



CHILD & ADOLESCENT HEALTH OUTCOMES



FMS

Gates Foundation

AUTHORS:

Prof (Dr.) A Venkat Raman
Prof Anabel B Bara
Dr. Warisha Mariam
Dr. Ruby Gloria Barla
Dr. Arushi Singhal
Dr. Priyanka Arora
Dr. Tabassum Khan
Dr. Sharadindu Kadali

Copyright and Disclaimer

Copyright © (YEAR) Confederation of Indian Industry (CII) and Women Collective Forum (WCF). All rights reserved.

Without limiting the rights under the copyright reserved, this publication or any part of it may not be translated, reproduced, stored, transmitted in any form (electronic, mechanical, photocopying, audio recording or otherwise) or circulated in any binding or cover other than the cover in which it is currently published, without the prior written permission of CII and WCF.

All information, ideas, views, opinions, estimates, advice, suggestions, recommendations (hereinafter 'content') in this publication should not be understood as professional advice in any manner or interpreted as policies, objectives, opinions or suggestions of CII and WCF. Readers are advised to use their discretion and seek professional advice before taking any action or decision, based on the contents of this publication. The content in this publication has been obtained or derived from sources believed by CII and WCF to be reliable but CII and WCF do not represent this information to be accurate or complete. CII and WCF do not assume any responsibility and disclaim any liability for any loss, damages, caused due to any reason whatsoever, towards any person (natural or legal) who uses this publication.

This publication cannot be sold for consideration, within or outside India, without express written permission of CII and WCF. Violation of this condition of sale will lead to criminal and civil prosecution.

Published by

Confederation of Indian Industry (CII), The Mantosh Sondhi Centre; 23, Institutional Area, Lodi Road, New Delhi 110003, India, Tel: +91-11-45771000; Email: info@cii.in; Web: www.cii.in; and

Women's Collective Forum, C/o Ugraya Agro Farm Pvt Ltd At Post Shrugartalital Guhagar Ratnagiri Maharashtra India 415703; ; Email: richa.sharma@womenscollectiveforum.com; Web: womenscollectivforum.org

Foreword

The health and wellbeing of India's children and adolescents are the reflection of our nation's strength and promise. In every young life, whether in the cities or the farthest villages, there lies untold potential for progress, innovation, and resilience. As a society, our greatest responsibility is to ensure that our children and adolescents have the opportunity to thrive.



This report, collaboratively developed by the Women's Collective Forum (WCF), Confederation of Indian Industry (CII), and the Faculty of Management Studies, University of Delhi (FMS), is not merely a compilation of data and recommendations. It is a call to action for every policymaker, educator, health worker, and family member and to recognize that health is not an isolated goal, but a continuum, determined by nutrition, education, psychosocial support, and gender equity. As someone who has seen first-hand the impact of community engagement and empowerment across India, I believe that real change is born of collective will and the courage to challenge deep-rooted barriers.

We know the challenges. We have seen them, in the persistence of anemia, the rising tide of non-communicable diseases, the silent crisis of adolescent mental health, and the inequities that keep girls from reaching their full potential. But we also know what it takes to overcome them: commitment, clarity of purpose, and the willingness to build bridges between government, industry, and civil society.

This report offers a thoughtful synthesis of evidence-based strategies and a blueprint for multisectoral action. I urge all stakeholders to look beyond the numbers - to the faces and futures of the millions whose lives we seek to transform. Let us strengthen systems, fortify our frontline workers, and champion innovations that reach the most vulnerable and create a healthier, more equitable, and empowered future for the nation.

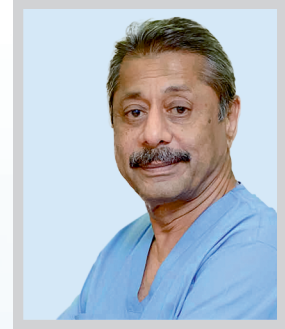
Smriti Z. Irani

Chairperson, Alliance for Global Good
Gender Equity and Equality and
Advisor, Women's Collective Forum

Foreword

Improving Child and Adolescent Health Outcomes

The health and wellbeing of children and adolescents are foundational pillars of any nation's progress. India has made considerable advances in reducing child mortality and addressing malnutrition; yet as this comprehensive report underscores, the challenges faced by our young population extend far beyond these gains. Issues spanning mental health, communicable and non-communicable diseases, and equitable access to quality care demand a strategic, multisectoral response.



Developed collaboratively by the Women's Collective Forum, Faculty of Management Studies (FMS), University of Delhi, and Confederation of Indian Industry (CII), this white paper offers a forward-looking, evidence-based roadmap to transform child and adolescent health outcomes. Anchored in a life-course approach and leveraging innovations in digital health, policy convergence, and community engagement, it articulates a vision where every young person is empowered to thrive, resilient and healthy.

