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**PRIA**

# research paper

MAY 2021



## OUR HEALTH, OUR VOICE

Preliminary Findings of Mobile-Based  
Participatory Survey with Adolescents  
in Gurugram, India

**OP/2021/002E**

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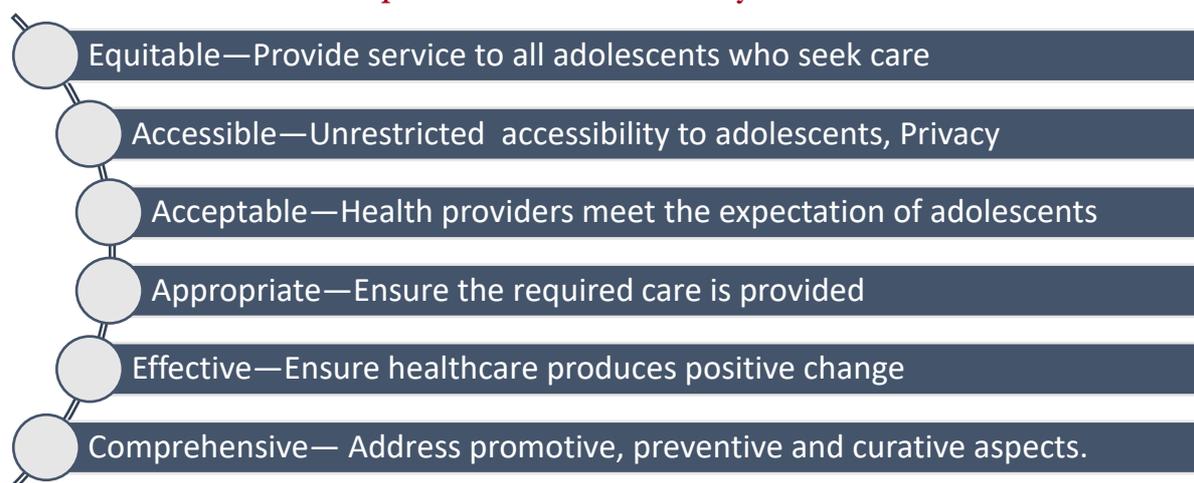
## 1. Introduction

Reaping the benefits of India's demographic dividend will be central to India's economic development, but the largest generation of young people in human history faces enormous challenges towards realising their potential to contribute to the growth story. The Lancet Commission report titled, 'Our Future' had identified 'adolescence' as a "critical phase in life for achieving human potential" and concluded by recommending that only substantial investments in improving adolescent health and well-being would aid in India's progress towards achieving the UN Sustainable Development Goals.

But how does one generate evidence into priority areas of public policy that will ensure holistic development of adolescents, especially those belonging to marginalised communities? Drawing upon PRIA's prior experience of engaging with youth, the research titled 'Our Health, Our Voice' seeks to advance the use of participatory research methodology into the thematic area of adolescent health. Through active participation of adolescent boys and girls living in urban informal settlements in Gurugram, a thriving satellite city of New Delhi in India, the research seeks to generate evidence on the health conditions of adolescents – seen from their eyes, and raising their voice on those health concerns that they are most vulnerable to. How do they seek and use health-related information? Which public health policies and program interventions do they think promote 'adolescent friendly' health?

This participatory research is a collaborative process with adolescents, the local university, care-givers, grassroots health workers, city (municipal) officials, and policy makers. On the demand side are the adolescents and their care givers (parents), and on the supply side is the health system – the National Health Mission (NHM), and the flagship Rashtriya Kishore Swasthya Karyakram (RKSK), under which Adolescent Friendly Health Clinics (AFHC) are to be set up.<sup>1</sup>

### Principles of Adolescent Friendly Health Clinics



The research uses a series of participatory tools – transect walk, mobile-based participatory survey, Focus Group Discussions and multi-stakeholder dialogues – involving adolescent boys and girls in all stages of the research process to understand their healthcare-seeking behaviour, the accessibility to health services, and the extent of utilisation of AFHCs. Their

<sup>1</sup> An Adolescent Friendly Health Clinic is envisioned as a safe space for adolescents to seek redressal and treatment for their needs with regard to Sexual and Reproductive Health (SRH), nutrition, drug and substance abuse, mental health and Sexually Transmitted Infections (STI).

inputs have helped shape the questions in the survey questionnaire, analysis of the data is shared in meetings with them and the community, their insights are central in the group discussions that generate community demand for health services, and their interactions with government officials and health workers in multi-stakeholder dialogues will help find a way forward for action that results in improving adolescent-friendly health services.

This report presents the preliminary findings from the survey questionnaire that was administered to 330 adolescents aged between 10 and 19 years, of which 141 (42%) were boys and 189 (58%) were girls. Questions related to their awareness on sexual and reproductive health, nutrition, menstrual hygiene, health-related problems such as drug and substance abuse, and health-seeking behaviour. Data on other indirect indicators that affect health, such as sanitation, water supply, and living conditions in their houses, was also collected. The survey was conducted in five informal settlements (Sikanderpur, Ghata, Harijan Basti, Chakkarapur and Nathupur) in Gurugram in February 2021.

COVID-19 precautions were strictly adhered to during the survey process, and informed consent was obtained from the adolescents before administering the questionnaire.

## 2. Methodology

The survey has the distinction of using a community-university partnership. In December 2020, PRIA signed a Memorandum of Understanding with Gurugram University, a public university. University students were identified as co-researchers and trained to undertake the survey. Animators (field facilitators) drawn from the five settlements were selected and trained along with the student researchers. One student researcher and one field facilitator were paired to administer the questionnaire with adolescents in the community.

The researchers first needed to get familiar with the physical settlement and its community assets. A transect walk around the settlement helped identify the prevalent health infrastructure and the physical conditions. Subsequently, a pilot testing of the questionnaire was undertaken along with the target population before it was finalised with the research team and the community and student researchers.<sup>2</sup> The pilot testing of the questionnaire also helped the research team validate the adaptation to the local social context.

The questionnaire was uploaded as a Google Form, and responses from the adolescents were collected on smartphones. Smartphones were provided for the duration of the survey to field facilitators who did not own a personal smartphone. A two-day workshop in January 2021 built capacity of the university researchers and animators on mobile-based survey techniques. Mock interviews were held to familiarise the two-member teams with the questionnaire and to introduce them to the methodology of administering the survey questionnaire. The workshop also helped iron out discrepancies in the questionnaire.

To learn more about the methodology of digital survey, see this video:

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<sup>2</sup> The questionnaire is adapted from the *Indian Adolescent Health Questionnaire (IAHQ)* developed by Long et.al, 2013. After assessing for emerging adolescent health issues during transect walks and informal conversations with the community, the IAHQ tool was adapted to the local context. (Long KN, Long PM, Pinto S, Crookston BT, Gren LH, Mihalopoulos NL, Dickerson TT, Alder SC. Development and validation of the Indian Adolescent Health Questionnaire. *J Trop Pediatr.* 2013 Jun;59(3):231-42. doi: 10.1093/tropej/fmt006. Epub 2013 Feb 16. PMID: 23418132; PMCID: PMC3693506.)



Our Health, Our Voice : Participatory Research with adolescents in Gurugram

### 3. Key findings

Adolescent boys and girls in Sikanderpur, Ghata, Harijan Basti, Chakkarpur and Nathupur, who participated in the study, are students (almost all the respondents are in school) and unmarried. Mothers remain their primary caregivers, paying attention to the nutrition needs of both their sons and daughters.

The level of awareness of Sexually Transmitted Infections (STI) is very low, among both adolescent boys and girls. What little knowledge they do have on sexual and reproductive health (SRH) and STI is gathered in conversations with their mothers and school teachers. Preference to discuss matters related to sex with frontline health workers remained low.<sup>3</sup> During informal discussions, some mothers reported that the adolescent children of informal migrant workers have faced discrimination from health workers. Health services provided by government policies and programs remain on paper, with minimal awareness and use by the target group (adolescents) of available public health services (especially under RKSK and from AFHCs).

#### Key findings from the survey

- Adolescents, who were surveyed, live in large families (minimum 5 members per household) in densely populated physical settlements. These settlements are associated with poor-quality construction, and poor sanitation and water supply. Unsanitary physical conditions and living in small rooms with poor ventilation can have long-term adverse effects on the overall health of adolescents.
- Almost all the adolescents surveyed belong to migrant families. These families have limited access to social protection and identity documentation (such as Aadhaar

<sup>3</sup> The ASHA/ANM (as frontline health workers) is mandated under the RKSK to conduct home-visits and enquire about the well-being of adolescents. Reasons for low interaction between the adolescents and frontline health workers will be discussed in the FGDs.

cards, ration cards, etc.). The lack of permanent residency in the urban informal settlements acts as a barrier to securing identity documents and reduces the access to and awareness of public health and welfare schemes.

- Adolescent girls in all the five settlements have a high level of awareness of menstrual hygiene products and mode of disposal of menstrual waste. Nearly three in four adolescent girls, who admitted to entering menarche, were using branded sanitary napkins. They, however, continue to be subject to social taboos associated with menstruation.
- Knowledge of sexual practices and STI is inadequate among both adolescent boys and girls. Nearly four in five participants had no knowledge of at least one symptom of Sexually Transmitted Diseases. Majority have never attended any training session on SRH.
- Frontline health workers and doctors were least likely to be consulted by the adolescents on matters of SRH. The most preferred source of information on SRH was the adolescent's mother, followed by school teacher. Friends and peer-groups also emerged as a preferred source of information on sex, especially among out-of-school children.
- There is a significant gap in health communication. Nearly nine in ten adolescents reported not having attended any training or information dissemination session on nutrition-related issues. Similar, four in five adolescents reported not having received any training on SRH.
- Awareness of AFHC facility provided through RKSK was poor among the adolescents with low rates of utilisation of health services. Two in five adolescents reported visiting health centres, primarily, for receiving treatment for Non-Communicable Diseases (NCD) during their last visit.
- Consumption of nutrient-rich foods (like fruits and vegetables) was observed to be higher in adolescent girls than adolescent boys.
- Adolescent boys tend to drop out of school more frequently than girls. The primary reason was to start working to supplement family income.

## 4. Survey analysis

### 4.1. Age and Family Background

Data was collected and analysed for boys and girls in two age groups, the first between 10 and 14 years, and the second between 15 and 19 years. There was an almost equal split of participants in both age groups – 45% were in the age group of 10 to 14 while 55% belonged to the 15 to 19 age group. At the time of the survey, a very small proportion (less than 1%) of the participants were married.

