of NGOs, based on the experiences with the Srijan network – a yearly conference on Adolescent Health that brings the network members and partners together could make an important contribution and provide MAMTA with additional visibility.

There is growing competition in India, regionally and globally in the field of ASRHR and adolescent health more generally. The project has been one of the factors that have stimulated this increasing attention to adolescents and youth, and MAMTA will now need to be clear about its role and how it can be particularly value-added. Fortunately, the project has laid strong foundations for MAMTA to continue to make important contributions to policies and programmes, to ideas and actions that will improve and maintain the health of young people, which in turn will have important repercussions on public health and the social and economic development of individuals, families and communities.

Annexes

Annex 1. Success Stories of Young People

Alok Dasgupta: A Young Campaigner on SRHR

Alok Dasgupta, 24 years, is a passionate advocate on young people's reproductive and sexual health issues in the eastern state of West Bengal. The journey of Alok began from 2005 when he became a peer educator in one of the Youth Information Centres run by Ashurali Gramonnayan Parishad(AGP), a SRIJAN partner in South 24 Parganas. At that time, he was a young 15 years old high school student. His interest took him to the Youth Information center to learn more about sexual and reproductive health. He participated actively in weekly issue based discussions and activities at the centre. Seeing his interest, the organisation started to give him more opportunities for participating in the state level SRIJAN activities such as for trainings for Gender and Sexuality, Peer Education and exposure visits to other SRIJAN states.

Through his visits to SRIJAN members of other states he started expanding his networks of friends who were SRIJAN's peer leaders. He demonstrated good leadership skills and in the year 2007, he was elected by voting as the Secretary, National Youth Forum.

In 2011, Alok graduated in Sociology and joined as Program officer in Health Vision & Research, SRIJAN's state facilitating agency for West Bengal. He identified peer leaders of 17 intervention districts of SRIJAN in the state and formed a 'SRIJAN Forum'. He got his forum to register in 2010 and started working in these districts with his fellow peer leaders. Since, the forum doesn't have any funding it is doing small activities on Sexual & Reproductive Health and Rights in the district with the support of personal contributions. He is currently working as 'State Coordinator' of Health Vision & Research and is additionally leading the 'SRIJAN Forum' a big network of peer leaders on SRHR.

Manisha Yadav: A tale of Strengthened Vision and sense of responsibility

Manisha Yadav, 20 years, from Village Chatnag, Allahabad District, northern state of Uttar Pradesh is now a valuable asset as a "resource person" on Sexual & Reproductive Health and Rights (SRHR) and Gender issues for the Department of Information & Broadcasting (Govt. of India) in Allahabad. Five years ago, her reality was very different. She was a 15-year old girl from a very poor family that was struggling for its survival. She managed to study till class8 as her mother was keen that Manisha should not be illiterate like her. But after that, her family's circumstances compelled her to stop further education.

During the same period, in the year 2008, she met one of the outreach workers, Sangeeta Devi, of Manjul Mahila Kalyan Samiti; an NGO partner of MAMTA working in the Allahabad District of UP. With Sangeeta, Manisha shared her quest for knowledge and desire to make a change in the lives of other girls in her area who live in the similar circumstances as she did. Her desire was to bring forward girls of her age who lived in isolation from education, information and opportunities. Sangeeta took her to one of the Youth Information Centres (YIC) operated by Action Project of MAMTA near her village.

