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Adolescent Friendly Health Clinics in India— Are They Friendly Enough?

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Abstract

Almost 60% of premature deaths among adults are traced back to an individual's lifestyle during their adolescence. A rapid phase of development coupled with sexual maturity, adolescence requires special attention by healthcare providers and communities. Access to Sexual and Reproductive Health (SRH) services by adolescents is met with barriers of awareness, acceptability and distance in India and globally. Recognising this challenge, the Government of India, in 2014, launched the Rashtriya Kishor Swasthaya Karyakram (RKSK) program to ensure the holistic development of adolescents. Adolescent Friendly Health Clinics (AFHCs) were launched as a part of the RKSK program to provide counselling and curative services to adolescents on SRH issues among others and bridge the problem of accessing SRH services. This paper aims to evaluate if and to what extent AFHCs' claim to be 'friendly' is accurate. Based on the review of the existing literature, a list of indicators is prepared to further evaluate and analyse these AFHCs. The paper finds that healthcare providers are not purpose-trained to adequately deal with adolescent SRH needs. Further, privacy is a major concern for adolescents as their consultations are not conducted in fully private areas. It is also seen that adolescents do not have enough knowledge about their own SRH needs, leading to not having enough or any conversations about the same. The paper argues that adequate training for healthcare providers, including soft skills and reiterating the importance of privacy would make AFHCs more accessible to adolescents. Thus, increasing the utilisation of the same along with destigmatisation of conversations surrounding SRH needs.

Keywords: Adolescence, RKSK, AFHC, Healthcare, Barriers, Adolescent-Friendly

1.0 Introduction

“Girls talked about how health service providers shunned them if they came asking about contraceptives”— (World Health Organization, 2018)

16% of the world's population (7.7 Billion), that is, 1 in 7 people are adolescents, and South Asia is home to 30% of adolescents, accounting for more than any other region in the world (Adolescent Demographics, 2019). More than 33% of the disease burden and almost 60% of premature deaths among adults can be traced back to lifestyle behaviour such as substance abuse, poor eating habits, sexual abuse and inadequate access to health services, during their adolescence (Lule, 2006).

Adolescence is a period of rapid development during the transition phase from childhood to adulthood. This development occurs in the physical, mental and social domains, with each posing its own health needs, and challenges in addressing these needs. This rapid change is accompanied by sexual maturity, which can be perplexing and difficult to cope with.

Thus, there is a need to address the Sexual and Reproductive Health (SRH) of adolescents. As they transit this period, they must be given special attention as development in this period determines their future contribution to society as adults. To optimally address these challenges, they require universal access to empowering and supporting health services.

This paper is structured as follows, Section 2 describes phases in adolescence, the Sexual and Reproductive Health (SRH) needs during these phases and the challenges faced in addressing these needs. Section 3 contextualizes these needs and challenges to the Indian scenario. Section 4 describes the national-level Rashtriya Kishor Swasthya Karyakram (RKSK) program aimed at the holistic development of adolescents. Section 5 outlines the features of the Adolescent Friendly Health Clinics (AFHCs), a key component of the RKSK program and the SRH services it provides. Section 6 empirically evaluates the ‘friendliness’ of the SRH services at AFHCs based on a literature review. Section 7 discusses the key findings. Section 8 concludes with recommendations for making services more adolescent-friendly.

2.0 Adolescence: Its Phases, Needs and Challenges

Adolescence is a complex period with rapid development in physical, cognitive and psychosocial domains (Adolescent Health, 2019).

2.1 Phases of Adolescence

WHO defines adolescence as the period between the ages of 10 and 19 (ibid.). To better understand and address the needs of this period adequately, it can be further classified into three distinct phases— Early, Mid and Later (World Health Organisation, 2003). Early Adolescence (10-13), consists of spurts of growth and the beginning of sexual maturation. In Mid Adolescence (14-15), they start developing a strong sense of identity, with friends as primary socialization agents. Finally, in later adolescence (16-19), they fully transition into adulthood with a distinct identity of their own (ibid.)