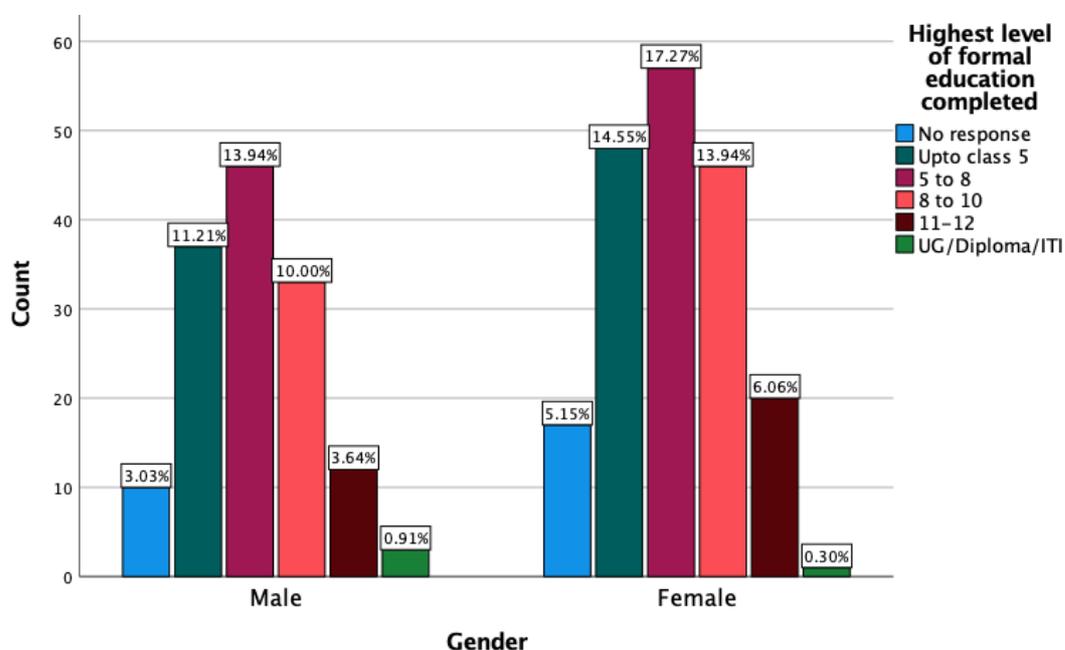
The majority of the adolescents surveyed belong to migrant families, with the highest percentage having migrated to Gurugram from West Bengal. Most of their parents are engaged in informal sector work such as domestic work (mothers) and security guards or

housekeeping staff (fathers). They live with their families, sharing space in a small, single room with at least four other family members.

Post the COVID–19-imposed lockdown (June 2020), almost all the adolescents had gone back with their parents to their home villages. In March 2021, almost a year later, they continue to face challenges as many of their parents had lost their jobs during the lockdown.

#### 4.2. Educational Status

A very high percentage (93%) of the adolescents, both boys and girls, were educated in formal educational institutions. All the respondents in the survey were above 10 years of age. Hence, almost all of them had completed primary education. However, as the age increased, so too did the tendency to drop out of school or formal education, which was observed among both boys and girls, as can be seen in Figure 1. Only 10% of boys and 13.94% of girls have completed secondary education (between Class 8 and Class 10). While only about 4.55% of boys had completed high school (Class 12) and some form of higher education, the corresponding percentage for girls was higher (6.36%).



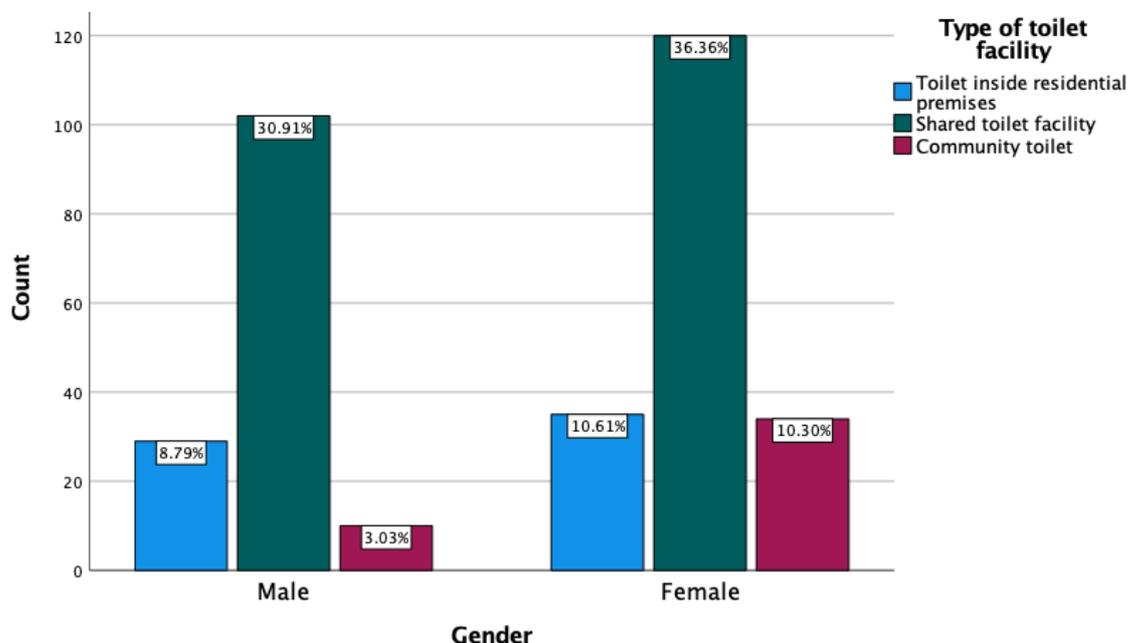
**Figure 1.** Highest Level of Education Completed

A majority of the participants had never worked for pay, especially girls, which is corroborated by their answers related to school attendance. However, the primary reason young boys dropped out of school was to work to supplement family income.

#### 4.3. Housing and Infrastructure

The densely populated informal settlements in which these adolescents live have a mix of two types of houses – permanent concrete-roofed structures and make-shift, semi-permanent structures (such as houses made with corrugated tin sheets or covered by tarpaulins). A majority of the adolescents who participated in this survey lived in concrete structures with a sturdy roof. But for almost a third (31%) of them living in make-shift homes, their challenge to live a healthy life increases. Even a small room in a multi-storeyed structure sets the families of the adolescents back by ₹5,000 (around \$100) a month. With average incomes of the families around ₹10,000 (around \$200) a month, the steep cost of housing affects the space a family can live in.

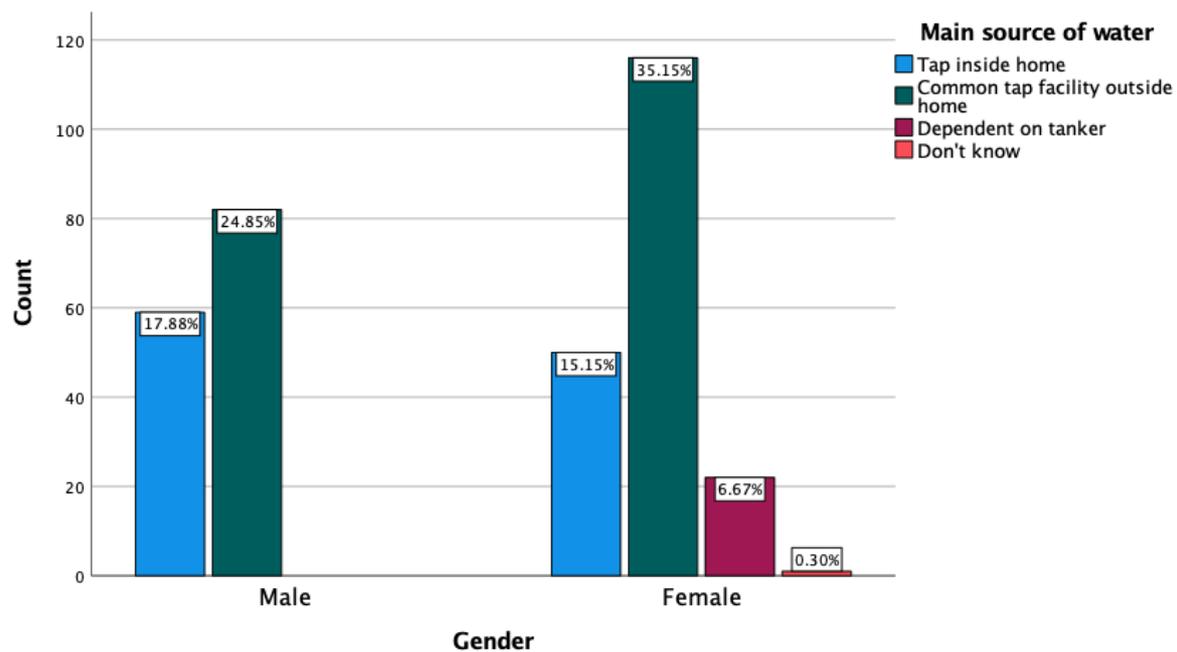
Only 20% of adolescents had a toilet facility inside their homes. The most common arrangement for toilets was a shared toilet facility, used by all residents living in a floor or building (Figure 2). A small proportion of the adolescents (primarily girls) used community toilets as well.



**Figure 2.** Type of Toilet Facility Used by the Participants

Lack of access to a roofed or covered toilet facility within their residential spaces highlights safety and privacy as possible concerns. Informal discussions revealed safety concerns among adolescent girls who lacked access to toilet facilities at home and had to go out in the open.

Majority of the households with adolescents have access to water within their homes (Figure 3). A common or shared tap facility outside their homes provides water to the families in urban informal settlements. Informal discussions with the adolescents hinted at irregular water supply, which is exacerbated by the water crisis in cities such as Gurugram. A small proportion (6.67%) of the participants had to depend on tankers for water supply. The tankers are expensive personalised water supply sources for those families or settlements which do not have access to piped water facility provided by the municipality. However, a severe water crisis in the settlements was not observed.



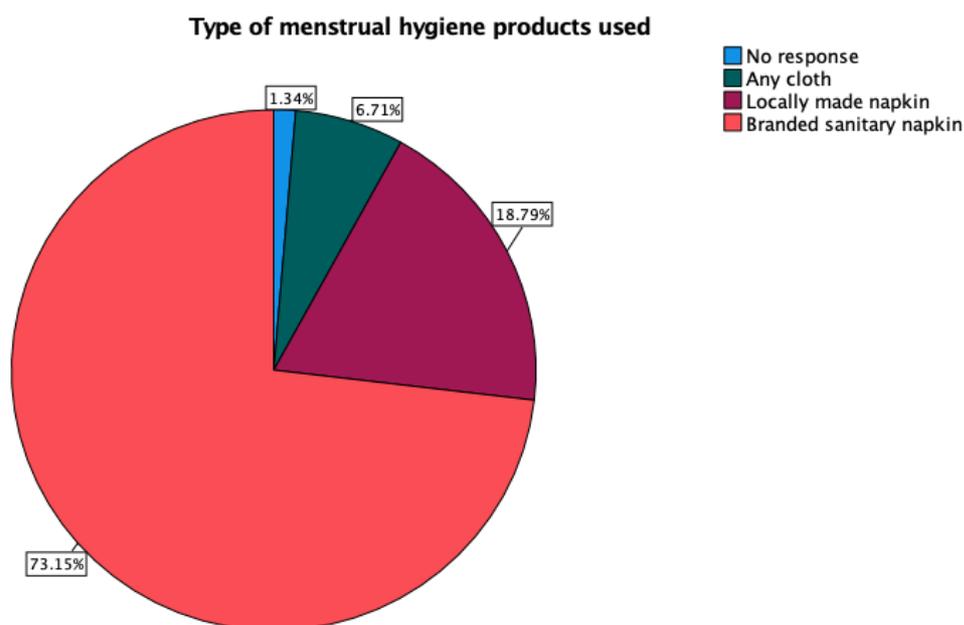
**Figure 3.** Main Source of Water Supply in the Informal Settlements

#### 4.4. Menstrual Hygiene and Menstrual Health

The mean age of menstruation among adolescent girls was 12 years. Out of the 189 adolescent girls, who participated in the study, 149 participants reported entering the phase of menarche.

