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MEANINGFUL PARTICIPATION OF YOUNG PEOPLE IN POLICIES AND PROGRAMMES TO ENSURE ENHANCED ACCESS TO SEXUAL REPRODUCTIVE HEALTH (SRH) INFORMATION AND SERVICES IN INDIA

Pandey A*, Arya N, Tuteja P and Sadiqe S

Policy Engagement, The YP Foundation, India

Abstract: India is home to an estimated 370 million young people, the largest in the world (Census 2011, Population Projections for India and States, 2011 – 2036) making Sexual and reproductive health (SRH) a critical component for ensuring health and well-being of young people thereby contributing to their holistic development. Given the current policy environment in the country, there are only two government programmes namely Rashtriya Kishor Swasthya Karyakram (focuses on adolescents, below age of 18) and Mission Parivar Vikas (focuses on married couples, both over and under the age of 18) with provisions for ensuring access to information and services pertaining to SRH. These programs have an obvious blind spot, with unmarried young people over the age of 18 left out from the service provision. Therefore, the challenge to address the diverse SRH needs of young people still persists. In order to comprehend the obstacles involved in the SRH service delivery for young people, a qualitative assessment was conducted through 90 key informant interviews with health service providers and RKSK programme implementers identified using randomised sampling technique across 10 states. The qualitative data was codified and analysed to highlight the key findings based on the narratives and anthology of the respondent's feedback. The qualitative assessment led by young people highlighted the lack of awareness, staggered access to information among adolescents about the SRH services, low footfall of adolescents at Adolescent Friendly Health Clinics (AFHCs), incompetent and judgemental service delivery by the providers as key findings behind high unmet need of SRH services among young people. Using this data, youth champions across four states supported the government health functionaries in anchoring 6 Adolescent Health and Wellness Days (AHWDs) influencing about 2.5 lac people. This model of ecosystem approach of centering young people's experiences to strengthen, design and deliver programmes ensures sustainability and effectiveness of SRH initiatives

Keyword: young people, sexual reproductive health rights, India, adolescent health, SRH programmes

Introduction

Sexual and reproductive health care programme implementers and providers offer a wide range of services to help young people make educated decisions about their sexual lives. Because these services improve people's quality of life and enable them to exercise their sexual and reproductive rights, they are significant investments with long-term benefits for society and future generations. Numerous studies show sexual reproductive services fall well short of needs in Lower Middle Income Countries (LMICs). Particularly, adolescents have significant unmet requirements as compared to all women of reproductive age who wish to prevent pregnancy. For instance; women aged 15–19 who wish to avoid getting pregnant have a significantly larger unmet need for modern contraceptives (43 percent vs. 24 percent). There are copious obstacles that adolescents must overcome in order to receive contraceptive care, such as social pressure to have a child if they are married or the anxiety of disclosing that they are sexually active in case of unmarried. A million pregnancies among adolescents in LMICs are anticipated to occur annually, half of which are unwanted (Adding It Up, 2019). Among LMIC, India being the world's most

*Corresponding Author's Email: *abhinav@theypfoundation.org*

populated country is currently experiencing a youth bulge that makes it the largest population of youth including adolescents in the globe. Therefore it becomes crucial to ensure the sexual and reproductive health and well-being of more than 253 million adolescents (10-19 years) in the country (Census, 2011). In the recent few decades, the country has witnessed a strong focus on adolescent well-being with significant strides in the improvement of health indicators.