The transition through these three phases though seen in all adolescents; the order and extent of each phase are influenced by the environment in which they live and grow, and the prevailing cultural and societal norms of that environment.

2.2 The vulnerabilities of adolescence

The rapidity of the development in multiple domains in this period provides little time for an adolescent to become aware, understand and adapt to the changes they experience in their body and mind. These changes coupled with sexual maturity, makes them vulnerable to sexual violence and injury, with girls disproportionately affected as compared to boys.

For instance, the first sexual intercourse experience may involve coercion and/or violence. Guttmacher Institute (2017) based on their review of studies on adolescents from more than 100 developing countries between the years 2002 and 2015, report 3-23% of adolescent females aged 13–17 experienced sexual violence in the past year; whereas it was 0–13% among adolescent males. At such an early age of exposure to sexual activity, adolescents require proper guidance to navigate through their experiences. This is especially important to understand when there is no standardised understanding of Comprehensive Sexuality Education (CSE) among developing nations (ibid.). The presence of CSE in national curricula is no evidence that is being implemented properly. World Health Organization (2013) observes sexual violence has a further consequence for girls in the form of unsafe abortion, unwanted pregnancies, dropping out of school, substance abuse etc. which severely compromises their capacity to be healthy and productive members of the society in the later phases of their life. Further, married adolescents are exposed to more frequent unprotected sexual intercourse and are often cut off from resources in schools to learn more about contraception and reproductive health threats (Ringheim, 2007).

2.3 Sexual and Reproductive Health (SRH) Needs of the Adolescent

To support and empower adolescents to successfully manage the above vulnerabilities they require adequate access to a range of preventive, promotive and curative services aimed at improving their knowledge and awareness of their sexual and reproductive health (SRH) needs. Such services could be mental health support, substance misuse assistance, assistance in detection and prevention of injuries and violence.

To optimally address the SRH needs of the adolescents, the UNFPA (Supplement To Background Paper on Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage, 2019) recommends the following package of health services as essential—

1. Prevention and treatments of HIV and STI (Sexually Transmitted Infection)
2. Safe abortion services

3. Detecting and preventing sexual and gender-based violence (GBV)
4. Antenatal, childbirth and postnatal care
5. Counselling and services for infertility
6. Detecting, preventing and managing reproductive cancers
7. Counselling and services for sexual health and well-being
8. Comprehensive sex education
9. Counselling and services for modern contraceptives

2.4 The challenges in making SRH services available and accessible

For adolescents to adequately utilise the SRH services, they need to be available and accessible. For services to be available, there should be special clinics designated to address their needs. These clinics need to be staffed by healthcare providers who are purpose-trained to deal with the SRH needs of the adolescents. The range of services provided by these healthcare providers must comprehensively address the needs of adolescents. These clinics should be equitably distributed such that their services are available to all who require access to them.

Even if these services are available, to adequately utilise them, the adolescents may face several barriers in accessing them. Some of these barriers can be:

1. **Awareness barrier:** Challenges faced by adolescents in receiving SRH services is the lack of awareness about the same. If there is a lack of awareness about services, they automatically become under-utilised. There is unawareness about the existence of these clinics. Another barrier is the lack of health literacy among adolescents, about one's SRH needs, such as menstruation, not knowing about STIs, contraception etc. This unawareness coupled with the stigma attached to these concepts in various cultures leads to unawareness of the services related to them, and their utilisation. Within this unawareness, gender is a factor that influences a person's risk-taking and health-seeking behaviours. It intersects with other factors which lead to inequalities in accessing healthcare, such as economic dependence, patriarchal structures, the burden of domestic roles and responsibilities, limited influence over resources (Gender and Health, 2019). Oftentimes girls are discouraged from using or not told about services due to the aforementioned reasons.

2. **Distance barrier:** These services may also require them to travel long distances. This causes a great issue in accessing these services (World Health Organization, 2013).