The adolescent girls reported high levels of awareness regarding menstruation and practices to be followed during menstruation, but their knowledge of STI was found to be poor (see section 4.5.2). A majority of the girls used commercially available menstrual hygiene products, like branded sanitary napkins, easily available in the local shops in their settlements (Figure 4). They were well aware of hygienic and environment-friendly means of disposing menstrual waste. Frontline health workers are mandated under RKSK to provide sanitary napkins free-of-cost to the adolescent girls in the community. However, their dependence on branded sanitary napkins purchased from the open market indicates that poor outreach of adolescent menstrual health service through government health workers.

Initial assessment alludes to knowledge and awareness of menstrual health management, primarily due to accessibility of menstrual hygiene products. Further understanding of their health-seeking behaviour for infections, menstrual hygiene practices, and sexual and reproductive health decisions is necessary to derive a holistic understanding of their sexual behaviour.



**Figure 4.** Type of Menstrual Hygiene Products Used

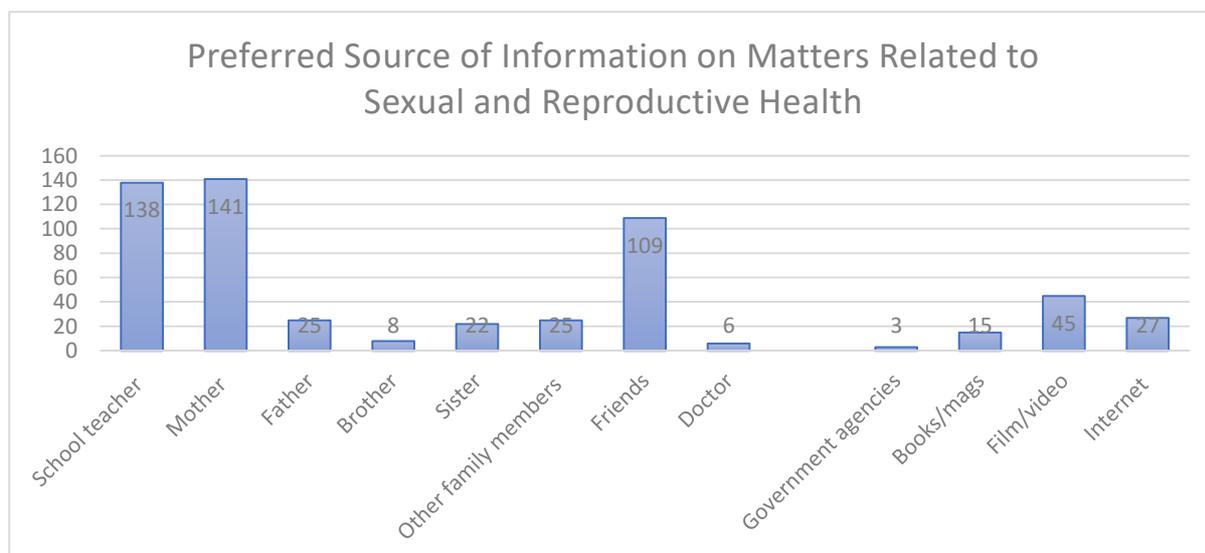
Social taboos continue to be imposed on the adolescent girls during menstruation. Enforcing restrictions on social participation of women during menstruation is a common feature in India's social context. Majority of the participants reported facing such restrictions in some form, either being disallowed from entering the kitchen or taking part in religious activities. Unhindered access to everyday social life was reported by many of the adolescents indicating a behaviour change within the community when it comes to such social determinants related to menstruation. Luckily, only a few girls reported being dissuaded from attending school when they are menstruating.

#### 4.5. Sexual and Reproductive Health, and Sexually Transmitted Infections

Knowledge and awareness of STI is very low among both adolescent boys and girls. Community health workers are not preferred as a source of information, or seen as important stakeholders in the health-seeking behaviour related to SRH and STI among adolescents.

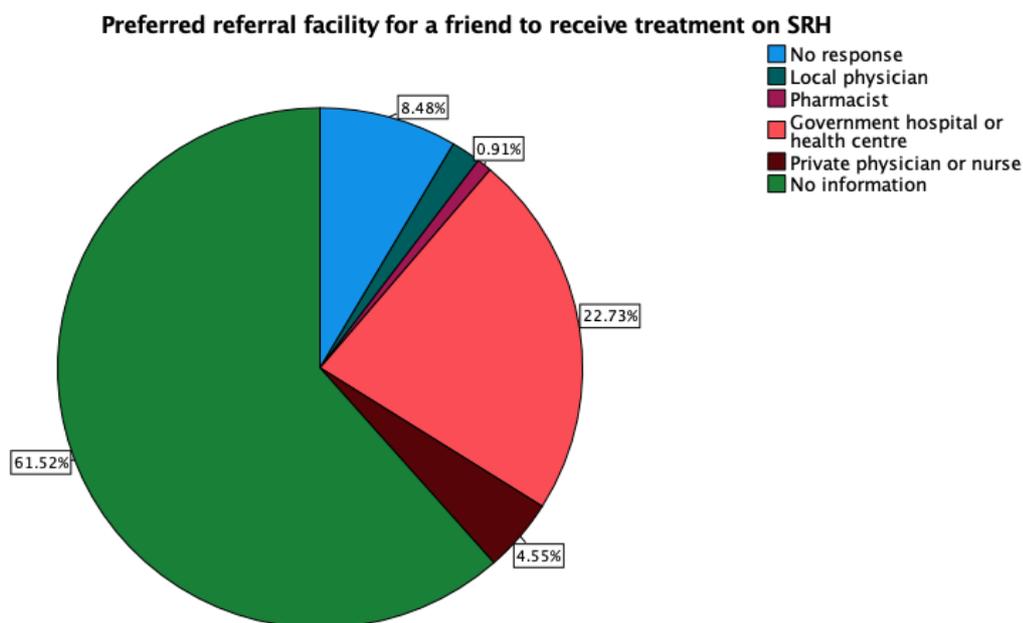
##### 4.5.1. Sexual and Reproductive Health

Mothers, being the primary care-givers of the adolescents, are also the preferred source of information on matters related to SRH (Figure 5). The second most preferred source of information was the 'teacher'. For out-of-school children, 'friends' or 'peers' emerged as their source of information; how reliable this information available from peer groups was a matter of concern. Adolescents showed the least affinity to identify frontline health workers or doctors as source of information on SRH matters. Low preference for healthcare professionals and frontline health workers for information on SRH needs is indicative of poor outreach of the public health system in low-income communities. The healthcare professionals are mandated to exclusively provide medical services to adolescents ensuring complete anonymity. Frontline health workers are required to provide door-to-door service delivery, especially watching out for symptoms of anaemia, providing awareness about menstrual health practices, enquiring about infections and ensuring regular supply of iron folic tablets for adolescent girls.



**Figure 5.** Preferred Source of Information for SRH Information

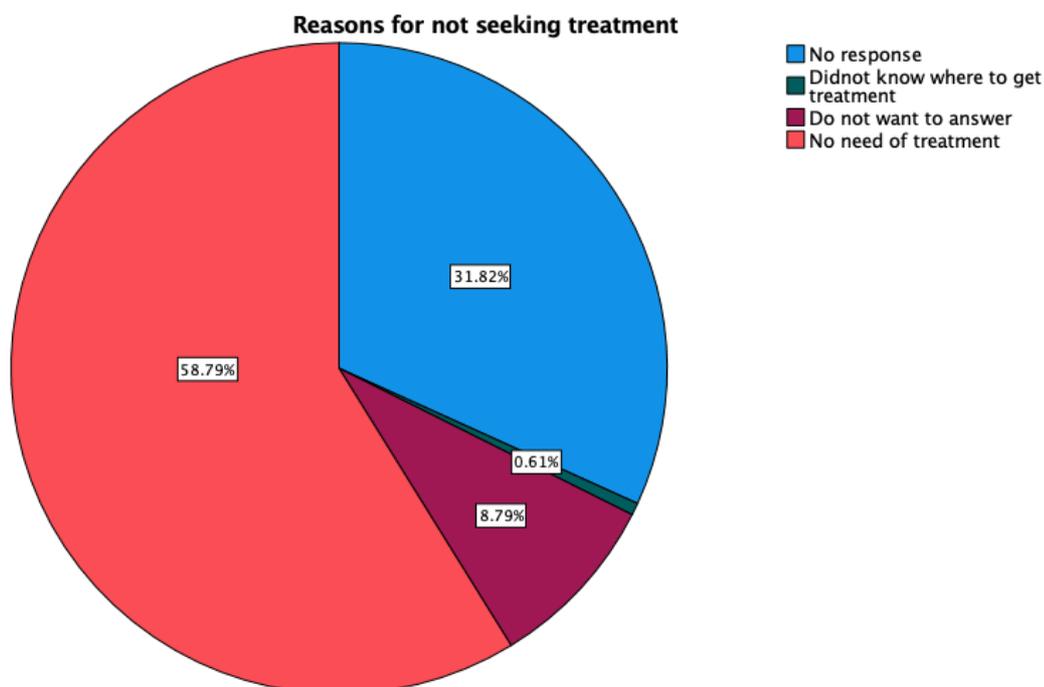
The researchers were aware that adolescents could possibly hesitate to speak directly about their own SRH issues and need for treatment. Thus, the adolescent boys and girls were asked if they were aware of possible facilities for treating their friends, should they need professional help for SRH issues. A majority of them did not have any information regarding the health centre they could approach to get advice and treatment, indicating \low utilisation of AFHCs. However, when asked for their preference of choice of facility for treatment, they would prefer to refer their friends to a government or public health facility (Figure 6).



**Figure 6.** Preferred Referral Facility for the Friends who want to Seek Treatment Related to SRH

Those who were willing to speak directly about their SRH issues revealed that they did not seek treatment, primarily because there was 'no need for treatment' (Figure 7). Almost 9% of the participants did not want to answer the question, and nearly 32% gave no response to

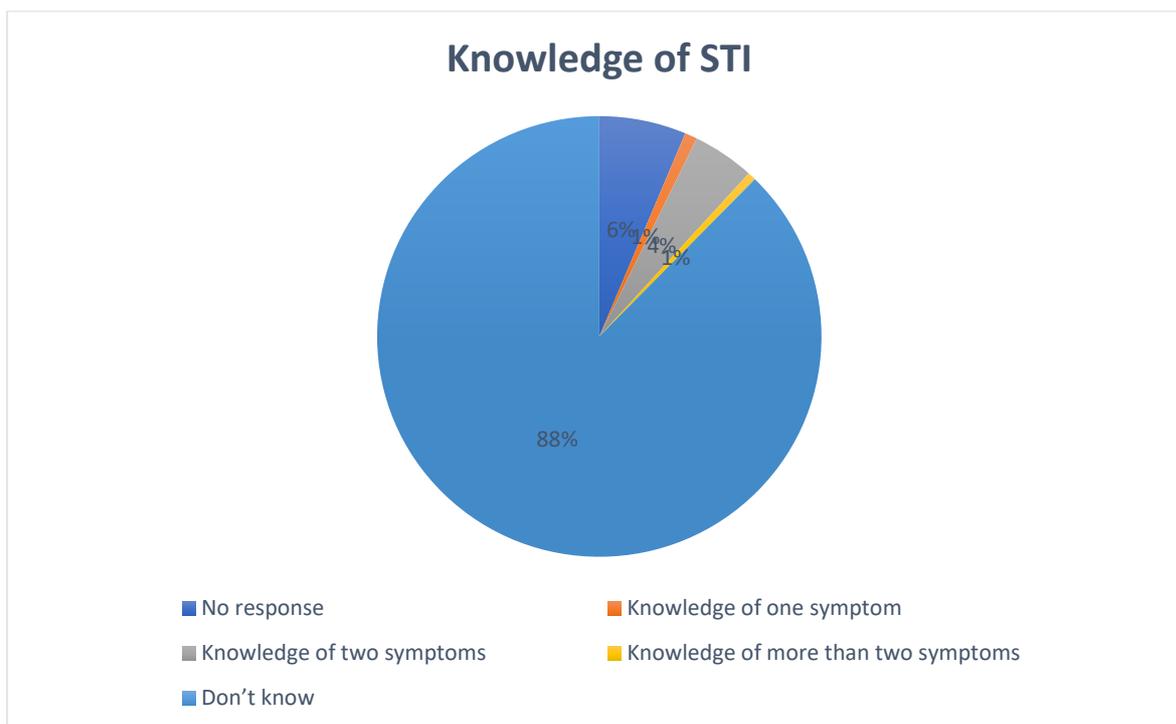
the question. Less than 1% admitted that they did not know where to get treatment. During the sharing of the survey data, some mothers spoke of discouraging their daughters from seeking treatment for SRH-related issues, even if daughters need treatment. Is SRH not a health concern for these adolescents? Or is it a health issue that needs attention (the 41% lack of response to the question being indicative of a barrier to openly revealing this information)? The social determinants of SRH health-seeking behaviour will be discussed in the FGDs.