Compared to earlier generations, the development indicators for young people have improved substantially. For instance, early marriage among adolescent girls has reduced from 26.8 percent in 2015-16 to 23.3 percent in 2019-21 while teenage pregnancy (women age 15-19) has declined from 7.9 percent in 2015-16 to 6.8 percent in 2019-21. Additionally, the adolescent fertility rate for women aged 15-19 years has reduced from 51 to 43 in a decade (National Family Health Survey, 2019-2021). Although the above indicators have significantly improved, there is still room for further progress. For instance, the issue of child marriage still persists in many hamlets of the country and India's target of eliminating child marriage by 2030 in alignment with Sustainable Development Goals (SDGs) will require accelerated and concerted efforts. Additionally, there are few other critical areas that need to be addressed including scaling up and improving quality of adolescent friendly health services, enhancing learning outcomes in schools, strengthening mental health programmes and reducing gender based violence especially against girls and young women. (World Health Organisation, 2024)

The national adolescent health programme, Rashtriya Kishor Swasthya Karyakram (RKSK) and School Health and Wellness Programme (SHWP), in India have played a major role in alleviating the challenges faced by adolescents with its strategic framework to bridge these gaps and address the evolving needs of the emerging generation. The facility, community and school based interventions designed under these specific programmes adopts preventive and promotive approach in ensuring health and well-being of adolescents. Despite these comprehensive and well-intended policies and programmes dedicated for adolescents, there are huge gaps when it comes to the implementation of these programmes on ground. Evidence shows that there have been inconsistencies in the training component of RKSK programmes, especially the training of Peer Educators (Sathiyas). Limited number of training sessions, insufficient training duration, lack of uniformity in the training content and poor quality of training are some gaps identified in the RKSK programme implementation. (Jain N et al, 2022)

The Ministry of Health & Family Welfare (MoHFW) and the Ministry of Education (MoE) are working together to deliver national-level training for the SHWP under Ayushman Bharat. Block-level trainers train teachers from each school to be Health and Wellness Ambassadors. These teachers then use interactive activities to teach students about illness prevention and health promotion each week. Among the difficulties in executing the school health program were the need to train a large number of teachers, run the program with just two teachers per school, and deal with the teachers' busy academic calendar. There has always been the scarcity of the resources. It is difficult to train 8.6 million teachers in the government system and that too just in the rural areas. (Jain N et al, 2022)

The absence of a suitable cadre of counsellors and insufficient training programs for counsellors to handle sensitive subjects including mental health, gender-based violence, and sexual and reproductive health (SRH) were among the stated flaws. Because of the lack of privacy, the existence of AFHCs

inside hospitals discourages adolescents from availing these services. Other obstacles that were mentioned were a lack of suitable space, a shortage of competent counsellors, and ignorance of AFHCs. One of the government representatives also shared that "Our counsellors lack the necessary skills to address delicate topics such as sexual reproductive health, mental health, and gender-based violence." (Jain N et al, 2022)

However, it is also an underlying fact that adolescents are not a monolith and homogeneous group and therefore their health needs are diverse. Moreover, given the geographical diversity across the country in terms of political priorities, infrastructure, human resources, socio-economic, cultural and political backgrounds among others, it becomes imperative to tailor the policies and programmes for adolescent health. This requires an evidence-based approach with local solutions and policy recommendations from the adolescents, implementing partners and service providers in addition to drawing the attention of decision makers and programme implementers catering to the emerging needs of adolescents.

Sustained and multi-pronged approaches are needed to address a number of challenges adolescents face such as increased need for access to contraceptive care and sexual & reproductive health information, services, commodities and choices; child, early & forced marriage and childbearing, gender-based violence among others. A range of factors such as poverty, lack of education, inadequate knowledge and limited or no access to basic healthcare services (including SRH), and socio-cultural determinants further aggravate the above issues. These critical factors have not been adequately addressed in the previous researches and studies. Moreover, these studies lack the lived experiences of adolescents and young people. Hence, it is imperative to focus on generating more qualitative evidence and push for its inclusion in the policy designing and formulation processes.

The qualitative study adopted the following objectives:

1. To critically review the current SRH policies and programmes for adolescents/youth to highlight the specific challenges and barriers to SRH service delivery.

2. To collect at least 50,000 responses from adolescents/youth about what they want for their health and well-being.

3. To identify barriers to SRH service delivery by facilitating conversations of young people with SRH programme implementers and service providers.

4. To facilitate young people to lead and anchor at least 5 Adolescent Health and Wellness Days (AHWDs) of RKSK programme in consultation with the district health department.