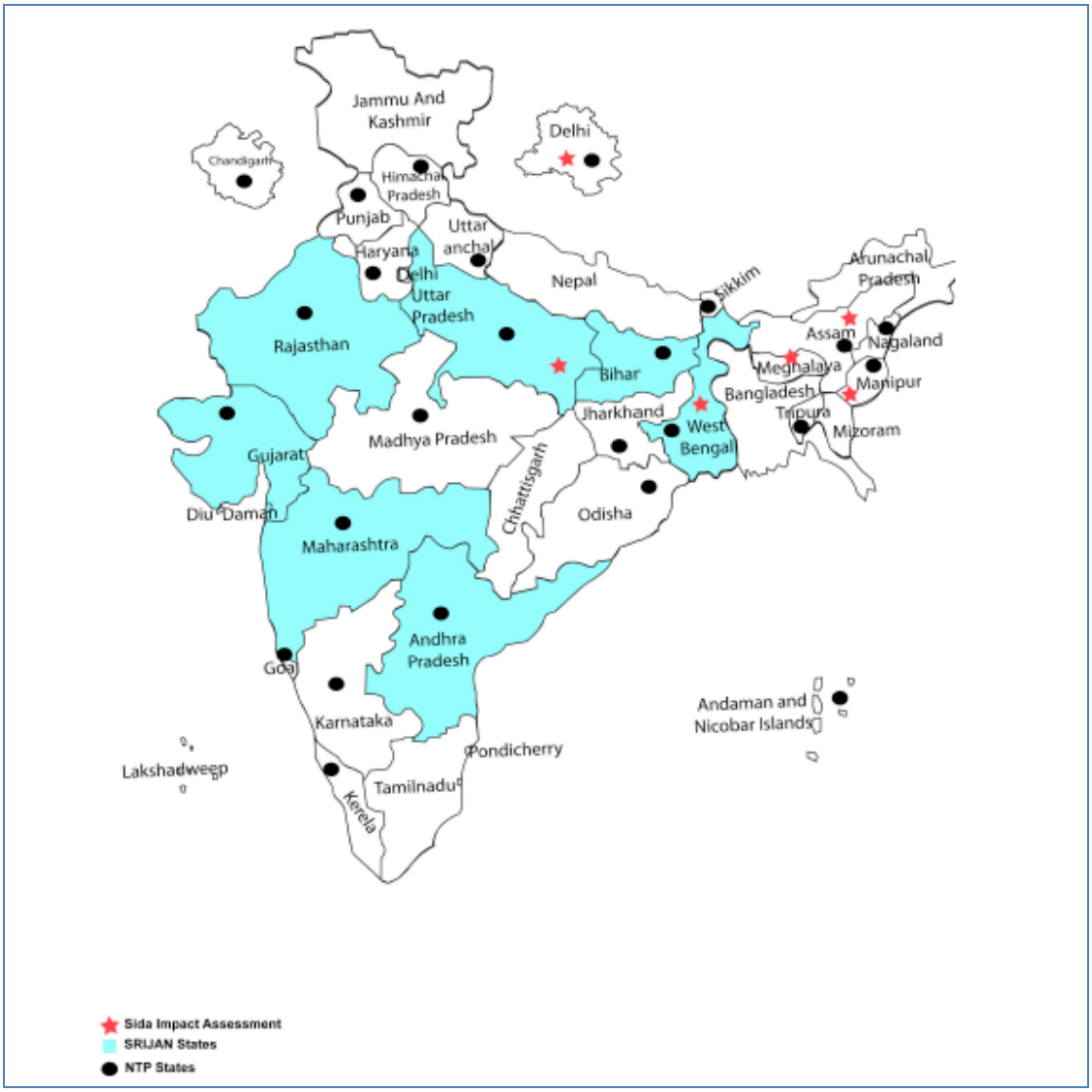
This was the day when, Manisha's life began changing. She joined the YIC and became a regular member. She learnt basic information on SRHR that was delivered by peer educators during regular YIC activities. In four months, she became a *peer educator* and *in-charge of the YIC.*. Her thirst for knowledge impressed the NGO's senior members; they decided to help her in continuing her education. NGO advocated with the district education officer (DEO) to support her education through a scholarship. The effort was successful and she was able to continue her education in secondary school. In the school, Manisha became a centre of attention for other girls who wanted information on sexuality and gender issues. She used to talk on adolescence and its related developments, age of marriage, conception, contraception, sex and pleasure, STI and HIV/AIDS etc.

In her personal life, she decided to delay her marriage against the desires of her parents and wanted to support her siblings until they become mature enough to stand on their own. She decided to start her career as a sexuality education facilitator in the schools at one of the MAMTA's projects.. Later, she became a member of the District Youth Form (DYF) and State level Youth Partnership Platform (YPP).

After two years, her talents were noticed by Mr.M. U Khan, Field Publicity Officer, Department of Information and Broadcasting, GoI, Allahabad Region, who was desperately searching for a young resource person for their community awareness programme on SRHR. She was invited to join their initiative. Initially, she was hesitant to take on heavy responsibilities as she was in her final year of high school. But the department was supportive and allowed her to continue her education.