3. **Acceptability barrier:** Oftentimes adolescents may feel uncomfortable or unwilling to access services due to fears related to judgement, maintenance of privacy and confidentiality, and discomfort that they experience with the healthcare provider. They may not be able to communicate freely about their needs with the healthcare provider. If the adolescent feels unwelcome, likely, they would not utilise the services (World Health Organization, 2013). They want to be treated with respect and dignity. The aforementioned characteristics determine the friendliness and acceptability of services provided to the adolescents, and hence their propensity to utilise the available services.

3.0 Adolescents in India

In India, adolescents make up 20.9% (~253 million) of the total population. Of this, ~72% reside in rural areas (Census 2011). India's adolescent population has risen by 40% since 1990 and their health risks are growing rapidly (Azzopardi et al., 2019).

India is considered a 'multi-burden' country, as adolescents face the burden of malnutrition, anaemia, unawareness on SRH issues, substance abuse, communicable and non-communicable diseases, mental health concerns, and injuries and violence (including gender-based violence)- (Ministry of Family and Health Welfare, 2014, Azzopardi et al., 2019). These contribute to increased morbidity and mortality not only during adolescence but also later in their lives. This estimated to be 2500 DALYs¹ (disability-adjusted life years) per 100,000 adolescents (ibid.). More specifically, the adolescents face a number of issues related to their SRH needs. These could be risky sexual behaviour, early and unwanted pregnancies, STIs—such as HIV/AIDS, menstrual hygiene, contraception etc.

According to the National Family Health Survey (NFHS-3- 2005-06), only 14.1% (14.7% urban versus 13.9% rural) of unmarried sexually active female adolescents used a contraceptive, and only 13% (16% urban versus 12.4% rural) of currently married adolescents reported contraceptive use. The unmet need for contraception is 27.1% (Nath & Garg, 2008). A study conducted in Ahmedabad shows that only 15.15% of adolescents knew Sexually Transmitted Diseases, while less than half were aware of contraceptive methods (Dixit et al., 2017).

¹One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability (WHO n.d.)

These statistics indicate that SRH needs to be a priority in India. The SRH services being provided must address these health needs of Indian adolescents.

3.1 Challenges in addressing SRH needs in India

Socio-economic gradient, gender disparities and cultural norms when coupled with limited access to information generate varied experiences of accessing healthcare services for different groups of adolescents. There is a need to make this experience equitable to all adolescents such that those who require these services the most can access them. In making this happen, there are several challenges related to availability and accessibility factors. Some of these are:

1. **Adequate training of healthcare providers:** For services to be available, healthcare providers must be well-trained. Empirical studies suggest, not all of them are trained in addressing adolescent needs. A study conducted in Andhra Pradesh and Madhya Pradesh indicates that a major factor that might hinder the ability of healthcare providers to provide SRH services to young people is their discomfort in doing so. Most workers were uncomfortable talking to young men and unmarried young women about their SRH needs.
2. **Awareness barrier:** Many adolescents, especially girls, face challenges to their healthy development into adulthood due to a variety of factors- including structural poverty, lack of information, negative social norms, inadequate education, lack of vocational training, lack of awareness of parents about the needs as well as services and clinics (Ministry of Family and Health Welfare, 2014). Marriage, before the legal age of 18 years, is an important factor that affects the health of girls in India. According to NFHS-3, 47% of the currently married women, aged 20–24, were married on or before 18 years of age. Of the respondent girls, who were 15-19 years old at the time of the survey, 27% were married compared to less than 3% of the boys in the same age group. Right to health ascertains individuals' right to bodily autonomy, which is central to SRH, once married, girls are restricted to their households and not given autonomy, bodily or otherwise.
3. **Acceptability barrier:** Privacy concerns, coupled with judgmental staff passing moralistic comments discourage an individual from accepting the services (Population Council, 2014). Several times, the routine hospitals do not entertain adolescents coming alone, especially when they have issues regarding sexual and reproductive health. Most hospitals require the

parent to accompany them and/ or to permit any procedure or testing as per the legal requirement (Health and Physical Education Class 9, 2019). A focused group discussion also indicated that stigma attached to SRH services hinders adolescents from utilising these services (Nair et al., 2013).

4. **Distance barrier:** Findings from a focused group discussion suggest that facilities requiring adolescents to travel long distances discourage them from utilising services (ibid.).