This report is both a call to action and a guide for policymakers, healthcare practitioners, and civil society alike. It reminds us that investing in the holistic development of young Indians is not merely a health imperative, it is an economic and social priority vital for realizing India's demographic dividend and sustainable development goals.

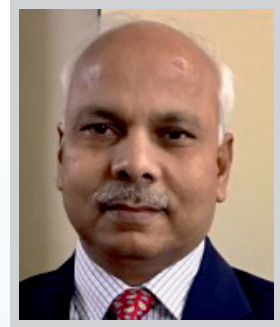
I commend the collaborative effort behind this analysis and invite all stakeholders to engage with its insights and recommendations. The future of India depends on the health and potential of its children and adolescents. By acting decisively and inclusively today, we can build a healthier, more equitable society tomorrow.

Dr. Naresh Trehan

Chairman, CII Steering Group on Health and CII Healthcare Council
Chairman and Managing Director, Medanta – Medicity

Foreword

As the Dean of the Faculty of Management Studies (FMS), University of Delhi, it's my privilege to introduce this white paper on 'Child and Adolescent Health Outcomes'. This document is a piece of hard work and true reflection of the passion and dedication of our faculty and the students. This white paper addresses one of the most important challenges facing our country right now- the health and well-being of our children and adolescents.



For a country that is soon to be the third largest economy of the World, the health of our children continues to be a cause of concern. However, their health isn't just a matter of public policy, but a collective responsibility. This paper reiterates the importance of urgently addressing the challenges our children and adolescents face, such as malnutrition, mental health and the gaps in our healthcare system. The paper offers a helpful, yet actionable path forward. The recommendations are thoughtful and grounded, urging all stakeholders to support in creating a health system that focuses on people centric, preventive approach for better health outcomes among children and adolescents. The paper also focuses on bringing young people to the table and encouraging collaboration across different sectors

I express my deep appreciation and gratitude to everyone who contributed to this work. This project truly embodies our mission here at FMS: to create knowledge that not only lives in academic journals but also inspires real, meaningful change in our communities. I believe this white paper will become a valuable resource for anyone who shares our commitment to building a better India.

Professor (Dr.) A. Venkat Raman

Dean,
Faculty of Management Studies, University of Delhi

Table of Contents

Executive Summary	07
Introduction:	10
Investing in India's Future- Prioritizing Child and Adolescent Health Outcomes for Sustainable Development	
Methodology	11
Current Health Status Challenges: Landscape and Regional Disparities	13
Nutrition	
Communicable Diseases	
Early Child Development	
Injuries and Violence	
Impact of Child and Adolescent Health Challenges: Measure of Public Health Indicators	20
Policy Framework and Program Implementation	23
National Health Policy (2017) and National Education Policy (2020)	
Early Childhood Development (ECD)	
Rashtriya Bal Swasthya Karyakram (RBSK)	
Rashtriya Kishor Swasthya Karyakram (RKSK)	
Other Important Policy Initiatives	
Strategic Priority Driven	
Nutritional Programme For Adolescents	
Malnutrition	
Poshan Abhiyaan – Anemia Mukta Bharat – Pm Poshan	
Communicable Diseases	
Universal Immunization Programme (UIP)	
Mental Health	
Evidence-Based Policy Recommendations	42
Conclusion	47
References	48

EXECUTIVE SUMMARY

Children and adolescents constitute both India's present responsibility and its future strength. Their health is inseparable from the country's long-term development, labour productivity, and social resilience. Indian health policy has made meaningful strides. Guided by the **RMNCAH+N** strategy under the National Health Mission, India has embraced a life-cycle approach that integrates reproductive, maternal, newborn, child, and adolescent health with nutrition as a cross-cutting priority. But beneath that progress, systemic gaps and emerging threats persist—and demand coordinated, insightful action.

Government-led progress is real and structural. Initiatives such as Rashtriya Bal Swasthya Karyakram (RBSK) and Rashtriya Kishor Swasthya Karyakram (RKSK)¹ have enhanced early screening, preventive care, and adolescent health services. The **POSHAN Abhiyaan**, now consolidated under **Saksham Anganwadi & Poshan 2.0**, has been instrumental in addressing stunting, undernutrition, and anemia by promoting community-based monitoring, convergence mechanisms, and behaviour change communication.¹ Within this framework, the Scheme for Adolescent Girls (SAG) plays a critical role: it provides nutritional supplementation while simultaneously offering non-nutritional interventions such as health check-ups, referral services, life-skills education, vocational guidance, and nutrition counselling. Complementarily, Mission Indradhanush and its intensified versions have significantly raised immunization coverage across hard-to-reach populations.² Furthermore, the School Health Programme under the Ayushman Bharat initiative has contributed to improved health literacy and screening in educational institutions.³