**Figure 7.** Reasons for not Seeking Treatment for Sexual and Reproductive Health

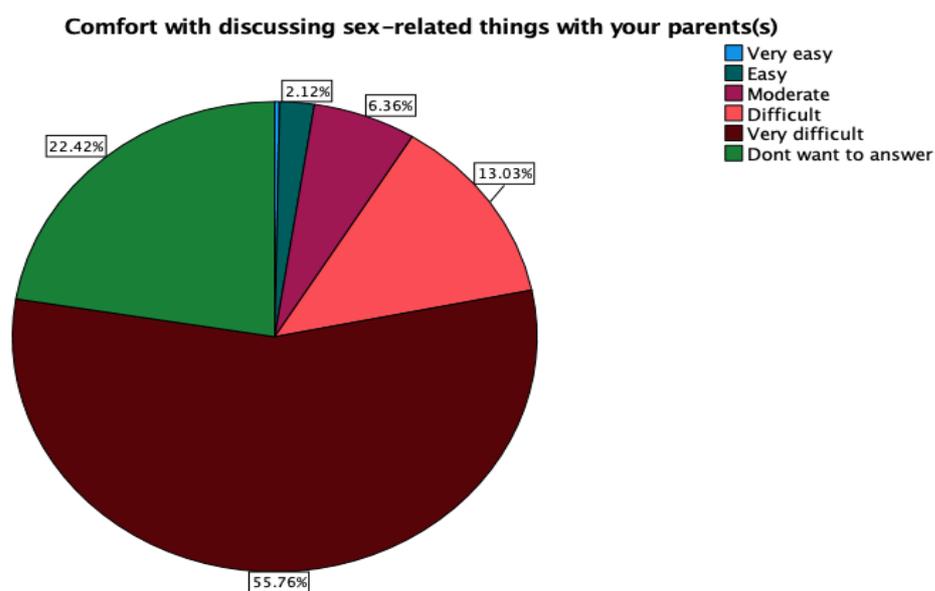
#### 4.5.2. Sexually Transmitted Infections

Enquiring about adolescent knowledge of STI symptoms was done by presenting four common and physically recognisable signs of infection: (i) discharge from vagina/penis, (ii) pain during urination, (iii) burning sensation in genital organs, and (iv) ulcer in genital organs. Adolescents were asked to identify what health risk (disease) these symptoms were associated with. Around 89% of the participants could not identify even one symptom and only a small proportion of the participants could identify two symptoms (Figure 8). The lack of awareness about STI would also mean that the adolescents did not know about the possible source of these infections and how they can spread. The lack of awareness regarding STI is a major barrier in exercising responsible sexual behaviour.



**Figure 8.** Level of Awareness Regarding Sexually Transmitted Infections

This gap in knowledge is possibly because SRH and STI are never discussed openly, either in families or in schools. Many of the participants rated their ability to initiate discussion on issues related to sex with their parents as ‘very difficult’ (Figure 9). The gap is widened due to poor communication and outreach of RKSK, especially to the adolescents belonging to marginalised and vulnerable backgrounds, by health care workers, under which they are required to create awareness with regard to SRH issues like contraception, pregnancy, and abortion, in addition to identifying symptoms and treatment options for STI.



**Figure 9.** Discussing Sex-Related Matters with Parent(s): Level of Comfort

#### 4.6. Nutrition

Nutrition is an important component of human health and assumes importance especially in the phase of adolescence when physiological and psychological changes take place. In recent times, in order to improve nutritional outcomes among Indians of all age groups, the Government of India has launched the *Poshan Abhiyan*. The Indian Council of Medical Research-National Institute of Nutrition (ICMR-NIN) periodically publishes nutrition targets and recommends nutrition intakes.<sup>4</sup> The expert committee of the Indian Council of Medical Research (ICMR) has recommended that every individual should consume at least 300 grams of vegetables in a day. In addition, fresh fruits (100g) should be consumed, ideally every day. The recommended pattern of everyday consumption of nutritious food items, as outlined by the ICMR, is uniform for both boys and girls.

The questionnaire attempted to understand the dietary intake of basic food items, like fruits, vegetables, and meat, among the 330 adolescent boys and girls. Even though there are other nutritious food items that adolescents can consume, the questionnaire focused on three available and cost-effective sources of nutrition, viz. vegetables, fruits, and non-vegetarian food like chicken, fish and mutton. It was observed that less than half (30-40%) of the adolescents surveyed met the ICMR guidelines for daily consumption of vegetables and fruits (less than 20% consumed fruits at least twice a week). Over 90% of the adolescents are non-vegetarians, but less than 20% consumed meat or fish at least twice a week.

The intake of unhealthy food items by adolescents was assessed by analysing consumption of aerated (soft) drinks. By asking about their past history in attending training sessions on nutrition and health, the questionnaire seeks to establish whether nutrition-related behavior was effectively communicated to the adolescents.

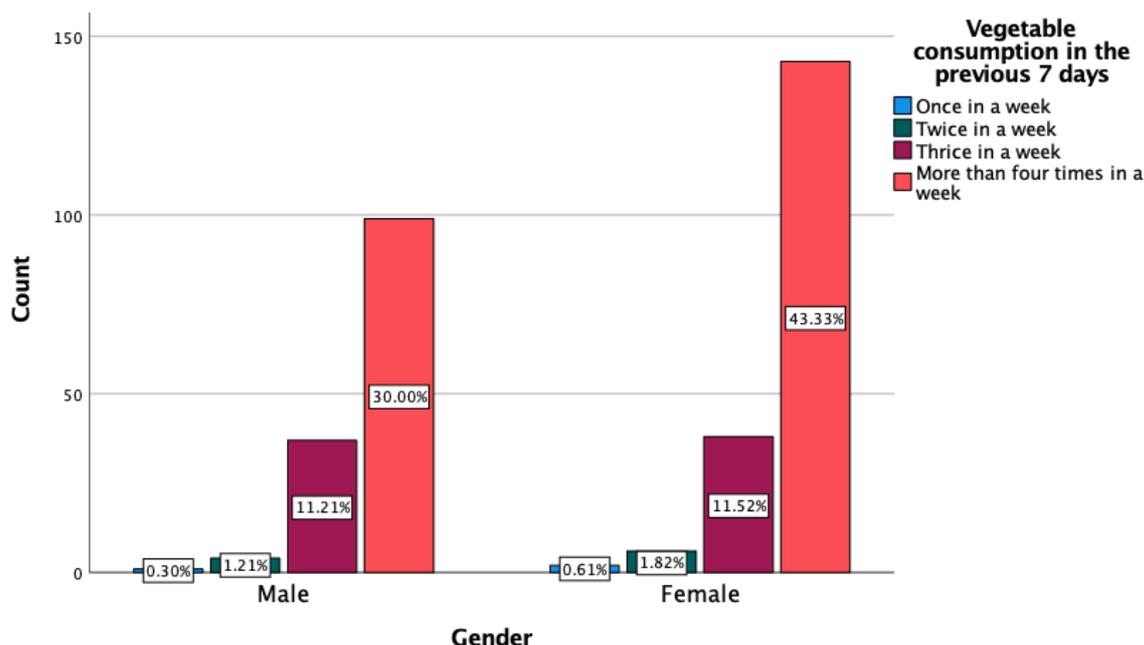
Given the social context of India, interestingly, in these findings it appears girls are not discriminated against when it comes to food given by their mothers. A higher percentage of girls reported consuming vegetables more than four times a week, and non-vegetarian food at least twice a week.

##### 4.6.1. Consumption of Vegetables

Majority of the participants (30% boys; 43.33% girls) confirmed eating vegetables more than four times a week (Figure 10).

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<sup>4</sup> The latest ICMR-NIN report, published in 2020, titled “*Nutritional Requirements of Indians*”, highlights the recommended dietary intake according to age group.

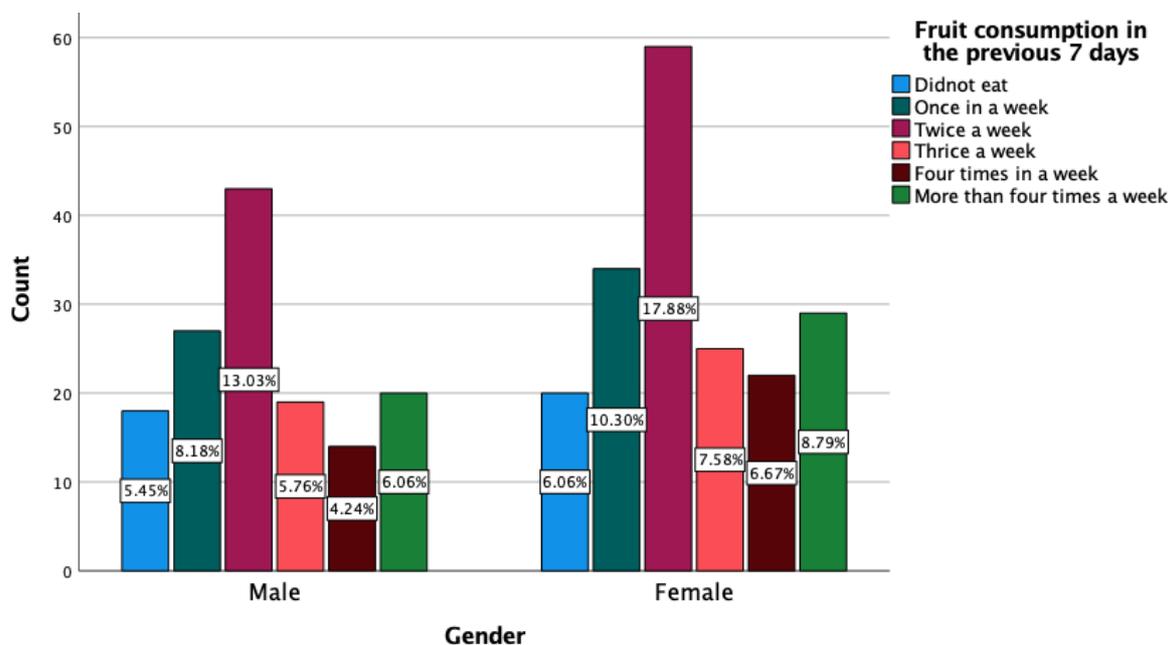


**Figure 10.** Weekly Pattern of Consumption of Vegetables by the Participants

Although this is below the ICMR guidelines for daily consumption of vegetables, it can be seen to indicate healthy eating behaviour, on average.