4.0 Rashtriya Kishor Swasthya Karyakram (RKSK) program to address the SRH needs

The government taking cognisance of the unmet health needs of adolescents launched Rashtriya Kishor Swasthya Karyakram (RKSK) program in 2014 to ensure the holistic development of adolescents.

4.1 Purpose and Aim of the RKSK Program

The overall purpose of the RKSK program is to help adolescents reach their full potential by making well-informed decisions.

To achieve this purpose, it has the following aims:-

1. Increase availability and access to information about adolescent health.
2. Increase accessibility and utilisation of quality counselling and health services for adolescents.
3. Forge multi-sectoral partnerships to create safe and supportive environments for adolescents.

4.2 Objectives of the RKSK Program

To achieve the stated aims it lays down four objectives—

1. Improve knowledge, attitudes and behaviours concerning SRH
2. Promote healthy menstrual hygiene
3. Decrease teenage pregnancies
4. Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

These objectives address the SRH needs of adolescents in India by promotional and preventive strategies such as providing information about sexual maturity during adolescence, the

process of growing up (with a focus on the 10–14 age group), safe sex and reproduction, genital health and hygiene. These strategies also include counselling on concerns related to growing up, sexuality, relationships, body image and identity (with focus on the 10–14 age group), promotion of responsible sexual behaviour, information on the management of unwanted pregnancy, the legality of abortion and consequences of unsafe abortion, information on causation, transmission and prevention of RTIs/ STIs and HIV, and giving access to non-clinical contraceptives such as condoms, oral contraceptives and emergency contraceptives (Ministry of Family and Health Welfare, 2014). This strategy attempts to achieve the objectives by shifting focus to a community-based program, and preventive care with strong diagnostic and curative services, providing primary care to adolescents in India.

4.3 Key Focus Areas

To achieve its stated objectives the RKSK Program has identified the following six key areas These areas are:

1. **Nutrition**— Creating awareness on nutritious diets, and providing weekly iron and folic acid supplements to adolescents.
2. **Sexual and Reproductive Health**— improving knowledge and awareness levels concerning SRH, promoting menstrual hygiene practices, and improving birth preparedness among adolescents.
3. **Non-communicable diseases**—To promote behaviour change for the prevention of non-communicable diseases.
4. **Substance misuse**— Raising awareness on the consequences of substance misuse.
5. **Mental Health**— Addressing mental health concerns of adolescents.
6. **Injuries (including GBV)**—To promote favourable attitudes against injuries and violence, including GBV among adolescents.

4.4 The components of the RKSK Program

In alignment with its key focus areas, the RKSK provides facility-based services such as Adolescent Friendly Health Clinics (AFHCs); and community-based services such as Peer Education Programme (PE).

5.0 Adolescent Friendly Health Clinics (AFHC)

The AFHC consists of a wide variety of curative and counselling services on diverse adolescent health issues ranging from SRH to Nutrition, substance abuse, injuries and violence (including GBV), non-communicable diseases and mental health.

The AFHCs are located in the existing Primary Health Centers (PHC), Community Health Centers (CHC) and District Hospitals (DH) and Medical Colleges.

The AFHCs are staffed by well-trained healthcare providers to effectively address the SRH needs of adolescents. The staff comprises of Medical Officers (MOs), Auxiliary Nurse Midwives (ANMs) and Counsellors. The PHCs comprise of two MOs (1 male and 1 female), 1 ANM, 1 female health assistant At CHCs and DHs, there are two dedicated counsellors (1 male and 1 female), two MOs (1 male and 1 female) and two staff nurses (Ministry of Health and Family Welfare, 2014).

5.1 Services and commodities provided by AFHCs

AFHCs seek to give access to various commodities such as sanitary napkins and contraceptives; counselling on menstrual disorders, personal hygiene, menstrual hygiene, use of sanitary napkins, use of contraceptives etc; curative services such as treatment of STIs, sexual concerns, menstrual disorders, sexual abuse etc (ibid.).

