

Original Research Article

Awareness of adolescent friendly health clinics among youth in Western Rajasthan: a pilot study

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ABSTRACT

Background: Adolescent Friendly Health Clinics (AFHCs) were established to address the unique health needs of adolescents, offering services related to physical, mental, and reproductive health. However, limited awareness among youth may hinder their utilization. The objective was to assess the level of awareness regarding AFHCs among adolescents and to sources of information among adolescents regarding AFHCs.

Methods: A cross-sectional pilot study was conducted among 50 adolescents from a school in Barmer district, Rajasthan, using a structured questionnaire. Data were analyzed using descriptive statistics to evaluate awareness and its sources.

Results: Only 28% of participants were aware of AFHCs. Teachers were the most common source of information (18%), followed by healthcare workers (6%) and family members (2%). The majority of adolescents had no knowledge of AFHCs (72%), despite having educated parents and access to schools.

Conclusions: Awareness about AFHCs among adolescents remains critically low. Targeted interventions involving schools, healthcare providers, and families are essential to bridge this gap.

Keywords: Adolescent health, Awareness, AFHC, RKSK, Adolescent, Rajasthan

INTRODUCTION

Adolescence is a transformative phase marked by a multitude of physical, psychological, emotional, and social changes. It is a period of intense growth and development that lays the foundation for a healthy and productive adult life.^{1,2} Recognizing the unique needs, the Government of India under the National Adolescent Health Programme (Rashtriya Kishor Swasthya Karyakram-RKSK) has established Adolescent Friendly Health Clinics (AFHCs). These clinics aim to provide adolescents with access to holistic, confidential, and youth-friendly healthcare services. AFHCs offer a range of services including counseling, treatment of minor ailments, nutritional advice, menstrual hygiene

management, sexual and reproductive health services, and mental health support.³⁻⁵

Despite the availability of such dedicated services, their utilization by adolescents remains suboptimal. One of the major barriers to accessing AFHCs is lack of awareness about their existence and the range of services offered. Without adequate knowledge, adolescents may continue to rely on informal or unreliable sources for their health concerns, or worse, may not seek help at all. Therefore, assessing awareness levels becomes critical for improving adolescent health outcomes. This study seeks to evaluate the awareness of AFHCs among adolescents and to explore the relationship between awareness and socio-

demographic variables such as age, gender, education, and family background.⁶⁻⁸

Need for the study

The Government of India's initiative to set up AFHCs under RKSK was a major step forward in addressing these gaps by offering specialized, adolescent-centric services in a non-judgmental and confidential environment. However, for these services to make a meaningful impact, adolescents must first be made aware of them.⁵

Lack of awareness about AFHCs hinders service utilization, which in turn affects the physical, mental, and social development of adolescents. While AFHCs are present in many parts of the country, anecdotal evidence and program reviews suggest that utilization rates are low. In rural and semi-urban areas, awareness levels are even more limited due to poor outreach, low health literacy, and social stigma.¹²⁻¹⁴

Given this context, it becomes crucial to evaluate how well-informed adolescents are about the existence and functions of AFHCs. Understanding this will help in designing better health education campaigns and outreach strategies. The findings from this study will not only guide the main research project but also offer preliminary insights for policymakers and healthcare professionals aiming to strengthen adolescent health programs. This study was conducted to assess the level of awareness regarding AFHCs among adolescents and the sources of information among adolescents regarding AFHCs.

METHODS

The present study employed a cross-sectional research design to assess the awareness of AFHCs among adolescents. This pilot study was conducted as a preliminary step toward a larger main research project, with the goal of testing the feasibility, clarity of tools, and practicality of the study processes. A sample of 50 adolescents was selected using a convenience sampling technique from a single school located in Barmer district, Rajasthan from January 2024 to February 2024. The inclusion criteria consisted of adolescents aged between 11 to 19 years, representing both early and late adolescence and the community adolescents were excluded in the study.

Before initiating data collection, ethical approval was obtained from the Institutional Ethics Committee of AIIMS, Jodhpur, Rajasthan. Additionally, formal permission was secured from the Chief Medical and Health Officer (CMHO), Barmer, ensuring compliance with all administrative protocols.

Data were collected using a pre-tested structured questionnaire comprising both closed and open-ended

questions. The questionnaire was divided into two main sections:

Socio-demographic profile

This included variables such as age, gender, religion, parental education and occupation, and type of family.

Awareness of AFHCs

This section included items measuring awareness about the existence, services, and sources of information regarding AFHCs.

Data collection was conducted in a classroom setting with prior written consent from parents and written assent from the participants were comfortable and their confidentiality was maintained. Once the data were collected, they were cleaned, coded, and entered into statistical software for analysis.

The findings from this pilot study helped identify gaps in adolescent knowledge about AFHCs and guided necessary modifications to the data collection tool for the main study.