5. To seek recommendations from health service providers and programme implementers for enhancing youth engagement in SRH programme implementation.

Materials and Methods

In order to advance the health and well-being of adolescents in India, a three pronged strategy was adopted. First approach emphasised on collecting demands from adolescents and youth (16 to 24 years)

about what they want for their health and well-being. It was implemented through the implementation of the global 1.8 billion: Young People for Change campaign in collaboration with the PMNCH in which demands were collected from 53,260 young people including adolescents from more than 12 states/UT. The demands were collected using What Young People Want (WYPW) chatbot (6376) and other offline means (46884). One of the major demands emanated from the process included adolescent/youth friendly health services.

Secondly, in order to comprehend the obstacles involved in the health service delivery for young people especially adolescents, a qualitative assessment was conducted through 90 key informant interviews with health service providers and RKSK programme implementers identified using randomised sampling technique across 10 states of India from all regions of the country.

The below table provides a detailed overview of the geographic distribution of types of health facilities and healthcare workers/service providers identified from 18 districts across the selected states. The states were intentionally identified from all regions of the country to get acquainted with diverse realities and perspectives of the regions.

Table 1: Sample Size: The table provides a comprehensive list of respondents from within the RKSK programme that were identified in consultation with the district health department.

State	District	Type of Health Facility	Type of key informant	No. of key informant
Assam	Golaghat	Adolescent Friendly Health Clinic (AFHC)	Counsellor	2
		Ayushman Arogya Mandir (previously known as Health & Wellness Centre)	Community Health Officer (CHO)	1
		Health Sub-Centre	ASHA Workers	2
	Jorhat	AFHC	Multipurpose Counsellor	2
		Primary Health Centre (PHC)	ASHA Workers	1
			Community Doctor	1
			ANM	1
	Rohtas	District Hospital	ANM	1
		Youth Health Centre	Counsellor	1
			District Health Officer	1

Bihar	Nawada	Government Hospital	ASHA Worker	1
		Anganwadi Centre	Anganwadi Worker	1
		Community Health Centre (CHC)	Medical Officer	1
			ANM	2
			ASHA Worker	1
		Health & Wellness Centre	CHO	1
Haryana	Panchkula	PHC	Senior Medical Officer	1
			ANM	1
			Medical Officer and AFHC Supervisor	1
			Counsellor	1
		District Hospital	District Nodal Officer	1
Himachal Pradesh	Shimla	Zonal Hospital	District Programme Officer	1
			Medical Officer	1
			Social Worker	1
		Shimla and Solan	District RKSK Coordinator	1
		Kumarsain Health Centre, Shimla	ASHA Worker	1
		CHC	ANM	1
		PHC	ASHA Worker	1
		District Hospital	Counsellor	1
		Office of Civil Surgeon	District RKSK Coordinator	1

Jharkhand	Dumka	AFHC, CHC	Block Programme Manager	1
		Sub-divisional hospital	ANM	1
		PHC	Sahiya (ASHA Worker)	3
	Bokaro	Health & Wellness Centre	CHO	1
Karnataka	Dakshin Kannada	Sneha Clinic (AFHC)	ASHA Worker	1
			CHO	1
			Counsellor	1
			Medical Officer	1
	Vijaynagar	Government Hospital	Medical Officer	1
			ANM	1
			ASHA Worker	1
			CHO	1
			Medical Officer	1
			AFHC Counsellor	1
Madhya Pradesh	Rajgarh	Sub-Health Centre	ANM	2
			CHO	2
			ASHA Worker	1
		Anganwadi Centre	Anganwadi Worker	1
		District Hospital	Medical Officer	2
			AFHC Counsellor	2
		CHC	Counsellor	1
			Nodal Officer	1