5.2 Adolescent-Friendly Features of AFHCs

The key 'friendly' component of AFHC mandates equitable facility-based curative and counselling services for adolescents. These features recognise and address the barriers that adolescents face in accessing SRH services:-

1. **Awareness Barrier-** The benchmark for AFHCs states that individuals will have awareness about the clinic and the range of services it provides. The community members would also be aware of the services and understand the need for the same (Adolescent Health (RKSK), n.d.)
2. **Distance Barrier-** The clinic would not require the adolescents to travel long hours (ibid.)
3. **Acceptability Barrier-** To successfully address the acceptability barriers (see Section B.1) the clinics have several adolescent-friendly features. These features are: The clinics would

4. be established in areas where adolescents can visit without any fear of social consequences. Privacy and confidentiality would be maintained, with non-judgmental and competent health service providers.

6.0 Performance evaluation of AFHCs

Based on the literature reviewed, in this paper, the following indicators will be used to evaluate the adolescent friendliness of AFHCs:-

1. SRH literacy of adolescents:

Knowledge about their own SRH needs is an important tool to understand and effectively utilise services directed towards them. Knowledge and awareness have been used interchangeably in this paper.

2. Maintaining privacy and Confidentiality:

Adolescents should have the freedom to discuss their concerns without the fear of their conversation being overheard or discussed with someone else. In this paper, privacy refers to the state wherein the adolescents have a separate space with no disturbance. Confidentiality refers to keeping discussions between oneself.

3. Treating adolescents with respect:

Treating adolescents with dignity and as valued individuals, and giving them space to express concerns; the staff should be non-judgmental and not provide moralistic comments on actions.

4. Competency to understand address the full range of needs:

The healthcare providers are adequately trained to deal with adolescent needs.

6.1 Performance Evaluation of AFHCs: How friendly are they

AFHCs, an important component of the RSKS Program, comprise features, which are adolescent-friendly, designed to address access-related barriers and make services acceptable to adolescents. This paper aims to assess the extent of the friendliness of these features in practice. To do so, it reviews empirical studies which have evaluated the functioning of AFHCs.

Population Council (2014) evaluated 12 AFHCs in Jharkhand, Maharashtra and Rajasthan states. They surveyed 2131 adolescents² and 24 mystery clients³. In Rajasthan, the official records maintained at the Department of Health showed the CHCs to be having fully functional AFHCs. However, visits to these CHCs revealed there were neither designated facilities nor fixed timings for providing adolescent-related services; And these services were provided in the general OPD. In Jharkhand, in two instances, the AFHC was closed on the day of the visit, and care-seekers were tended to by a physician in the general OPD.

They report the findings on Adolescent friendly features of the clinics as follows:

- On SRH Literacy: The majority of the respondents reported that they did not seek advice for SRH issues because they either considered them not to be too serious or felt hesitant and embarrassed.
- On Privacy: As conversations could be overheard and their physical examination could be seen by others. Care-seekers from all three states reported that others were present during their consultation.
- On Respect: As providers made moralistic judgements on their behaviour; especially while dispensing contraceptives to unmarried girls.
- On Competency: In instances in all three states, providers spent less than a minute with the adolescents, while time spent with ANM/counsellor ranged anywhere between 5-60 mins. As a result, the information provided to care-seekers on SRH needs and on the prescriptions were limited.

Human Rights Law Network in Delhi (2018) evaluated 4 DISHA (Delhi Initiative for Safeguarding Health of Adolescents) clinics under RKSK and one slum cluster. They interviewed 31 adolescents (5 boys and 26 girls) and three ANMS of DISHA. They report the findings on Adolescent friendly features of the clinics as follows:

- On SRH literacy: Most of the adolescent girls were unaware of the use of contraceptives, and some had misconceptions about the same. None of the sexually active girls had used a contraceptive previously. They reported that they were aware of newer menstrual hygiene practices and had tried using them, however, returned to the traditional methods soon after. The boys seemed aware of contraceptives and took part in regular sexual activities.