These achievements provide a strong foundation, and the next phase requires consolidating gains while addressing evolving priorities. Undernutrition and anemia remain significant, even as rising childhood overweight and obesity point to new risks of metabolic disease. This dichotomy is particularly pronounced in urbanizing contexts and portends increased risk of metabolic disorders later in life. Communicable diseases such as tuberculosis, HIV, and other sexually transmitted infections remain prevalent among adolescents due to inadequate awareness and social taboos surrounding sexual health. **Mental health has also emerged as a critical fault line.** Depression, anxiety, and suicide are increasingly reported among adolescents, but stigma and limited psychosocial infrastructure inhibit early identification and care. Expanding access to adolescent-friendly mental health services will be essential to safeguard wellbeing in this age group. These parallel burdens highlight the urgent need to address both “old” and “new” threats within a unified health strategy.

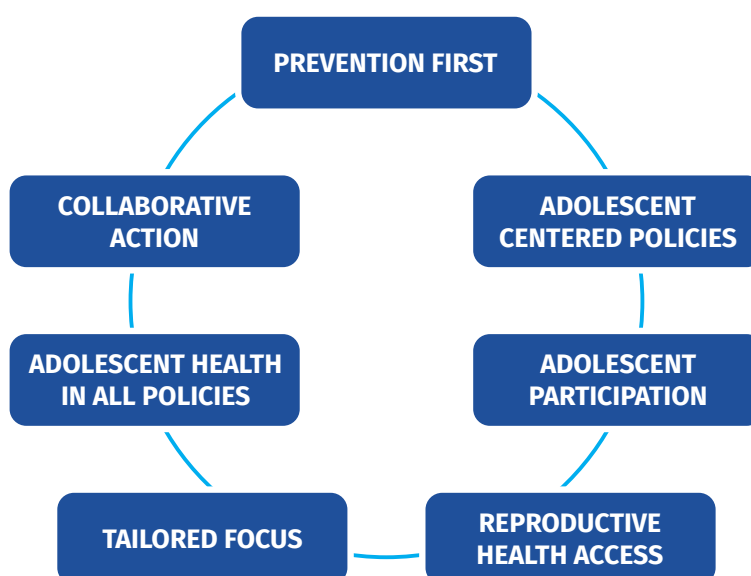
Improving access and service experience is equally critical. Adolescents often face difficulties navigating health systems, concerns around confidentiality, and barriers created by costs, stigma, or restrictive legal frameworks. Health workers, while technically skilled, also require additional training in engaging effectively with adolescents and families in ways that build trust and encourage care-seeking.

Early childhood development (ECD) continues to need reinforcement. Coverage and quality, especially in the first 1,000 days, remain uneven. Teenage pregnancy, often associated with child marriage and limited reproductive health education, continues to affect maternal and neonatal outcomes. Patterns of substance use, road traffic injuries, and gender-based violence further influence adolescent health, calling for stronger prevention and referral systems.⁴ Road traffic injuries and gender-based violence further compound the public health burden, with adolescents disproportionately affected due to limited enforcement of legal safeguards and weak referral pathways.

The task ahead is to consolidate and extend the RMNCAH+N approach. The framework is in place; the opportunity now lies in strengthening implementation, integrating emerging priorities, and ensuring convergence across sectors such as education, nutrition, social protection, urban development, and digital access. A transformative shift toward prevention-first, adolescent-centered, and equity-driven health systems is urgently warranted. Moreover, child and adolescent health must be embedded as a cross-cutting theme within all policy domains—from urban planning and education to digital access and climate resilience.

Strategic investments in these areas yield high returns. A healthier generation of children and adolescents translates into stronger learning, enhanced workforce productivity, and inclusive economic growth. Notably, the global Sustainable Development Goals (SDGs), particularly SDG 3 (“Ensure healthy lives and promote well-being for all at all ages”), underscore the imperative to address adolescent health as a cornerstone of sustainable development. The global adolescent health strategy advocates for equity, resilience, and participation, aligning closely with India's evolving health policy landscape.⁵