Now, Manisha is actively involved in the awareness programs on SRHR by the department and is pursuing her graduation at the same time. Besides, being the main bread earner for her family, she is a guide and role model to her siblings and many more other girls in her area who are facing similar life situations as Manisha had faced few years ago.

Annex 2. Map of assessment areas and rationale for their selection



States	Reason for selection of the state for inclusion in the assessment
Uttar Pradesh (UP)	• Most populous state in the country • Poor in social and health indicators • Represents North/Central India • Maximum numbers of Srijan Network partners • NTP participants available in significant numbers (12-14) • MAMTA has had long investment in the state other than Sida support and continues to implement projects in the state • Poor record on NRHM performance (health governance is poor)
West Bengal (WB)	• Eastern state with cultural context of eastern India • Significant size of network partners, although the network was discontinued in 2009. • Has strong NGO-state government relationships • Moderate on health indicators • MAMTA has not had direct work in the state except with NTP

	participants and a few NGOs • Reasonable record on NRHM performance (health governance, especially community base, is better)
North East (Assam, Manipur, Meghalaya)	• MAMTA does not have any direct implementation work in the region • Distant states and have entirely different geographical and socio-cultural settings • NTP participants available in significant numbers (8-10) • Mainly focused on Medical Colleges, Public health systems and strengthening NGO's work on HIV through NTP

Annex 3. Timeline of the Assessment

Activities and Responsibilities	September				October				November				December				Jan	
Clarify objectives, focus and methodology for the assessment, time-line and structure for the report (BD/RM)																		
Develop space for collating documents and saving shared documents (RM)																		
Develop matrix for reviewing documents and criteria for selecting documents to review (BD)																		
Agree on key informants, methods for contacting them and questions (RM/BD)																		
Develop questions for key informants (RM)																		
Send questionnaires to selected key informants e.g. participants in NTP and ITP (RM)																		
Review selected documents provided by MAMTA (RM/BD)																		
Carry out skype interviews e.g. key informants outside New Delhi (BD/RM)																		
Srijan network face-to-face and virtual interviews (RM/BD)																		
Carry out face-to-face interviews with key informants in New Delhi e.g. MOHFW, MAMTA, NGOs (BD/RM)																		
Carry out interviews with key informants in NE (BD/RM)																		
Synthesize findings from document reviews (RM/BD)																		
Literature review of development assistance (BD)																		
Synthesize findings from key informant interviews (RM/BD)																		
Prepare draft conclusions and recommendations (BD/RM)																		
Present key findings New Delhi (BD)																		
Draft report for review by MAMTA (BD/RM)																		
Finalize report (BD/RM)																		

Annex 4. Key Documents reviewed

MAMTA's documents:
Srijan network

- Chronicling Foot Steps of SRIJAN's Journey: Towards Mainstreaming Young People's Reproductive and Sexual Health Rights (YRSHR), Process Documentation and Strategic Overview of Networking – documents the processes and gives a strategic review of the Srijan network in 7 states for 7 years
- Partnerships for change: Evolution of Srijan (Sexual and Reproductive Health Initiative for Joint Action Network), 2009

Program documents

- *Young People's Health and Development: A Sexual and Reproductive Health Centred Action Approach: 2003-2008 – A Project Overview. MAMTA, Sida and RFSU*
- *Sometimes all they need is a voice - Advocacy Process Documentation*: Making A Case for Young People's Sexual Reproductive Health and Rights. 2009. MAMTA, Sida and RFSU
- When Knowledge is Power……. To prevent school based Sexuality Education Programme. 2009. MAMTA, Sida and RFSU
- Touching Lives Empowering Communities: Evidences from Pilot Interventions. 2009. MAMTA, Sida and RFSU
- Building Trust: A Report on How to mobilize communities to increase young people's reproductive and sexual health in India. 2009. MAMTA, Sida and RFSU

Evaluation documents

- Evaluation of the Swedish strategy for development cooperation with India 2005 – 2009. Commissioned by the Swedish International Development Cooperation Agency. Final report 2008-09-10. Kim Forss. Andante - tools for thinking AB.
- Mid-Term Evaluation of the Young People's Health and Development: A Reproductive and Sexual Health Centred Approach - A collaborative programme between RFSU, Sweden & MAMTA, India. November 2006, Gordon Tamm and Rukmini Rao
- Evaluation of Evolving Strategies for Better Health and Development of Adolescent/Young People India (MAMTA-RFSU collaboration), December 2002. Gordon Tamm, Rukmini Rao and Viveca Urwitz