² This study surveyed youth too, that is, individuals upto the age of 24

³ Mystery clients are undercover patients

- On Respect: There was a lack of respect as one of the ANMs shared the story of an adolescent who had conceived and how she proceeded to scold the girl
- On Competency: The ANM at the clinic informed that she received no additional training to deal with adolescent issues other than standard/regular ANM training. DISHA clinics operated within government dispensaries with no dedicated staff for adolescents

Dixit et al. (2017) evaluated 10 Urban Health Centers in Ahmedabad. They interviewed 99 adolescents and all the healthcare providers present at the time of the visit. They report the findings on Adolescent friendly features of the clinics as follows:

- On SRH Literacy: All adolescents were aware of menstrual hygiene practices. However, only 48% had knowledge about contraceptives and 15.15% were aware of STIs.
- On Privacy: 9 out of 10 adolescents (91%) mentioned inadequate privacy during the consultation, and 3 out of 5 (42%) mentioned curtains were not available during consultation.
- On Respect: The majority of the healthcare providers (92.5%) had friendly and respectful behaviour towards adolescent care-seekers.
- On Competency: 70% of the providers provided health education, counselling and information about services and provided these services without discrimination.

Kumar et al. (2017) interviewed 1463 adolescents in the urban Dehradun and rural Chakrata block of the Dehradun District. The mean age was 14.4 years, and half of the interviewees were girls. They report their finding as follows:

- On SRH Literacy: A higher proportion of girls (Rural: 78%, Urban: 89%) were aware of condoms as contraceptives than boys (Rural: 29%, Urban: 69%). The proportion of adolescents who had sexual intercourse was higher in rural areas (27%) as compared to urban areas (16%), and with the proportion being highest among rural boys (32%). Awareness about HIV/AIDS amongst them was 64% in rural and 84% in urban areas, and knowledge about its prevention by condoms was highest among urban females and lowest amongst rural males.
- On Privacy: In the rural area, 8 out of 10 (85%) adolescents felt privacy was adequate during the consultation, whereas in urban areas it was 6 out 10 (61%).
- On Competency: In the rural area, 91% were satisfied with their interaction with providers and were able to communicate their needs, whereas it was 88% in the urban area.

Mahalakshmy et al. (2018) evaluated two primary health centres in Puducherry and interviewed 311 adolescents. The report of their findings are given below.

- On Privacy: The adolescents (OR interviewees) were apprehensive about privacy during a consultation with the AFHCs, and hence would prefer to visit a private clinic.

A study (“Evaluation of Adolescent-Friendly Health Services in India,” 2009) evaluated three sites, that is, Safdarjung Hospital, Delhi; Government Medical College and Hospital, Chandigarh and Government Medical College and Hospital, Kolkata. In each site they interviewed, 4 providers in the adolescent clinics, 25 adolescents and 25 parents were interviewed⁴. They report their findings as follows:

- On Privacy: The confidentiality in the AFHC was found to be more than the other OPDs. However, the consent of the parents was required to access the services at the AFHC. There were separate waiting areas for the adolescents in the clinics, and consultation had adequate privacy. Both Confidentiality and privacy levels were much lesser in Delhi’s clinics when compared with those at Chandigarh and Kolkata.
- On Competency: The care-seekers liked the environment and the friendliness of the staff.

Hoopes et al. (2016) conducted a meta-synthesis of studies that have evaluated AFHS initiatives in India during the period from 2000 to 2014. They report the findings as follows:

- On Competency: A study conducted in Rajasthan in the year 2010 found providers were not competent as training was inadequate. Similarly, another study conducted in all the 9 districts of Delhi in the year 2013 found that medical officers, both in government and private clinics, were not adequately trained.

⁴ These clinics were upgraded to AFHC in 2014

7.0 Discussion of evaluation results

The previous section reviewed 7 studies that empirically evaluated the performance of the AFHCs.