Nagaland	Wokha	Adolescent Reproductive Sexual Health (ARSH) Centre	ASHA Worker	1
		AFHC	Counsellor	1
	Kohima	ICTC	Counsellor	1
		AFHC	Counsellor	1
			Medical Officer	1
		District Hospital	Counsellor	1
	Kiphire	AFHC	GNM	1
	Mone	AFHC	Counsellor	1
Rajasthan	Jaipur	Anganwadi Centre	Anganwadi Worker	3
		Urban - Primary Health Centre	ANM	1
			GNM	2
		Health & Wellness Centre	CHO	1
			Medical Officer	1
		SMS Hospital	Counsellor	1
		CHC	CHO	1
Uttar Pradesh	Lucknow	CHC	ASHA Worker	1
			ANM	1
			GNM	1
		Centre of Excellence for Adolescent Health & Development (Model AFHC)	Counsellor	1
			Nodal Officer	1
	Varanasi	Sub-Health Centre	ANM	1
			ASHA Worker	1
			CHO	1

	CHC	Family Welfare Counsellor	1
	District Hospital	Counsellor	1

The type of key informants included the following:

- Medical Officer/Doctor - 12
- AFHC/Family Welfare/Multipurpose/ICTC Counsellor - 21
- Community Health Officer - 10
- ASHA Workers - 16
- ANM/GNM - 17
- Anganwadi Workers - 5
- Nodal/Programme/Health Officer - 5
- District RKSK Coordinator - 2
- Block Programme Manager – 1
- Social Worker - 1

These interviews delved deeper into key topics of Sexual and Reproductive Health and Rights (SRHR), seeking to grasp the ground realities within the existing adolescent health programmes like RKSK and SHWP focussing on the Adolescent Friendly Health Clinics (AFHC) and other affiliated facilities crucial for adolescent health and well-being. The qualitative data was codified and analysed to frame the findings based on the narratives and anthology of the respondent feedback.

Third and the final approach was evidence based action that was undertaken based on the insights and nuanced realities on ground shared by the health service providers and programme implementers. As a part of this process, 9 on-ground campaigns and 6 Adolescent Health and Wellness Days (AHWD) were organised. The AHWDs took place in 2 districts each of Nagaland and Assam and other two in the states of Himachal Pradesh and Haryana with the support from district health departments. AHWDs are an integral component of the RKSK and SHWP to promote awareness among adolescents on their health and well-being issues. This qualitative work captures the data and lived experiences collected by our youth champions. The insights from this evidence generation process and focussed action highlights the key findings, challenges, and recommendations.

Figure 1: AHWD celebration, Jorhat, Assam

Figure 1: AHWD celebration, Panchkula, Haryana

Figure 3: AHWD celebration, Wokha, Nagaland

Figure 4: AHWD, Shimla, Himachal Pradesh

Figure 5: AHWD celebration, Golaghat, Assam

Figure 6: AHWD celebration, Kiphire, Nagaland

Data Analysis

Data analysis involved a dual approach, using coding for qualitative responses to identify recurring themes and patterns in the in-depth interviews carried out by the youth champions, while applying statistical analysis for quantitative data to assess thematic wise understanding on What Young People Want. Qualitative data coding was done systematically on an excel sheet to categorise responses based on recurring patterns of perspectives and insights shared by the respondents, while quantitative analysis will include descriptive statistics to summarise findings. This approach allowed for a comprehensive understanding of barriers to young people's engagement in SRH programs by combining depth with measurable insights.

Results and Discussion

The key informants held diverse positions and educational backgrounds within the healthcare domain. This diversity proved to be instrumental in understanding holistic overview of the multifaceted issues and challenges faced by the service providers in delivering the health services particularly the SRH. Through these engagements, we endeavoured to gain insights into the operational dynamics of the RKSK program, with a specific focus on its implementation within AFHCs and associated healthcare settings. Discussions spanned a broad spectrum, including awareness on the services, access to services, quality of care, community engagement, policy gaps, and the socio-cultural context influencing adolescent health outcomes.

The analysis of the narratives and feedback from respondents revealed the following key findings:

All respondents underscored that as mandated the primary health care services provided at the AFHCs include nutrition, immunity from common illness, diabetes, psychosocial health, control of communicable disease, delivery services, also provide services and counselling for sexual and reproductive health including pre-marital counselling. The commodities include menstrual products, medicines, IFA tablets, condoms, and emergency contraceptive pills.