ITP

- Its about living life: Experiences from MAMTA/RFSU Training program about Sexual and Reproductive Health and Rights for young people, 2008, MAMTA and RFSU

NTP

- Preliminary report of National Training Program on Youth Friendly Health Services in India, 2012–2013. Lund University, NIHFW and MAMTA

MAMTA Annual Reports

- 2003-2008

GOI and adolescent issues in country

- Draft Adolescent Health strategy, MOHFW, GOI. September 16, 2013
- RMNCH+A strategy
- S.J Jejeebhoy and K.G. Santhya. *Sexual and reproductive health of young people in India: A review of policies, laws and programmes*, Population Council, 2011 and Draft Adolescent Health Strategy, MOHFW, GOI, 2013

Sida's policies on SRH

- *Sweden's International Policy on Sexual and Reproductive Health and Rights*, Stockholm, 2006
- *Sweden India Development Cooperation in Health, 1960-2013*, Embassy of Sweden, New Delhi, November, 2013

Annex 5. Key informants

List of Key Informants		
Uttar Pradesh		
Names of Key Informants	**Organization**	**Designation**
SRIJAN Members		
Mr U C Pathak	Social Welfare Institute, Varanasi	Chief Functionary
Mr. Satish Kumar Srivastava	Samarpan Sewa Samiti, Bhadoi	Chief Functionary
Mr. B P Pandey	Jan Kalyan Mahasamiti, Fatehpur	Chief Functionary
Ms Anita Nura	Daud Memorial Christian Grameen Vikas Samiti, Maharajganj	Chief Functionary
Dr S P Pandey	Pandit Govind Ballabh Pant Institute of Studies in Rural Development, Gonda	Chief Functionary
Mr. Raj Dev Chaturvedi	Gramin Punarnirman Sansthan, Azamgarh	Chief Functionary
Ms. Raj Laxmi Kakkar	LAXMI, Shahjahanpur	Chief Functionary
Dr. U C Pandey	AWARD, Kanpur	Chief Functionary
Ms. Manjula Shrivastava	Manjul Mahila Kalyan Samiti, Allahabad	Chief Functionary
Nagendra kumar	Manjul Mahila Kalyan Samiti	Peer Leader
Laxmi mishra	Manjul Mahila Kalyan Samiti	Peer Leader
Vaishali kushwaha	Manjul Mahila Kalyan Samiti	Peer Leader
Ranjita nishad	Daud Memorial Christian Grameen Vikas Samiti, Maharajganj	Peer Leader
Pawan kumar verma	Pandit Govind Ballabh Pant Institute of Studies in Rural Development	Peer Leader
Manish kumar	Pandit Govind Ballabh Pant Institute of Studies in Rural Development	Peer Leader
Rajeshkumar	Pandit Govind Ballabh Pant Institute of Studies in Rural Development	Peer Leader
NTP/ITP Participants		
Dr. Madhu Sharma,	GM, Planning, NRHM	
Dr. Hariom Dixit,	Ex. GM, Community Processes,SPMU- NRHM	
Dr. Mridula Sharma,	GM, Family Planning & IEC , NRHM	
Mr. Manish Kumar	General Secratery, Indian Institute of Young Insprirers	
West Bengal		
Names of Key Informants	**Organization**	**Designation**
Dr. Sudeb Das	Adampur Unnayan Samity, Malda	Chief Functionary
Ms. Rahima Khatun	Nari-O-Sishu Kalyan Kendra(NSKK), Howrah	Chief Functionary