RESULTS

50 adolescents were selected using a convenient sampling technique from a single school located in Barmer district, Rajasthan. The study included a total of 50 adolescents aged between 11 and 19 years. The age distribution showed that 36% of the participants were in the 11-14 years age group, while 64% belonged to the older adolescent group of 15-19 years. This indicates a higher representation of late adolescents in the study. In terms of gender distribution, 44% of the respondents were male, whereas 56% were female, suggesting a slightly greater participation of female adolescents. Regarding religious background, 94% of the participants identified as Hindu, while 6% were Muslim, highlighting that the majority of the sample belonged to the Hindu community. 38% mothers had no formal education, while 62% had completed primary or higher education. This suggests that a significant proportion of mothers had received some level of formal schooling. However, when it came to occupation, 86% of the mothers were housewives, whereas only 14% were engaged in paid work, indicating that most mothers in the study were primarily homemakers (Table 1).

The educational background of the fathers showed that 16% had no formal education, whereas 84% had completed at least primary or higher education. This suggests a relatively higher literacy level among fathers compared to mothers. In terms of occupation, 66% of the fathers were skilled workers, making up the majority of the working-class respondents. Additionally, 22% were unskilled workers, and 12% were engaged in farming. This distribution indicates that a significant proportion of

fathers were involved in skilled labor, contributing to household income through various occupations.

Family structure analysis revealed that 72% of the adolescents came from nuclear families, while 28% belonged to joint families. The predominance of nuclear families reflects the shifting trends in household structures, where smaller family units are becoming more common.

Overall, the socio-demographic profile of the adolescents in this study highlights a predominance of late adolescents, a slightly higher proportion of female participants, and a majority of Hindu respondents. The educational levels of parents, especially fathers, were relatively high, though most mothers were homemakers. Additionally, skilled labor was the most common occupation among fathers, and nuclear families were the dominant family structure in the sample.

Table 1: Sociodemographic profile of adolescents (n=50).

Socio-demographic profile	Frequency (N)	Percentage (%)
Age of adolescent (in years)		
11-14	18	36
15-19	32	64
Gender		
Male	22	44
Female	28	56
Religion		
Hindu	47	94.
Muslim	3	6.0
Mother's education		
No formal education	19	38
Primary and higher education	31	62
Mother's occupation		
Working	7	14
Housewife	43	86
Father's education		
No formal education	8	16
Primary and higher education	42	84
Father's occupation		
Farmer	6	12
Unskilled worker	11	22
Skilled worker	33	66
Type of family		
Nuclear family	36	72
Joint family	14	28

Table 2: Awareness of AFHCs among adolescents (n=50).

Awareness of AFHCs	Frequency (N)	Percentage (%)
Yes	14	28.0
No	36	72.0

Table 3: Sources of information about AFHCs (n=50).

Source of Information regarding AFHC	Frequency (N)	Percentage (%)
No Information	36	72
Health care worker	3	6
Teacher	9	18
Family member	2	2

Table 2 shows the awareness of AFHCs among adolescents. The findings revealed that only 28% (14 out of 50) of the participants were aware of AFHCs, while the

remaining 72% (36 out of 50) had no knowledge of these health facilities.

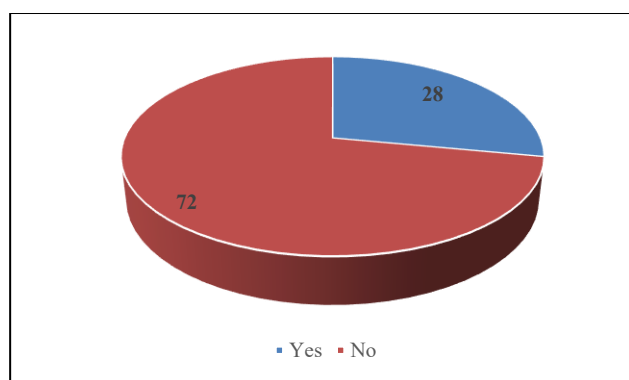


Figure 1: Awareness of AFHCs among adolescents.

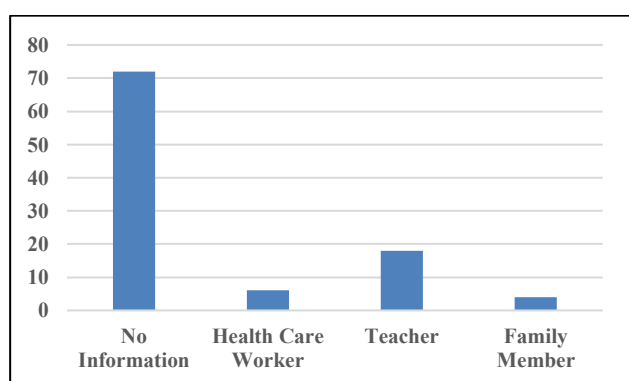


Figure 2: Source of Information regarding AFHC among adolescents.