	On SRH Literacy	On Privacy	On Respect	On Competency
Study A	Did not seek advice because did not consider problems serious enough or felt hesitant	Others present during consultation	Moralistic judgements	Limited information provided to care-seeker
Study B	Girls were unaware of contraceptives, did not try newer menstrual hygiene practices. Boys took part in regular sexual activities and were aware of contraceptives	-	ANM scolds girl for conceiving	Received no additional training, clinics operated with dispensaries
Study C	All aware about menstrual hygiene practices, 48% aware of contraceptives and 15.15% aware of STIs	Majority experienced inadequate privacy and 42% did not have curtains while being examined	Majority of healthcare providers were friendly and respectful	70% providers provided services with utmost knowledge and no discrimination
Study D	Urban girls more aware of contraceptives than boys, higher proportion of rural adolescents engaged in sexual intercourse, awareness of HIV/AIDS and its prevention higher in rural areas	85% adolescents experienced adequate privacy in rural areas, whereas in urban areas it was 61%	-	91% satisfied with interaction in rural areas, it was 88% in urban areas
Study E	-	Adolescents apprehensive of privacy, prefer to visit private clinic	-	-
Study F	-	Confidentiality in AFHCs more than general OPD. Privacy levels lowest among Delhi	-	Care-seekers found the staff friendly
Study G	-	-	-	Studies conducted in Rajasthan and Delhi found healthcare providers to be inadequately trained

This section summarizes the findings along with the key indicators of adolescent friendliness of the clinics as outlined in the RKSK program. Following this, it briefly discusses the findings in the context of accessibility and availability barriers faced by adolescents.

7.1 On SRH literacy

4 out of the 7 studies reviewed, reported findings on SRH Literacy. They found that adolescents were not adequately literate about their SRH needs. They had misconceptions about contraceptives and sexually active adolescents were not using contraceptives. They also found gender variation in the levels of SRH literacy; with the levels being higher among girls (78%) as compared to boys (29%) in rural areas. The explanation, perhaps, is as the consequences of unprotected sex is higher for a girl as compared to boys, they might be incentivized to seek more information about contraceptives. In addition, the studies found, during consultations at the clinics, the adolescents were hesitant to bring up and discuss SRH issues that bothered them. This, perhaps, is indicative of the stigma surrounding these issues due to the prevalent social and cultural norms. Such norms can be further accentuated by the patriarchal nature of societies, which can lead to a lack of autonomy and empowerment given to adolescents, and ask questions about oneself, which in Indian societies, is due to the stigma surrounding SRH needs.

7.2 On Privacy

5 out of the 7 studies reviewed, reported findings on Privacy. The studies report instances where there was no designated AFHC facility; with adolescents being treated in the general OPDs. In addition, adolescents had concerns about inadequate privacy levels during consultation. However, the privacy levels differed between urban and rural areas, with adolescents from rural areas reporting higher privacy levels. This difference was also seen in different tiers of cities, with adolescents from Delhi reporting lesser privacy levels than those from Chandigarh. This possibly could be due to better implementation of the RKSK program and a lesser caseload in rural areas. The studies also suggest the higher privacy levels in rural areas led to open discussion of SRH needs during consultation leading to higher satisfaction levels among adolescents about the services provided at the AFHC.

7.3 On Respect

3 out of the 7 studies reviewed, reported findings on Respect. The studies report adolescents having to face judgmental and moralistic comments about their behaviour during consultations in the clinic, especially among unmarried women seeking contraceptive measures. However, the evidence provided by the studies is inconclusive as another study reported that the majority of the healthcare providers displayed were friendly and respectful attitudes towards the adolescent care-seekers, which leads to higher satisfaction among adolescents.

7.4 On Competency

6 out of the 7 studies reviewed, reported findings on Competency. The studies report that the healthcare providers at the clinic were not adequately purpose-trained on SRH needs of the adolescents on one hand, and the other in communicating and discussing issues related to these with the adolescents. As a result, adolescents were hesitant in discussing their SRH needs, which may lead to reduced satisfaction levels and SRH Literacy.

The aforementioned problems of privacy and respect can be attributed to the training (or lack thereof) they underwent. This can lead to discomfort during consultation between the provider and adolescent as the providers may not fully understand what the adolescent may be experiencing, and may not be able to help them out effectively. This discomfort may lead to adolescents feeling hesitant to discuss their SRH needs. The prevalence of social stigma surrounding these issues may further accentuate this hesitation. Adolescents need to be able to communicate freely because these problems can get compounded, and would require major interventions at a later stage. Evidence shows that in instances where adolescents were given adequate privacy, they were able to communicate their needs freely, treated with respect, and satisfied with their experience at AFHCs. This also led to higher SRH literacy among them.