Mr. Zakir Hassan	Chapra Social & Economic Welfare Association	Chief Functionary
Alok Dasgupta	Health Vision & Research	State Programme Coordinator
Salendra sharma	CINI	Programme Manager
Nargis	NSKK	Peer Leader
Marufa modal	NSKK	Peer Leader
Sadia afreen	NSKK	Peer Leader
Sultana khatun	NSKK	Peer Leader
Tarikul hasan	Health Vision & Research	Peer Leader
Saheri	Health Vision & Research	Peer Leader
Abikesk ghosh	Adampur Unnayan Samity	Peer Leader
NTP /ITP Participants		
Dr.Arun Kumar De, Assistant	Professor Paed,Medical College Kolkata	
Dr.Mihir Sarkar	Assistant Professor NRS MCH,NRS Medical College Hospital, Kolkata	
Dr. Pallav Bhattacharya	Zonal Health Office, Kolkata	
Dr. Sukanta Chatterjee	Prof. & HoD of Paediatrics, Kolkata Medical College	
Dr. Indranoshee Das	ACS, OSD, NRHM-Assam, Guwahati	NTP participant
Dr. Return Pohsem	Nartiang PHC, Jaintia Hills, Meghalaya BPO,Meghalaya	NTP participant
Dr. Adreena Lyngdoh	MHO, Dep. Of Health & Family Welfare,Rynjah State Dispensary,MoHFW-Meghalaya	NTP participant
Dr. Hemam Ibemcha Devi	Deputy Director, NRHM-Manipur	NTP participant
Dr. Sinam Sucheta Devi	Deputy Director, NRHM-Manipur	NTP participant

People interviewed for the Assessment (key informant interviews)

Sida, donors, collaborators and government officials

- Åsa Heijne and Yasmin Zaveri Roy, Sida/Embassy of Sweden
- Gunila Essner, ex-Sida staff, Stockholm (by skype)
- Mr. Sandip Kumar Nayak, Joint Secretary, MoHFW
- Dr. Sushma Dureja, Deputy Commissioner, Adolescent Health Division and Ms. Anshu Mohan, Ministry of Health & Family Welfare, GoI
- Ms. Sheetal Rahi, Technical Officer, Adolescent Health Division, MOHFW
- Ms. Padma Jha Mehta, Dy. Adv (WR), MWCD
- Mr. Mayank Agarwal, AGD PIB Doordarshan and ex-NACO
- Dr. Ajay Khera, Dy. Commissioner (CH&I), MOHFW
- Prof. J.K. Das, Director NIHFW
- Vanita Nayak Mukherjee, Program Officer, Ford Foundation
- Ms. Dipa Nag Choudhury, Deputy Director, MacArthur Foundation
- Mr. Laurent, European Union
- Ms. Suneeta Singh, Director, Amaltas Consulting and MAMTA Board Member

- Dr. Rajesh Mehta, Regional Office for South-East Asia, WHO
- Mr. Venkatesh Srinivasan UNFPA
- Mr. Ravi Verma, Regional Director, Asia, ICRW
- Maria Hellvig, RFSU
- Maria Anderson, RFSU (by skype)
- Dr. Sunil Khanna, Oregan State University, USA (by skype)
- Dr. Martha Morrow, University of Melbourne, Australia (by skype)
- Prof. Anette Agardh, Lund University, Sweden (by skype)

ITP participants

- Mr. Manish Kumar, ITP Participant, Lucknow (by skype)
- Ms. Huibrom Rosenara , ITP participant

MAMTA staff

- Dr. Sunil Mehra, Founder and Executive Director
- Ms. Vandana Nair, Assistant Director, SRH
- Mr. Faiyaz Akhtar, Regional Manager
- Ms. Priyanka Sreenath, Regional Manager
- Mr. Murari Chandra, Regional Manager
- Ms. Archana Sarkar, Regional Manager
- Dr. S.K.Mishra, Sr. Advisor
- Mr. Syed Mukhtar, Deputy Director (F&A)
- Mr. Rajesh Ranjan Singh, Chief Operating Officer
- Mr. Prashant Pastore, Ex- MAMTA Employee [Assistant Director]
- Dr. S.S.Das, Ex- MAMTA Employee [Assistant Director]
- Ms. Iram Saeed, Ex-MAMTA Employee [Assistant Director]

Sexual Reproductive Rights for Youth in India - A Journey in Progress

In 2000 the Indian NGO Mamta (Health Institute for Mother and Child) started a project that aimed to improve adolescent sexual and reproductive health and rights in India. The project, supported by Sida, involved many partners and included a range of interventions. The report presents an overview of the adolescent sexual and reproductive health situation in India and synthesizes the findings from the impact assessment. The findings indicate that the project made important long-lasting contributions to adolescent sexual and reproductive health policies and programms in India and strengthen the capacity of MAMTA to tackle new emering issues that undermine adolescents health in general. It also concludes that the project not only had an impact in India, but also made important contributions regionally and globally.

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