The low level of awareness suggests a significant gap in the dissemination of information regarding AFHCs. Despite the presence of these clinics, a majority of adolescents remain uninformed about their existence and services. This lack of awareness may be attributed to limited outreach, inadequate health education in schools, and sociocultural factors that prevent open discussions about adolescent health needs (Figure 2).

Table 3 shows the sources from which adolescents received information about AFHCs. The findings indicate that a majority of the respondents (72%) had no information about AFHCs, further reinforcing the low awareness levels observed in the study. This suggests a significant gap in communication and outreach efforts regarding these healthcare facilities.

Among those who had heard about AFHCs, teachers emerged as the most common source of information, accounting for 18% of the responses. This highlights the critical role educational institutions and school-based health programs play in disseminating knowledge about adolescent healthcare services. Schools serve as an essential platform for promoting health awareness, and strengthening school-based interventions could help bridge the existing knowledge gap.

Health care workers contributed to spreading awareness among 6% of the respondents. This relatively low figure indicates that healthcare professionals, who are key stakeholders in adolescent health promotion, may not be sufficiently engaged in educating young individuals about AFHCs. Strengthening the role of health workers in community outreach programs and school health initiatives could enhance awareness levels. Only 2% of the adolescents reported receiving information from a family member (Figure 2).

DISCUSSION

Only 28% of adolescents in our study were aware of AFHCs, highlighting a significant gap. This low level of awareness is consistent with studies conducted across India. Kumar et al in Haryana found that only 26.5% of adolescents were aware of AFHCs, indicating limited outreach. Similarly, Meena et al in Rajasthan reported 30% awareness, attributing the low levels to minimal adolescent-specific IEC (Information, Education and Communication) activities and limited engagement by health workers.¹⁵⁻¹⁷

In our study, the majority of adolescents (64%) belonged to the 15-19 age group, with slightly more females (56%) than males (44%). This is consistent with findings from a study by Sinha et al conducted in Uttar Pradesh, where a higher proportion of late adolescents participated, and females were slightly more represented, possibly due to greater involvement in school-based interventions for girls. 72% of adolescents came from nuclear families aligns with Patel et al who noted a rise in nuclear family settings in urban and semi-urban India, driven by urban migration and changing social dynamics.^{18,19}

Parental education levels especially the higher percentage of fathers with formal education (84%) corroborate with a study by Garg et al which showed that paternal education is often higher in semi-urban Indian populations and is significantly associated with better health-seeking behavior among adolescents.¹⁷

Despite a relatively educated parental background, awareness levels remained low. This suggests that factors beyond parental education, such as outreach programs and community engagement, play a crucial role in disseminating information about AFHCs. The low awareness highlights the necessity of targeted health education programs, school-based awareness campaigns, and active parental involvement. The government and non-governmental organizations should work together to promote these clinics more effectively.

In our study, teachers were the most common source of information (18%), followed by healthcare workers (6%) and family members (2%). A large majority (72%) had no source of information at all. This pattern is consistent with findings by Sharma et al who found that schools were the most cited source of AFHC information among

adolescents, but the overall awareness remained low. Rani and Singh reported that peer educators and healthcare workers played a limited role, primarily due to poor training and low outreach intensity under RKSK. The minimal role of healthcare workers and family members echoes the conclusions of Nair et al who emphasized the need for community-level sensitization programs to better integrate parents and frontline health workers into adolescent health promotion efforts.²⁰⁻²²

Only 2% of the adolescents reported receiving information from a family member. This suggests that discussions regarding adolescent health services within families are minimal, possibly due to cultural taboos or lack of awareness among parents and guardians themselves. Encouraging open conversations about adolescent health within families and equipping parents with the necessary knowledge could significantly contribute to increasing awareness. Overall, the findings highlight a pressing need to improve information dissemination about AFHCs through multiple channels. Enhancing school-based awareness programs, increasing community engagement by health workers, and encouraging parental involvement in adolescent health discussions are crucial steps toward ensuring that more adolescents become aware of and utilize these essential health services.

Limitations

This pilot study includes its execution at a single setting and its small sample size. While these are limitations inherent to its design, this pilot study was conducted to test the feasibility of the research and inform the methodology for a future, larger-scale study.

CONCLUSION

The findings highlight a pressing need to improve awareness of AFHCs among adolescents. Strategies such as school-based awareness programs, community engagement, and social media campaigns should be employed to bridge the knowledge gap and encourage greater utilization of adolescent-friendly health services. Ensuring that adolescents have the necessary knowledge about these clinics will contribute to better health outcomes and overall well-being.

Recommendations

Schools should integrate health education sessions focusing on AFHC services. Parental Involvement: Educating parents about AFHCs can enhance adolescent health-seeking behavior.

Strengthening government initiatives to promote AFHCs through mass media campaigns and school health programs.

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Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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