Indian Journal of Youth and Adolescent Health
Volume 12, Issue 1 - 2025, Pg. No. 1-5
Peer Reviewed & Open Access Journal

Review Article

# Adolescent-Friendly Health Services in India: Bridging the Gap Between Policy and Practice

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**DOI:** https://doi.org/10.24321/2349.2880.2024012

## I N F O

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**How to cite this article:**
Aiswarya S, Debnath A, Ahana N, Zacharia M J, Indu P S, Kishore J. Adolescent-Friendly Health Services in India: Bridging the Gap Between Policy and Practice. Ind J Youth Adol Health. 2025;12(1):1-5.

Date of Submission: 2025-09-09

Date of Acceptance: 2025-09-15

## A B S T R A C T

Adolescents in India, comprising nearly one-fifth of the population, face a complex mix of health challenges spanning sexual and reproductive health, mental well-being, nutrition, substance use, non-communicable diseases, and injuries. Despite the introduction of dedicated policies such as the Adolescent Reproductive and Sexual Health strategy (2005) and the more holistic Rashtriya Kishor Swasthya Karyakram (2014), and the establishment of Adolescent-Friendly Health Clinics (AFHCs), a persistent gap remains between policy intent and actual service delivery. Evidence shows low awareness and utilization of AFHCs, particularly among boys, with access largely restricted to basic services like sanitary napkin distribution. Structural and human resource deficiencies, including lack of privacy, inadequate infrastructure, and insufficiently trained or sensitized providers, further deter adolescents from seeking care. Regional disparities are stark, with some states demonstrating well-functioning models while others struggle to establish even basic facilities. Stigma, around sexual health, menstruation, and mental health, remains a major barrier, silencing adolescents and pushing them toward unreliable sources of information. Policy evaluations suggest that solutions lie less in creating new frameworks than in strengthening existing ones through better training, accountability, and adolescent engagement. Expanding the role of peer educators, ensuring privacy and confidentiality in every clinic, and involving adolescents in governance are critical steps toward improving trust and utilization. Equally important is engaging schools, families, and communities to normalize health discussions and reduce stigma. Testimonies from adolescents highlight that respectful, confidential, and non-judgmental services are valued more than the mere availability of clinics or staff. India stands at a crossroads where adolescent health must be reframed as a societal investment rather than a programmatic obligation. By embedding equity, confidentiality, and youth participation at the core of implementation, India can convert its policy commitments into tangible outcomes, ensuring that adolescents grow into healthier, empowered adults and laying a stronger foundation for national progress.

**Keywords:** Adolescent Health India, Rashtriya Kishor Swasthya Karyakram (RKSK), Adolescent Reproductive and Sexual Health (ARSH), Adolescent-Friendly Health Clinics (AFHCs)

## Introduction

India is home to over 250 million adolescents (10–19 years), who make up nearly one-fifth of the population.[1] This group faces unique and overlapping health challenges, including sexual and reproductive health issues, mental health problems, malnutrition, substance abuse, and the rising burden of non-communicable diseases.[1,2] Unintended pregnancies and early marriage are particularly concerning: around 27% of girls are married before the age of 18, leading to nearly 10 million unintended pregnancies annually among those under 20 years.[1,2] Fertility remains high in this age group, with 43 births per 1,000 girls aged 15–19.[1] At the same time, HIV prevalence stands at 0.2%, and comprehensive knowledge about HIV is limited, with only 54% of adolescents demonstrating accurate awareness.[1,2] These challenges are compounded by gender inequality, stigma, and limited access to contraceptives, particularly in rural areas.[1,3]

Mental health has emerged as an urgent priority. Studies estimate that 7–14% of Indian adolescents live with diagnosable mental disorders, often linked to academic stress and social pressures.[4-6] Suicide is among the leading causes of adolescent mortality.[4-6] Recent evidence suggests alarmingly high prevalence of depression (31%) and anxiety disorders (41%) among adolescents.[7]

Nutritional deficits further exacerbate adolescent health risks. Over 50% of adolescents suffer from anemia, with prevalence reaching 56% among girls and 30% among boys[2,8,9] Undernutrition remains common, with 23% of adolescents underweight, while obesity is rising in urban areas (15%)[2,8,9] Micronutrient deficiencies, especially iron and vitamin D, are strongly associated with stunting, particularly in late-adolescent girls (57%).[8,9]

Beyond these, injury-related deaths account for 20% of adolescent mortality, with over 40,000 road traffic fatalities annually among under-20s.[1] Violence—including domestic and sexual abuse—affects nearly 30% of girls, with cultural norms and unsafe environments driving vulnerability, while boys face higher risks of injury.[2,10]

Against this backdrop, India's national adolescent health policies have evolved considerably. From the Adolescent Reproductive and Sexual Health (ARSH) strategy launched in 2005 to the more comprehensive Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014, there has been a clear recognition that adolescent health requires dedicated, rights-based, and holistic approaches.[11-13] The establishment of Adolescent-Friendly Health Clinics (AFHCs) under RKSK marked a pivotal step toward operationalizing these commitments. Yet, the evidence shows that major challenges remain in translating policy into meaningful outcomes at the grassroots level.