Just over one-sixth respondents shared that they are actively engaged with sexual reproductive health services including contraceptives and counselling to the adolescents that visit the facility.

On an average in a month, 24 adolescents are counselled by the counsellors/service providers at the health centre which makes it to just about one-sixth of the total target of 150 adolescents.

A pervasive judgmental attitude from health service providers deters young people from seeking SRH services. This includes stigmatisation and moral policing, particularly towards unmarried youth seeking contraception and other SRH services.

Culture and patriarchy still play a significant role in the utilisation of these services. Many healthcare professionals reported that decisions regarding accessing healthcare services are often made by men, leaving women largely dependent on them. Adolescent girls typically seek services primarily for menstrual issues, while adolescent boys rarely utilise these services.

> *"Majority of staff members of the health facility are known to the families of the adolescents in the community so they do not visit the clinic to avail contraceptive and reproductive health services due to the fear of being judged" (Counsellor, Nagaland)*

More than half respondents highlighted that the adolescents that visit the centre seek services around anaemia, menstruation, vaginal (white) discharge, nutritional deficiencies, anxiety and depression. SRH services are limited to menstrual hygiene management, and prevention of HIV/STD.

More than half respondents reported that their interaction with adolescents/youth happens mostly during group counselling sessions during field visits or during sessions in schools or awareness campaigns.

About all respondents shared that among adolescents that visit the AFHC clinics, are either married adolescents or menstruating girls. Boys and especially unmarried adolescents rarely visit the clinics.

> *"In the tea garden community of Assam, early and unintended pregnancy is a major concern among adolescents and youth as they lack adequate information and knowledge to address the challenges. Majority of the women from this community are anaemic because they drink tea with salt" (Counsellor, Assam)*

More than half respondents raised a concern that adolescents often rely on the internet and untrusted sources for information regarding their sexuality and reproductive health, which can be misleading.

A little less than half respondents also shared that they are overloaded with multiple responsibilities that leads to reduced focus on adolescents and youth.

> *"To ensure confidentiality and privacy, we maintain "Grievance boxes" at the clinic and answer the questions of the adolescents once a week" (Medical Officer, Madhya Pradesh)*

The issues and needs among adolescents regarding contraceptives mostly included "which methods of contraception are better and safer to use."

The roles played by parents, teachers, and religious leaders often act as barriers between service providers and adolescents. Healthcare professionals report that these factors prevent them from providing direct services to adolescents. As a result, adolescents tend to visit clinics only when the situation becomes critical.

These barriers and obstacles contribute to an increased unmet need for contraception and other SRH services especially among young people, impacting their overall health and well-being.

These findings from the qualitative assessment underscore the critical gaps in the current SRH service delivery and programme implementation mechanisms in the country. Despite the existence of dedicated government programs like RKSK, and SHWP for adolescents, and Mission Parivar Vikas (MPV) for reproductive age group, there remains a substantial portion of the young population, particularly unmarried individuals over the age of 18, who are left out of the service provision. This oversight highlights the need for more inclusive policies that address the diverse needs of all young people.

While AFHCs offer a broad range of services, only a fraction of adolescents, particularly regarding SRH services, are actively utilising them. This points to a need for stronger outreach and education efforts to bridge awareness gaps and encourage service uptake among youth. The dearth of awareness and staggered access to SRH information further aggravates the situation and pose significant threats that need to be addressed through comprehensive educational initiatives and outreach programs.

The judgmental attitudes of health service providers pose a considerable barrier to the uptake of SRH services. This results in undermining adolescents' willingness to seek SRH services, particularly contraception. Addressing this requires intensive sensitivity training for healthcare providers to foster a nonjudgmental, inclusive environment, crucial for building trust with young clients. There is a dire

need for sensitization and training of healthcare providers to foster a non-judgmental, supportive, and youth-friendly environment. This can help in building trust and encouraging young people to seek the services they need without any fear of stigma or discrimination.