#### 4.6.2. Consumption of Fruits

A majority of the participants (13.3% boys; 17.88% girls) consumed fruits twice a week, with less than 10% being able to eat fruits more than four times a week (Figure 11). At least 5-6% of adolescents did not eat any fruits in the seven days prior to when the questionnaire was administered. The consumption patterns showed a similar pattern for consumption of fruits when disaggregated for gender.



**Figure 11.** Weekly Pattern of Consumption of Fruits by Participants

### 4.6.3. Consumption of Non-Vegetarian Food

A pattern similar to consumption of fruits was observed among the adolescent participants when it came to consumption of non-vegetarian food items. The majority of participants (13.94% boys; 19.39% girls) reported consuming meat or fish only once a week. The proportion of adolescents who did consume non-vegetarian food more than twice a week significantly reduces thereon (Figure 12). Interestingly, more girls (30.91%) than boys (25.1%) are consuming meat and fish at least twice a week.

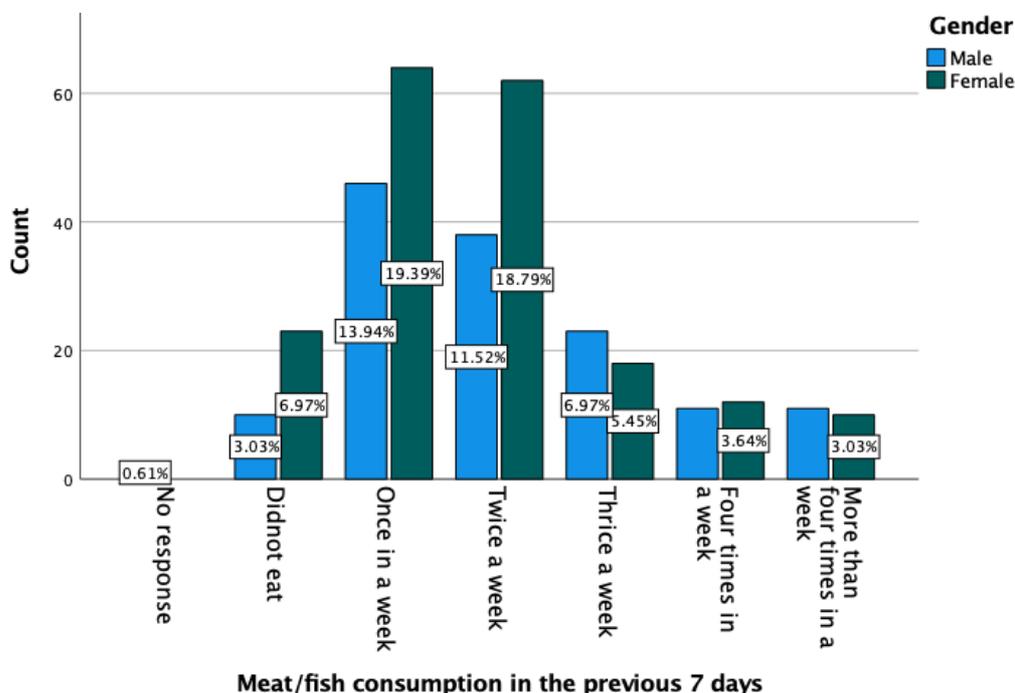
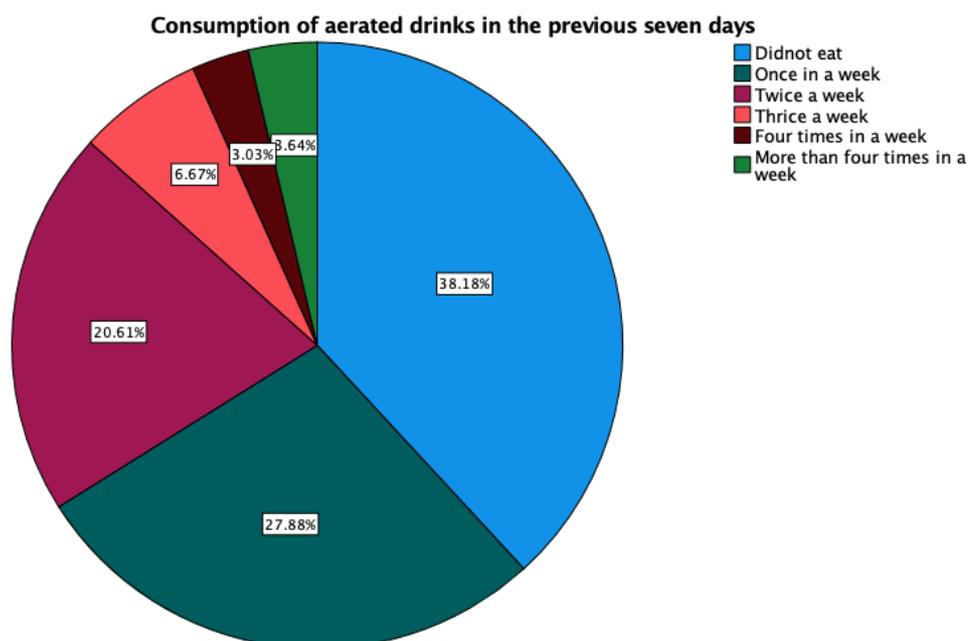


Figure 12. Weekly Pattern of Consumption of Meat-Based Products

### 4.6.4. Consumption of Aerated Drinks

Nearly 40% of adolescents reported not consuming any aerated drinks (Figure 13). About a third consumed them once a week, but the proportion of adolescents who reported consuming aerated drinks substantially reduced upon further enquiry.



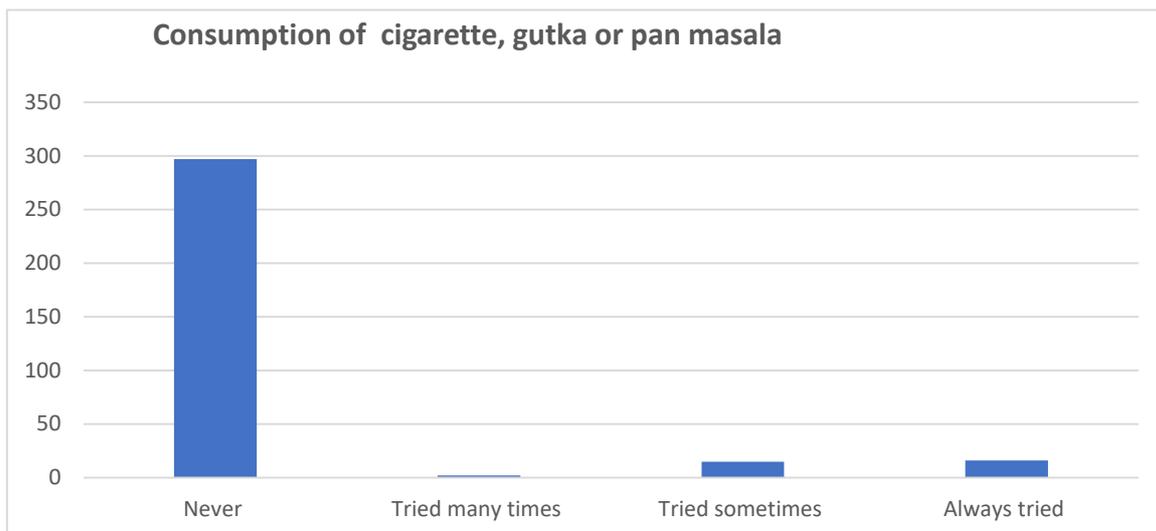
**Figure 13.** Weekly pattern of consumption of ‘unhealthy’ foods like aerated drinks

Initial findings also indicate a gap in awareness among adolescents regarding balanced and ‘healthy’ diet. The majority of the participants (303 out of 330 respondents, or nearly 92%) admitted to never having attended any training session on the benefits of a nutritious diet on their health. Awareness in the community regarding specific nutrition needs of adolescents was poor. Private Doctors were the main source of information on nutrition for those participants who admitted to attending awareness raising sessions. But seeking information from frontline health workers remains low.

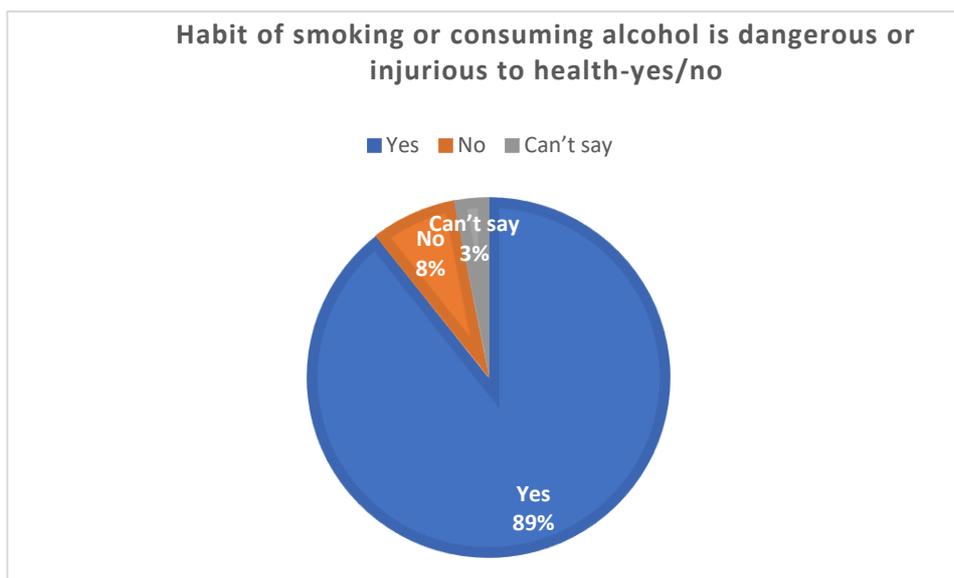
What factors influence consumption of high-priced foods like meat and fruits? Is low consumption of unhealthy foods like aerated drinks on account of awareness of the health risks, or because mothers are unwilling to spend on this item, or household budgets do not stretch for such ‘luxuries’? What kind of nutrition-related services can AFHCs provide? The factors influencing decisions on nutrition and the provisioning of health services that enable better nutrition among adolescents will be discussed during the FGDs with the mothers, who are the primary caregivers.

#### 4.7. Drug and Substance Abuse

Consumption of alcohol, tobacco-related products (cigarette, *gutka*, and *paan masala*) or banned drugs is relatively low among the adolescents in all the five settlements surveyed (Figure 14). The adolescents (89%) seem to be aware that smoking and consumption of alcohol is injurious to health and the majority have never consumed alcohol, cigarettes, or *gutka* (Figure 15).