## Challenges and Gaps in Adolescent Health Service Delivery

Despite policy progress, multiple studies show that adolescents in India still face significant barriers in accessing healthcare services under the Rashtriya Kishor Swasthya Karyakram (RKSK).

- **Low Utilization and Awareness:** Utilization of adolescent-friendly health clinics (AFHCs) remains strikingly low. In a mixed-methods evaluation conducted in Puducherry, fewer than half of adolescents were even aware of AFHC services, and actual use was limited to 15% of girls—mostly to access sanitary napkins—while almost no boys sought care.[17] Similarly, a study in rural Maharashtra found that only 35% of adolescents had heard of AFHCs, and just 20% had ever utilized them. Utilization was significantly associated with being female, underscoring gendered patterns of access.[18]
- **Infrastructure and Privacy Constraints:** Assessments of AFHCs across several states reveal major infrastructural deficiencies. In a multi-state study, while clinics scored well on accessibility (100%) and record maintenance (92.9%), they lacked designated clinical areas (71.4% deficient), IEC resources (57.1% deficient), and commodity disbursement (64.3% deficient). Alarmingly, referral systems were absent in nearly 93% of facilities.[14] Privacy was another major concern: six out of seven studies reported gaps in ensuring confidentiality, a critical component of adolescent care.[14] These deficiencies compromise trust and discourage adolescents from seeking services.
- **Human Resource and Training Gaps:** Training of healthcare providers is inadequate. Only 16% of providers had been trained in AFHC protocols, while 25.9% had received training on pre-exposure prophylaxis (PrEP), and 67% on adolescent communication.[13] Lack of provider competence and judgmental attitudes have been highlighted as barriers across evaluations.[14] This results in adolescents perceiving AFHCs as unwelcoming and undermines the very purpose of adolescent-friendly care.
- **Regional Disparities and Equity Issues:** The Common Review Mission (2024) found that while states like Odisha, Gujarat, and Karnataka had relatively strong coverage of AFHCs, others such as Tripura, Himachal Pradesh, and Jharkhand had minimal service presence.[11] Innovative models like Odisha's Sharda Clinics and Himachal's Nayi Disha Kendra demonstrate what well-equipped AFHCs can achieve, yet these remain exceptions rather than the norm.[11] Moreover, marginalized groups—including adolescents in rural, tribal, and urban slum settings—are often excluded

**ISSN: 2349-2880**
**DOI: https://doi.org/10.24321/2349.2880.2024012**

due to lack of outreach, transportation difficulties, and limited awareness.[11]

- **Sociocultural Stigma:** Deep-rooted stigma around sexual health and mental health continues to silence adolescents. Many avoid AFHCs due to fear of judgment by providers or community members. Girls often face mobility restrictions and require parental approval, while boys frequently perceive AFHCs as "for girls".[17,18] Stigma not only reduces service uptake but also perpetuates misinformation, forcing adolescents to rely on peers or unverified online sources.

Collectively, these findings reveal a systemic gap between policy intent and field-level implementation. AFHCs, envisioned as safe and supportive spaces, too often fail to meet even the basic standards required for adolescent-friendly care.[13,14]

## Policy Recommendations for Strengthening Adolescent Health Services

The evidence demonstrates that the biggest challenge is not the absence of policies but the weak implementation of existing frameworks like RKSK and AFHCs. To close the gap between policy intent and adolescent needs, the following reforms are recommended:

- **Enhance Provider Training and Sensitization:** Training is a cornerstone of adolescent-friendly healthcare. Yet, only 16% of providers have been trained on AFHC protocols, 25.9% on HIV pre-exposure prophylaxis (PrEP), and 67% on adolescent communication.[13] Comprehensive training programs—covering sexual and reproductive health, mental health, gender sensitivity, and non-judgmental communication—must be scaled up. Refresher trainings should also be institutionalized.[14]
- **Guarantee Privacy and Confidentiality:** Privacy breaches are among the most critical deterrents to adolescent healthcare use. Studies reveal that six out of seven AFHC assessments found gaps in ensuring privacy (14). Every clinic must have dedicated counselling spaces, strict confidentiality protocols, and IEC materials that reassure adolescents about their rights. Without this, even the most well-intentioned services will remain underutilized.
- **Improve Accountability and Monitoring:** The 16th Common Review Mission (2024) highlighted large variations across states in coverage and performance (11). Accountability must be strengthened through standardized quality benchmarks, regular audits, and independent evaluations. Facilities that meet adolescent-friendly criteria should be recognized, while underperforming clinics should receive targeted mentorship and monitoring.[14]
- **Integrate Peer Support and Youth Participation:** Peer educators under the Saathiya program have demonstrated value in improving adolescent awareness and engagement.[2] Their roles must be expanded to include active participation in planning and monitoring AFHC activities. Involving adolescents directly in program governance ensures services reflect their realities and builds ownership.
- **Strengthen Community Engagement and Support:** Evaluations in Puducherry and Maharashtra show that low awareness is a primary barrier to utilization.[17,18] Greater emphasis on school-based counselling, parent sensitization, and community outreach is needed. Partnerships with NGOs and local youth clubs can help address stigma and normalize conversations on sexual and mental health.[11]
- **Promote Gender-Responsive and Inclusive Approaches:** AFHCs are often perceived as female-centric, leading to low engagement among boys.[17,18] Services should be consciously inclusive, addressing the needs of both genders, as well as LGBTQ+ adolescents. The Menstrual Hygiene Scheme (MHS), which has suffered from poor implementation due to lack of sanitary pad supplies, must also be revitalized.[11]