The barriers that adolescents face in accessing SRH services can be adequately reduced if providers are purpose-trained. Designated clinics with better privacy would make these services available and acceptable, leading to better access and thus, utilising services. This would, further, lead to an increase in SRH literacy as adolescents would be able to discuss their needs and ask questions freely. In addition, the removal of the stigma surrounding discussions of SRH needs would require a community reorientation, emphasizing their importance. This evaluation suggests adequate training of healthcare providers would drastically improve the utilisation and acceptability of services. Since health is a state subject and the RKSK program is a national level program, its implementation can vary, however, uniform adequate training is important for better satisfaction of adolescents.

8.0 Conclusion

Globally, 1 in 7 people and in India, 1 in 5 are adolescents. Adolescence is a complex transitional period from childhood to adulthood, involving rapid changes in physical, mental and social domains culminating in Sexual and Reproductive maturity. The rapidity leaves adolescents with little time to understand their own SRH needs and the physical and social consequences of

these needs. The prevalent gendered norms and social stigma of the community serve as barriers to awareness of the same, especially of the girls. This makes the girls vulnerable to sexual abuse and violence, both physically and mentally.

To successfully empower and enable adolescents to cope with their SRH needs and the associated vulnerabilities, they require a set of curative and counselling health services. Due to the gendered norms and social stigma, the services provided need to be 'friendly' for adolescents to avail themselves. These adolescent-friendly features include privacy, respect, and non-judgmental and competent healthcare providers. However, to provide adolescent-friendly SRH services there exist several challenges. They could be related to making services available in terms of dedicated clinics staffed by purpose-trained health care workers; and making available services accessible by overcoming barriers related to awareness and acceptability.

The Government of India, in 2014, launched RKSK, a nationwide program with a focus on community-based health promotion and preventive care for adolescents. AFHCs, a key component of the RKSK program, intend to address the SRH needs in an environment perceived to be friendly by adolescents.

This paper aimed to evaluate how friendly these clinics are in practice by reviewing existing empirical literature on the performance of these clinics. The results suggest non-availability of designated AFHCs, and less than adequately trained staff in available AFHCs. The results further suggest, the adolescents have poor awareness about their SRH needs and also have acceptability concerns such as inadequate privacy, disrespectful and judgmental behaviour of health care staff. Similarly, adolescents also seemed hesitant in discussing their needs with providers. In addition, they also show in instances where these concerns were adequately addressed, the adolescents expressed satisfaction with the services and were better informed about SRH needs. Training for healthcare providers should include soft skills such as communicating with adolescents, maintaining their privacy and keeping their conversations in confidence and remaining non-judgmental during consultations. In addition, the training should include a better understanding of the SRH needs of adolescents for the providers to deal with the care-seeker. This would improve the acceptability and hence utilization of services at AFHC clinics. The prevalent social and cultural norms restrict discussions on SRH needs. A comprehensive sex education that helps normalise conversations on SRH needs and makes adolescents comfortable in their skin, is an important tool to empower and enable them to make better choices and be more aware.

Once the healthcare providers have received adequate training, they would be able to impart accurate sex education to adolescents. An important way to include adolescents in the program would be to engage them in the implementation of plans directed towards them for a better response. This would lead to them being involved and they would be wanting to make the program a success.

Thus, making designated AFHC facilities available and providing privacy would be a short-term solution, which is cost-effective and would improve utilisation of SRH services and higher satisfaction. This would further lead to higher satisfaction levels and SRH literacy levels. A medium-term solution to increase access and utilization would be adequate training for healthcare providers. A long-term yet effective solution would be community orientations to sensitise society to the importance of SRH needs and the removal of stigma. To conclude, addressing the SRH needs of adolescents is important to empower adolescents, give them autonomy, and become responsible and productive members of society.

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