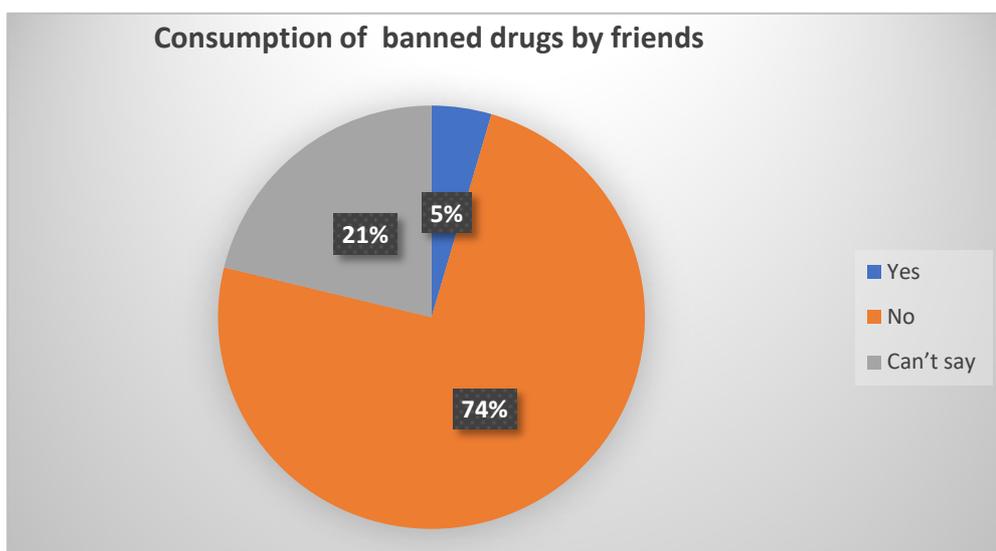


**Figure 14.** Consumption of Cigarettes / Gutka / Paan Masala



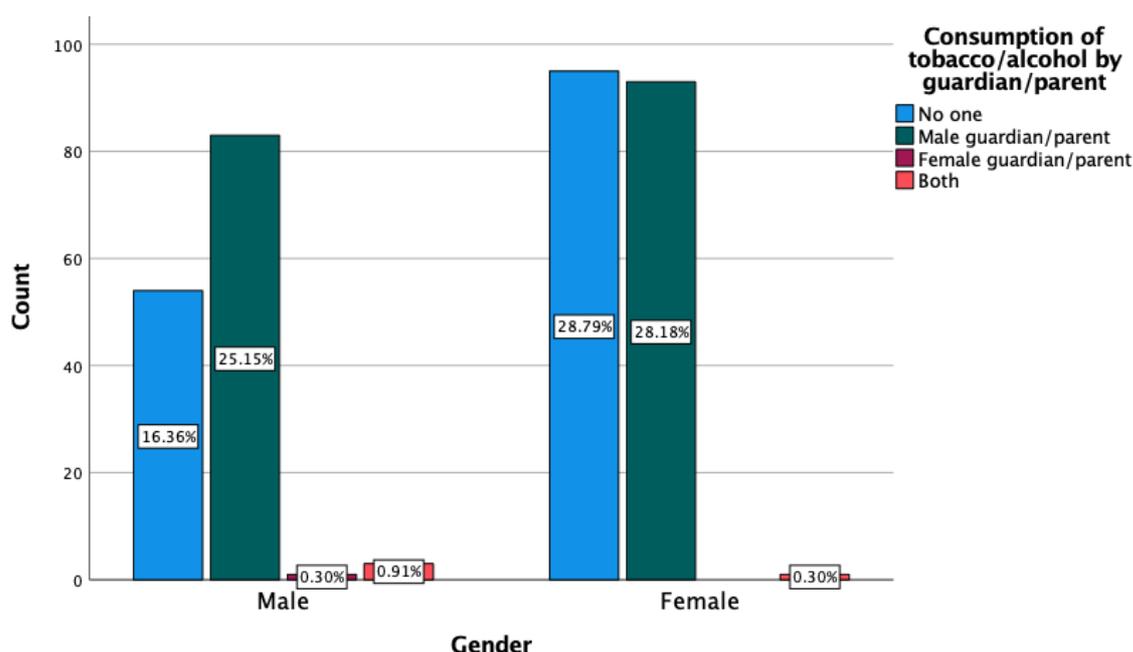
**Figure 15.** Perception of Effects of Consuming Alcohol or Smoking Tobacco on Human Health

The habit of alcohol and drug consumption is strongly linked to influence from the peer group. However, in our survey, the majority of the participants did not report that their friends or peers consuming banned or illegal drugs (Figure 16).



**Figure 16.** Pattern of Consumption of Banned Drugs by Friends

The majority of the adolescents have seen their adult male guardians consuming either tobacco-related products or alcohol, but parental and peer influence on consumption of drugs or intake of alcohol was reported to be low from the adolescents. They reported staying away from consuming alcohol and tobacco as they were aware of the harmful effects.



**Figure 17.** Parental/Guardian Influence on Consumption Patterns of Adolescents

However, literature on substance and drug abuse attests to the possibility of adolescents developing an affinity to alcohol and tobacco consumption while living in densely populated spaces such as the locations of the present study.<sup>5</sup> Are the adolescents making conscious decisions to stay away from drugs, alcohol, and cigarettes as a healthy behaviour choice, which they will continue in adulthood? How influenced are they by their adult female

<sup>5</sup> Osaki H, Mshana G, Mbata D, Kapiga S, Chagalucha J (2018) Social space and alcohol use initiation among youth in northern Tanzania. PLoS ONE 13(9): e0202200. <https://doi.org/10.1371/journal.pone.0202200>

guardians, peer educators, and health workers in making these decisions? These are questions for discussion that will be explored during the FGDs.

#### 4.8. Physical Injuries

Unintentional injury or accidents are a major reason for high mortality among adolescents. In the context of this study, an injury is reported when the participants have missed at least one day of usual activity (job, school or play) or required treatment by a doctor or nurse. In the current study, while the majority of adolescents (almost 60%; 24.24% boys and 35.15% girls) did not report any injury in the past 12 months (Figure 18), between 18% to 22% of them did suffer an injury, with higher percentage of girls suffering injuries (Figure 19). The injuries suffered were primarily due to a fall (28.79%). Between 2% and 5% reported getting injured in a road accident or getting hurt in a fight.

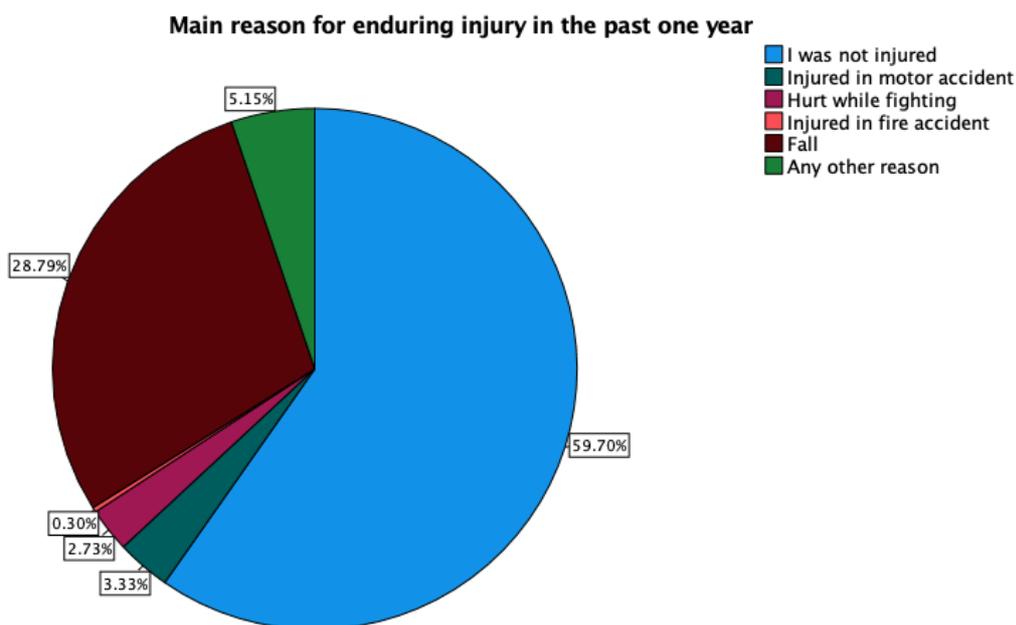
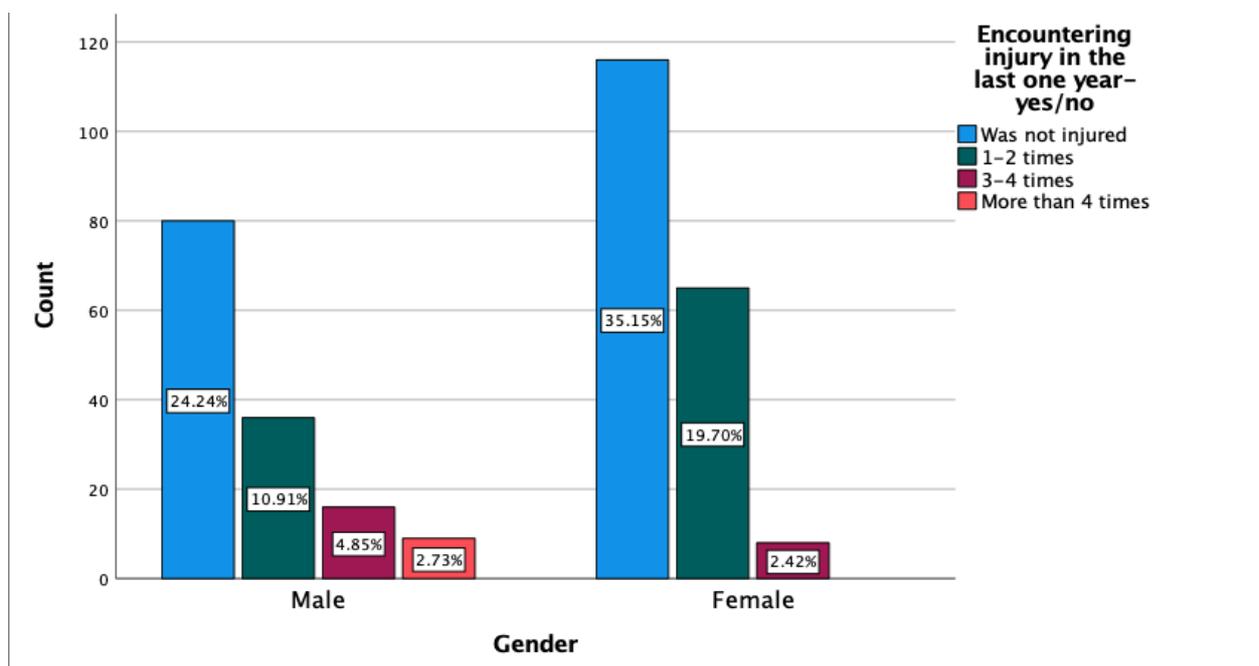