With healthcare access heavily influenced by gender norms and patriarchal dynamics, especially where men control healthcare decisions, programmes should be tailored to incorporate the needs of the diverse community. Educating families, and particularly involving male family members, could help in reshaping norms around adolescent healthcare access.

With counsellors reaching only one-sixth of the target adolescent population monthly, there's a clear indication of resource inadequacies. Strengthening the staffing and outreach capacities of AFHCs could improve service reach, ensuring a larger proportion of adolescents receive the intended counselling and support.

The initiative led by youth champions across four states, influenced about 2.5 lakh people through the implementation of AHWDs and on-ground campaigns, demonstrates a promising model. By centering young people's experiences and leveraging support from local authorities, this ecosystem approach can effectively enhance the design and delivery of SRH programs. Such models should be scaled up and integrated into the existing government initiatives to ensure their sustainability and effectiveness of the programmes designed for young people.

Policy Recommendations

The current SRHR policy landscape needs a revamp especially within the Rashtriya Kishor Swasthya Karyakram (RKSK) to expand SRH service delivery for young people aged 19 to 29, regardless of marital status, to address the evolving health needs of India's youth population. Currently, SRH services under RKSK primarily benefit adolescents up to 19 years, often leaving out critical age groups navigating similar challenges in reproductive health, contraception, and mental health as they transition into adulthood. Expanding the program's scope to include this older age bracket would ensure that unmarried young adults have equitable access to essential services, such as contraceptives, family planning, STI testing, and counselling. This inclusive approach acknowledges that SRH needs do not end at adolescence and that young people require continued support and nonjudgmental services to make informed choices, maintain good health, and mitigate risks associated with reproductive health.

Ensure competency-based, periodic training for healthcare providers, with a focus on Interpersonal Communication (IPC) to effectively address adolescent health issues within SRHR services. Such training should go beyond basic information dissemination and medical knowledge to incorporate the latest, evidence-based approaches for engaging with adolescents sensitively and effectively, especially around topics that can be stigmatised, like contraception and mental health. Regular training sessions would refresh providers' knowledge of evolving SRHR guidelines and enhance their interpersonal skills, enabling them to communicate clearly, listen actively, and create a safe, nonjudgmental environment for adolescents. By fostering trust and understanding, competency-based training empowers healthcare providers to better meet the unique emotional and informational needs of young clients, improving service uptake and overall health outcomes.

Adopt national quality standards at Adolescent-Friendly Health Clinics (AFHCs) at the primary and secondary levels of the public health system to ensure consistent, high-quality services across regions. This entails enforcing standardised protocols and best practices that align with the specific SRH needs of adolescents, including comprehensive counselling services that are both accessible and non-judgmental. By integrating these standards, AFHCs can offer tailored counselling and care, covering crucial areas like contraceptive guidance, mental health support, and preventive health education. Ensuring regular training for counsellors and monitoring adherence to quality standards will help build a trustworthy and supportive environment, ultimately improving service utilisation and health outcomes for adolescents.

Promote evidence-based, locally tailored solutions that centre adolescents' lived experiences in health program implementation so that it actively incorporates their real-world challenges and preferences into program design and delivery. By directly engaging adolescents and gathering data on their unique needs, health programs can develop interventions that resonate with local cultures, address specific barriers to access, and align closely with young people's daily realities. This approach not only makes services more relevant and trusted but also allows for ongoing, data-driven adjustments based on adolescent feedback, ensuring that programs remain responsive and effective in meeting evolving SRH needs.

Increase the budget for the Rashtriya Kishor Swasthya Karyakram (RKSK) and Sexual Health and Wellness Programs (SHWP) for enhancing their reach and effectiveness. This funding boost would allow for the expansion of adolescent-friendly health clinics, improved training for healthcare providers, and targeted outreach initiatives to raise awareness about available services. Additionally, it would facilitate the integration of innovative solutions, such as telehealth, to better serve youth in underserved areas, ultimately promoting improved health outcomes and reducing disparities among young people.