In sum, strengthening adolescent health services requires a multi-pronged strategy that combines capacity building, privacy assurance, accountability, peer participation, and community involvement. Importantly, these reforms must be guided by the principle of equity, ensuring that adolescents in rural, tribal, and marginalized communities are not left behind.

## Adolescent Voices: A Call from the Community

To truly understand the urgency of these reforms, one must listen to adolescents themselves – the intended beneficiaries of these services. Their experiences and aspirations form a compelling case for change. "Adolescence is a stage filled with change, curiosity, and self-discovery, yet it's also a time when many of us struggle to find the support we need," reflects Ahana, a 15-year-old student advocate. She describes the common hesitation among her peers to approach health clinics or counselors: "Unfortunately, in many communities, fear of judgement, lack of awareness, and stigma keep us silent." Ahana's words highlight the very real psychological barriers that even the best health program must overcome at ground level. When an adolescent girl feels too ashamed to ask for menstrual advice, or a boy fears ridicule for seeking help with depression, it is a stark indicator that our health services have not yet become the safe spaces they need to be.

Martin, a 14-year-old from Kerala, shares a similar perspective on mental health: "Stigma and discrimination

**ISSN: 2349-2880**
**DOI: https://doi.org/10.24321/2349.2880.2024012**

are the biggest barriers. Mental health issues are often seen as a weakness or even linked to supernatural causes rather than legitimate medical conditions," he explains. Martin recounts that even when teens like him overcome family or social reluctance to seek help, they may encounter new obstacles at the clinic – "judgmental or disrespectful attitudes from healthcare providers," and worries that what they say might not remain confidential. These first-hand accounts from adolescents underscore a crucial point: technical fixes alone (more clinics, more staff) will not suffice unless the ethos of care changes. Adolescents are perceptive; they quickly sense whether a service is truly friendly or just nominally so. As Ahana passionately argues, "Schools should have trained counsellors, open discussions on health, and platforms where we can speak without fear… When our voices are heard and respected, we are better prepared to shape a healthier, more understanding society". This advocacy from young voices demands that policymakers and providers treat adolescents not as passive recipients of care, but as stakeholders with valid opinions and rights.

Incorporating these community voices into policy dialogues can catalyze change. Their stories call for more than incremental improvements – they call for a cultural shift in how adolescent health is approached. The onus is now on all of us, from health professionals to administrators to community members, to answer this call. We must ensure that adolescents like Ahana and Martin no longer feel alone or unheard when it comes to their health.

## Conclusion and Way Forward

Over the past two decades, India's adolescent health agenda has matured from the limited scope of ARSH to the more holistic framework of RKSK.[11-13] This evolution reflects a recognition of adolescents as a distinct group with unique health needs spanning mental health, nutrition, sexual and reproductive health, substance misuse, non-communicable diseases, and injury prevention. The establishment of AFHCs, the introduction of peer educators, and the integration of digital tools such as the Saathiya app are all commendable milestones.[11,12]

Yet, evidence consistently highlights serious gaps in awareness, utilization, infrastructure, and quality of care.[13,14,17,18] Adolescents often remain unaware of the services available, and when they do engage, they frequently encounter challenges such as lack of privacy, insufficient counselling, or judgmental provider attitudes.[14,17,18] Regional disparities exacerbate inequities, leaving marginalized populations at greater risk.[11] Importantly, stigma—both societal and institutional—continues to be a formidable barrier to help-seeking.[17,18]

The way forward requires not new policies, but stronger implementation, accountability, and community integration. Programs like RKSK and Tele-MANAS will succeed only if adolescents find them accessible, confidential, and respectful.[11,14] Schools, families, and communities must become active partners in adolescent health, ensuring that services are not just available but also trusted and utilized.[17,18] Equity must remain at the forefront—addressing gender disparities, engaging marginalized groups, and tailoring services to local realities.[11]

Adolescent health is not merely a medical agenda; it is a societal investment. By placing adolescents at the center of solutions, addressing stigma, and ensuring safe, supportive spaces, India can transform commitments into impact. As adolescents themselves remind us, their voices must be heard, their privacy respected, and their health prioritized. The dividends will be immense—not only healthier and empowered youth but also a stronger foundation for national progress and development.[1-3,9]

**Acknowledgement:** None

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**ISSN: 2349-2880**
**DOI: https://doi.org/10.24321/2349.2880.2024012**