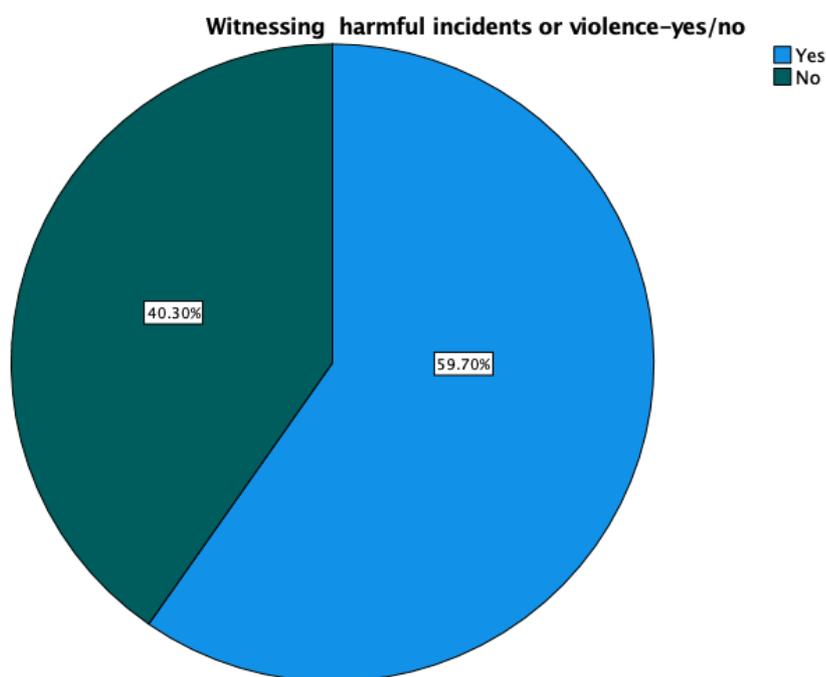
Figure 18. Main Reason for Injury in the Past 12 Months



**Figure 19.** Number of Times the Adolescents Were Injured in the Previous 12 Months

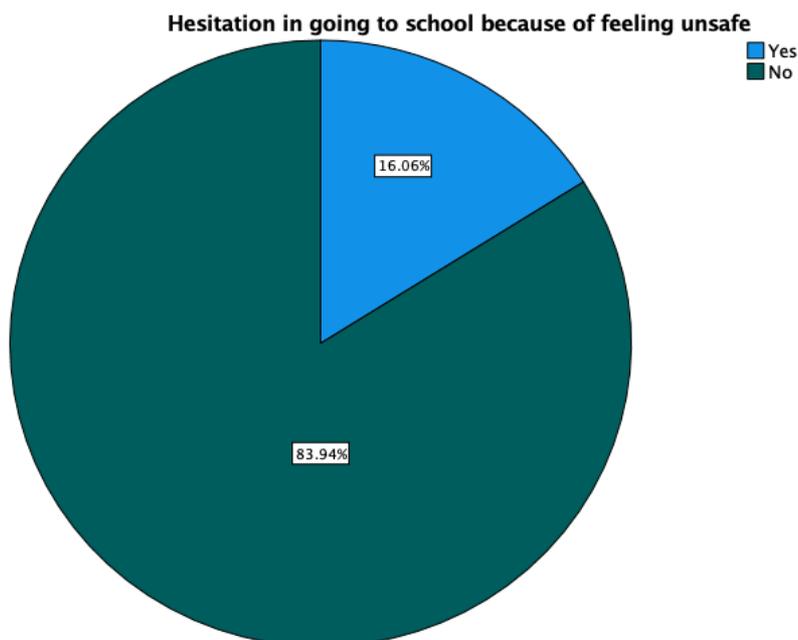
#### 4.9. Safety

The participants’ perception of safety in the community is largely of feeling ‘less safe’, considering that majority of the adolescents reported witnessing harmful incidents or violence in the community (Figure 20).



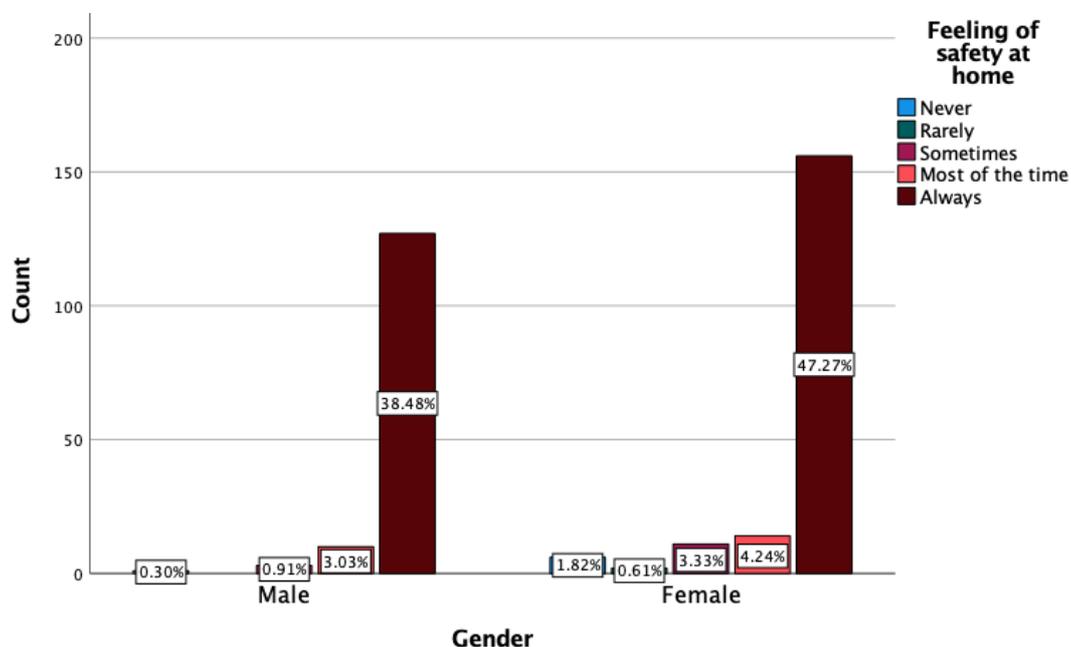
**Figure 20.** Adolescents Witnessing Harmful or Violent Incidents in the Community

However, only a small proportion of participants reported hesitancy in going to school due to safety concerns (Figure 21). Of those, the majority were in their early adolescence (10-14 years).



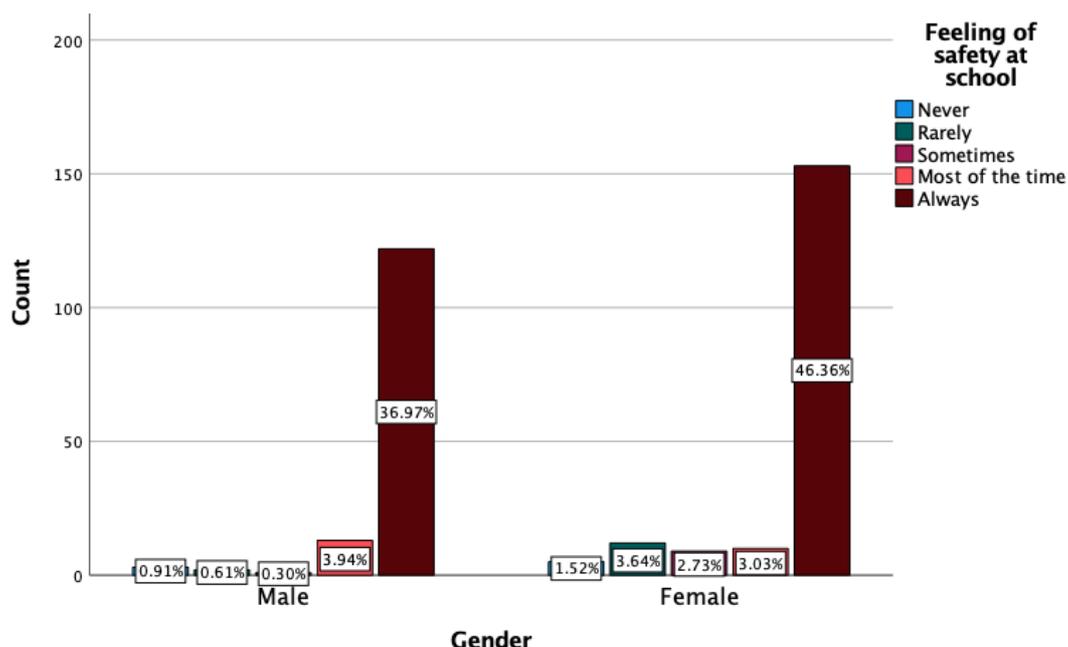
**Figure 21.** Hesitancy in Attending School Owing to Perceptions of Safety

Subsequent questions on safety sought to test the perception of adolescents regarding safety in their surroundings. The majority reported feeling safe at home. (Figure 22).



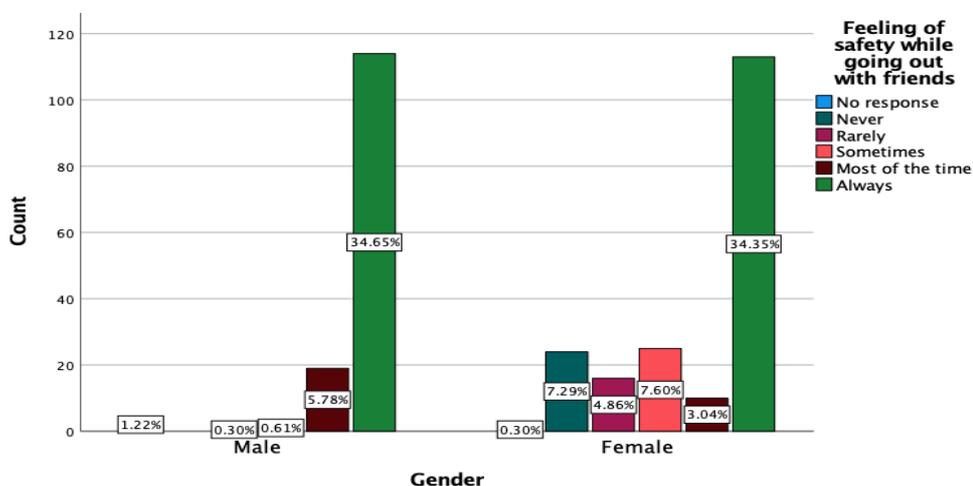
**Figure 22.** Perception of Safety at Home

The majority of the adolescents also reported feeling safe at school and this could be attributed to the high level of attendance in schools (Figure 23). More participants in late adolescence reported higher levels of safety in schools than their counterparts in early adolescence.



**Figure 23.** Perception of Safety at School

An almost equal number of adolescent boys (34.65%) and adolescent girls (34.35%) reported feeling safe while going out with friends (Figure 24). While 37.39% of adolescent girls reported always feeling safe, almost 20% reported never, rarely, or only sometimes feeling safe when going out with friends. How adolescents view 'safe spaces' is to be ascertained through qualitative enquiry during FGDs.



**Figure 24.** Perception of Safety while Going Out with Friends

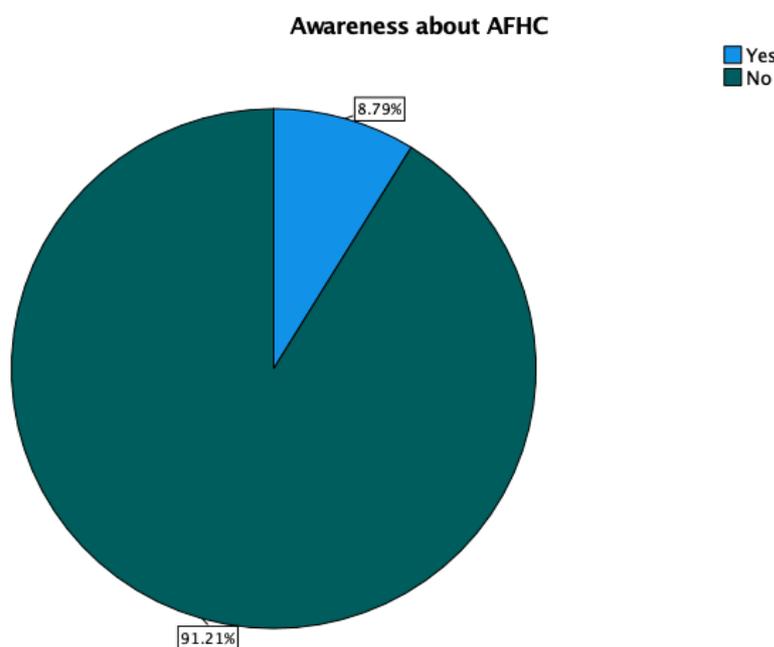
Overall, the safety profile of the community indicates that the adolescents perceive a feeling of safety in their homes, neighbourhood and community. Less reportage of concerns of safety could also imply fewer barriers to activities of everyday living. Perception of safety profile of adolescent boys and girls show consistency in patterns.