Mandate the implementation of the School Health and Wellness Programme (SHWP) in both private and government schools for promoting the holistic well-being of adolescents and ensuring equitable access to health education and services. This initiative would establish a standardised framework across all educational institutions, ensuring that students receive consistent, evidence-based information on sexual and reproductive health, mental health, nutrition, and physical well-being. Implementing SHWP in all schools would contribute to reducing health disparities, promoting healthy behaviours, and supporting the overall development of young people as they navigate critical life stages.

Strengthen inter-ministerial coordination and convergence beyond the health sector to address the multifaceted needs of young people effectively. By fostering collaboration among ministries such as education, women and child development, youth affairs and sports, and social empowerment and justice, comprehensive strategies can be developed that integrate health, education, and socio-economic support. This holistic approach ensures that programs are not only health-focused but also consider factors like access to education, employment opportunities, and mental well-being, ultimately creating an ecosystem that supports young people's overall development and empowerment.

Adopt a hyper localised approach in the implementation of IEC and SBCC activities in vernacular languages to effectively convey messages and information related to SRH services in indigenous and marginalised communities.

Leverage digital technologies and effective communication strategies through chatbot, tele counselling or text message services to enhance SRH service delivery for adolescents and youth while safeguarding their privacy and ensuring confidentiality.

Conclusion

Addressing the unmet SRH needs of young people in India requires a multi-faceted approach that includes policy reforms, educational initiatives, community engagement and attitudinal changes among service providers. By adopting an inclusive and youth-centred framework, it is possible to significantly improve the health and well-being of young people especially adolescents within the current adolescent health policy landscape, contributing to their holistic development and the broader socio-economic progress of the country. This model of ecosystem approach of centering young people's experiences in programme implementation process to strengthen, design and deliver programmes will ensure sustainable and effectiveness of government initiatives to ensure higher uptake of SRH services among young people for their health and well-being. The country is undergoing a phase of demographic dividend so the time is apt that young people should be considered as equal stakeholders when it comes to designing and implementing policies and programmes that are relevant to them.

Scope for further research

Future research should focus on specific areas to enhance understanding and impact within SRH programs for adolescents. Conducting longitudinal studies would be valuable for assessing the long-term effects of program modifications on primarily the service utilisation, attitudes towards SRH, and health outcomes. Additionally, comparative studies across diverse cultural and socio-economic contexts could shed light on how varying local dynamics influence program efficacy. Further research could also be explored around the impacts of targeted sensitivity training for providers, examining shifts in provider attitudes and their effects on adolescent engagement with services. By expanding into these areas, future studies could offer clearer, evidence-based recommendations for advancing SRH program delivery and engagement.

Limitations of Study

This study faced several limitations that may affect the generalizability of its findings.

Sample Size and Diversity: The sample size, though representative, was limited, which may not fully capture the diversity of adolescent experiences across different regions and cultural backgrounds.

Self-Reported Data: The reliance on self-reported data could introduce response bias, as participants may underreport or overreport their engagement with SRH services.

Short-Term Focus: This study offers a snapshot of current conditions without long-term follow-up, limiting insight into the evolving impact of SRH program changes.

Provider Perspectives: Perspectives from healthcare providers were only partially included, leaving room for further exploration of how provider attitudes and training affect service delivery.

Addressing these limitations in future research could provide a more comprehensive understanding of factors influencing adolescents' access to SRH services.

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Acronyms and Abbreviations

ANM- Auxiliary Nurse Midwife

ASHA - Accredited Social Health Activist

AWW - Anganwadi Worker

AFHC - Adolescent Friendly Health Clinics

AHWD - Adolescent Health & Wellness Days

CHO - Community Health Centre

ICTC - Integrated Counselling and Testing Centre

LMIC - Low Middle Income Countries

MPV - Mission Parivar Vikas

PMNCH - Partnership for Maternal Newborn and Child Health

PHC - Primary Health Centre

CHC - Community Health Centre

RKSK - Rashtriya Kishor Swasthya Karyakram

SHWP - School Health & Wellness Programme

SRH - Sexual Reproductive Health

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