#### 4.10. Health-Seeking Behaviour

The survey questionnaire also sought to assess the health seeking behaviour of adolescents. This was assessed through their involvement in and use of the AFHC for medical treatment and healthcare.

Overall, the adolescents reported poor awareness of the public health systems related to adolescent healthcare and well-being. Is the reported low health-seeking for treatment of non-communicable diseases an aberration, a consequence of the effect of the pandemic on treatment for general health issues in the past year, or is this a general trend among these adolescents? And even though majority reported they have sought treatment in government facilities, they are not using AFHC services.

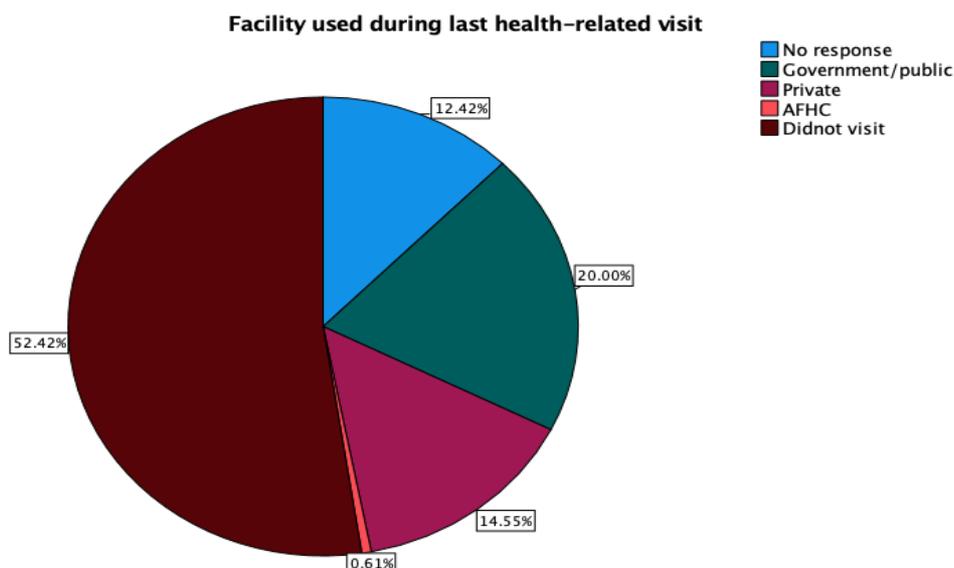
An overwhelming majority (91.21%) reported never having visited an AFHC, either to receive a health service, or to seek information on SRH (e.g., contraception, abortion), or STI (Figure 25). Majority of the adolescents are also unaware of the services and facilities provided in the AFHC.



**Figure 25.** Level of Awareness About Adolescent-Friendly Health Centre

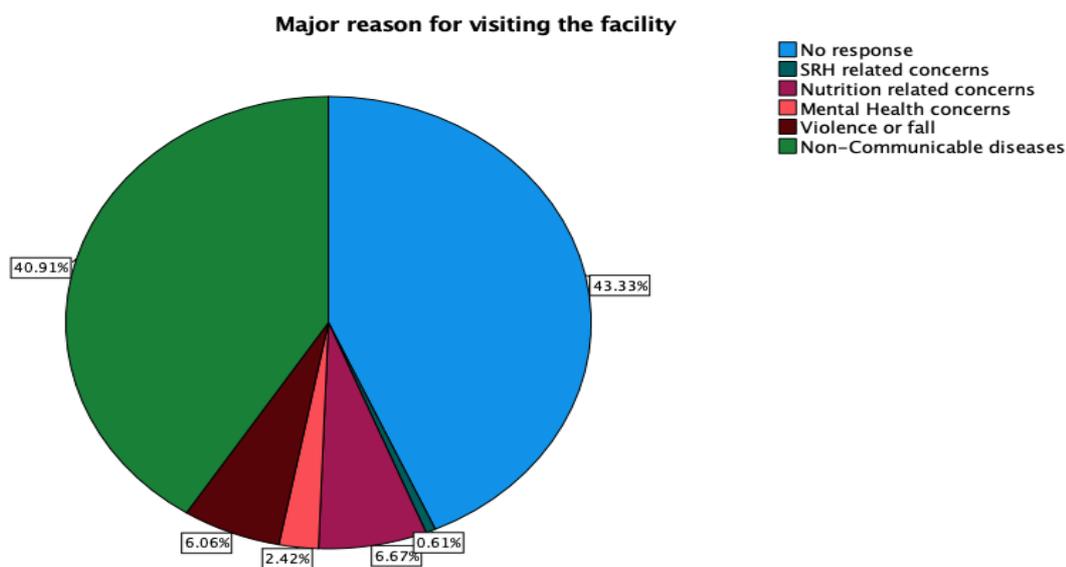
Seeking health services for normal ailments was severely affected for all communities due to the lockdown and burden of the COVID-19 pandemic on India's public and private health system, and this is reflected in our adolescent's responses, with more than half reporting not visiting a hospital or formal health care facility in the preceding 12 months before the survey. Among the adolescents who did report visiting a health facility, 20% went to a public (government) health facility to receive treatment, and 14.55% went to a private practitioner. Several (12.42%) could not remember if they had visited a health facility for treatment in the preceding 12 months.

The adolescents were asked to recollect the last time they had visited a facility to avail healthcare services. An overwhelming majority of the adolescents were unable to recall when they last visited a health facility for any health-related concerns. Among the ones who did remember a visit, a majority preferred to visit a government or public facility (Figure 26).



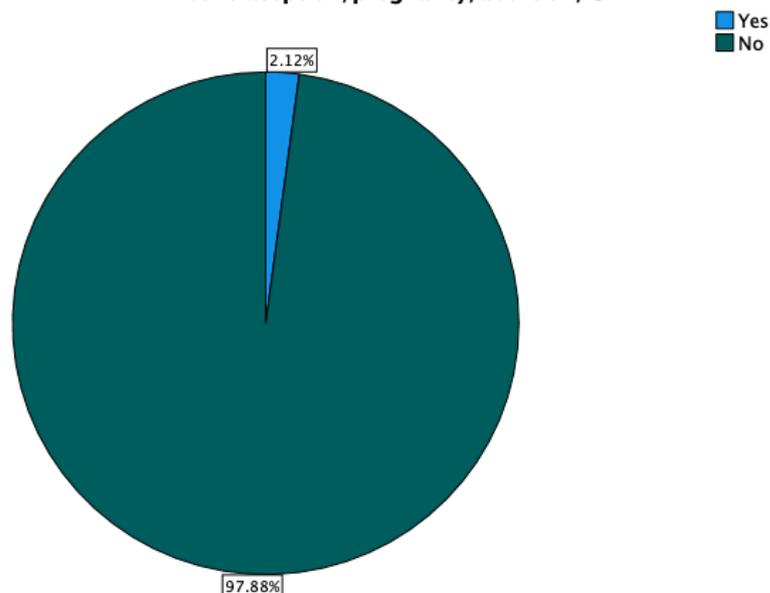
**Figure 26.** Type of Health Facility Used During Last Visit

When asked about the major reason for their last visit to a health facility, the majority reported availing services for non-communicable diseases (Figure 27).



**Figure 27.** Reason for Last Visit to the Health Facility

The majority of the adolescents reported not visiting a health facility to receive information on matters related to sexual health, like contraception, pregnancy, abortion and STI (Figure 28). This data further attests to low utilisation of available SRH services, an important area of health for adolescents. Even as the majority of adolescents in the study sample are unmarried, useful information on contraception, pregnancy, and abortion would go a long way in ensuring sustainable health-seeking practices going into adulthood.

**Visiting a health facility AFHC doctor to receive services or information on contraception/pregnancy/abortion/ STD**

**Figure 28.** Frequency of Visits to the Health Facilities to Address Concerns Related to Contraception, Pregnancy, Abortion, Sexually Transmitted Diseases

## 5. Conclusion

The questionnaire administered under the '*Our Health, Our Voice*' research has captured the influences on adolescent health, their health-seeking behaviour, their level of knowledge and awareness of health issues, and availability and use of public health services.

The gap in the level of awareness among adolescents regarding SRH practices and eating healthy can be addressed through sustained Behaviour Change Communication (BCC). During data-sharing sessions with the community, BCC material, translated into the two dominant languages spoken in the community (Bengali and Hindi), were distributed. AFHCs are also mandated to distribute government-prepared IEC material.

**স্বাস্থ্যকর জাহার**  
**পরিমিত মত খান, সুস্থ থাকুন**

**প্রকৃতির সঙ্গে জুড়ে থাকুন, সদা স্বাস্থ্যবান থাকুন**



আপনার শরীরের ওজনের ভারসাম্য ঠিক রাখুন



ধীরে ধীরে খান, ভালমত চিবিয়ে খান



বিভিন্ন খাদ্যতালিকা থেকে নিজের খাদ্য চয়ন করুন



প্রোটিন জাতীয় খাবার বেশী মাত্রাতে নিন, যেমন দুধ, ছানা, ডাল মাংস ইত্যাদি



বহিরের খাবার (জংকফুড) একদম খাবেন না



খাবারে মধ্য শাক-সবজির বেশী মাত্রায় খান

**স্বাস্থ্যকর অভ্যাস... সুস্থ জীবন... সুস্থ ভারত**  
**স্বাস্থ্যই সবচেয়ে বড় সম্পদ**

**পৌষ্টিক খাবারের সাথে সাথে পরিষ্কার স্বচ্ছ জল পান করার দিকে বিশেষ নজর দিন**



সহযোগী সংস্থা



আয়োজক সংস্থা



আয়োজক সংস্থা



প্রয়োজক সংস্থা



রাষ্ট্রীয় স্যানিটারি, মনুস্কের, হস্তের সোপ ও পানীয়ের খেতে বীজা এবং নিয়ন্ত্রণ কার্যক্রম  
বিস্তারিত জানতে সম্পর্ক করুন :  
স্বাস্থ্য এবং পরিবার কল্যাণ মন্ত্রণালয়, ভারত সরকার



RKSK

The lack of awareness about and use of AFHCs by adolescents is an on-ground challenge that policy makers and department officials need to address. AFHC guidelines mandate information on nutrition, SRH, prevention of injuries and violence, and substance misuse be made available to adolescents, along with addressing the conditions for non-communicable diseases. In order to address the low utilisation of AFHC services, barriers to effective utilisation of the services need to be identified and it is necessary that AFHCs be designed as per adolescents' needs. How AFHC services can be designed to become relevant and useful to the adolescents living in the informal settlements of Gurugram will be explored in FGDs and data-sharing activities with the adolescents who participated in this survey. A plan of action prepared by the adolescents themselves will be presented by them in forthcoming multi-stakeholder dialogues.

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