Strategic Policy Recommendations



Key Actionables

Focus Area	Key Partners	Proposed Actions
Prioritize Prevention and Wellness	Ministry of Health and Family Welfare; Public Health Systems	<ul style="list-style-type: none"> • Shift health system focus from treatment to prevention and wellness. • Align incentives across ministries to reduce preventable diseases, anemia, and adolescent years of life lost (YLL).
Reorient Measurement Towards Outcomes	National and State Health Departments	<ul style="list-style-type: none"> • Adopt consolidated outcome metrics across flagship schemes, including supplementation adherence, immunization coverage, referral completion, adolescent anemia prevalence, and YLL reductions. • Enable real-time monitoring and data-driven course corrections.
Institutionalize Adolescence as Policy Focus	Ministry of Youth Affairs; RKSK; Civil Society	<ul style="list-style-type: none"> • Develop adolescent-specific policies addressing nutrition, mental health, sexual/reproductive health. • Establish and strengthen youth advisory boards, peer-led feedback, and digital grievance redressal to engage adolescents as partners.
Strengthen Reproductive Health Access and Education	Education Departments; Health and Nutrition Programs	<ul style="list-style-type: none"> • Expand family planning and reproductive health service accessibility. • Integrate comprehensive sexual and reproductive health education into school curricula.
Tailor Programming to Urban and Rural Realities	Urban Development; Rural Health Services	<ul style="list-style-type: none"> • Customize health programming for unique urban and rural health challenges, including sanitation, hygiene, and chronic diseases.
Embed Child and Adolescent Health in All Policies	Urban Planning; Education; Digital Access; Climate Resilience	<ul style="list-style-type: none"> • Integrate health considerations across sectors including urban mobility, schooling, digital services, and environment to promote holistic wellbeing.
Strengthen Convergence and Partnerships	State and District Governments; Civil Society; Private Sector	<ul style="list-style-type: none"> • Foster joint planning, shared accountability, and integrated delivery mechanisms. • Engage civil society, academia, and the private sector in expanding outreach and innovation.
Enhance Service Delivery for Child and Adolescent Health	Health Facilities; Training Institutes	<ul style="list-style-type: none"> • Redesign facilities to ensure adolescent-friendly, confidential, age-appropriate integrated physical, mental, and nutritional health services. • Strengthen workforce capacity for adolescent engagement and holistic care.
Improve Data Systems, Research and Innovation	Health Informatics; Research Institutes	<ul style="list-style-type: none"> • Develop shared data platforms and analytics for integrated, disaggregated, actionable insights. • Transition from activity-based counting to outcome-oriented monitoring.

INTRODUCTION

Investing in India's Future—Prioritizing Child and Adolescent Health Outcomes for Sustainable Development

India is undergoing a demographic transition, with an increasing proportion of the population in the working age group (15–64 years).⁷ This shift necessitates policies that prioritize the health of young people to maximize the demographic dividend and support economic development. With almost 253 million individuals in the age group (10–19) years i.e. one-fifth the population, it is imperative to invest in this demographic dividend, for leveraging India's economic growth and competitiveness.^{8,9,10,11} This demographic advantage can only be realized if the health and developmental needs of these young people are adequately addressed.

The health situation of young people reflects both progress and persisting vulnerabilities. Mortality indicators have improved and service coverage has expanded through national programmes. However, India still faces significant challenges with 36% of children under five being stunted, 17% underweight, and 6% being wasted, despite improvements in Infant Mortality rates (IMR) across most states.⁶ Among adolescents, challenges extend beyond nutrition to include mental health concerns, substance use, road injuries, gender-based violence, and reproductive health risks. According to the **National Crime Records Bureau (2022)**, self-harm is one of the leading causes of death among adolescents below 18 years, with more than ten thousand such deaths recorded in that year. This underscores the urgency of strengthening adolescent mental health services and preventive interventions.³

Different stages of growth require distinct policy focus. The first 1,000 days and under-five years shape lifelong health, cognitive ability, and learning potential.¹² The school-going years (6–14) consolidate this foundation and prepare children for productive adult roles. Adolescence (10–19) is a decisive stage for nutrition, reproductive health, and psychosocial wellbeing, with implications for both individual trajectories and the broader demographic dividend.

Prioritising these groups delivers long-term benefits for the economy and society. Firstly, investing in child and adolescent health enhances productivity by ensuring a healthy workforce in the future.¹⁰ Secondly, it contributes to social development by reducing inequalities and promoting equitable access to education and healthcare.¹³ Lastly, it supports economic development by fostering a skilled and resilient population capable of driving economic growth.^{10,11}

India has already established comprehensive frameworks such as the Rashtriya Kishor Swasthya Karyakram (RKSK) and the Rashtriya Bal Swasthya Karyakram (RBSK) to respond to these needs. However, uneven implementation and resource constraints—particularly in rural and underserved areas—limit their effectiveness.¹⁴

This policy paper builds on that foundation. It reviews the critical issues shaping child and adolescent health in India, highlights areas where policy attention is most needed, and provides evidence-based recommendations to guide strategic investment. The goal is to consolidate gains, address emerging challenges, and accelerate progress toward the **Sustainable Development Goals (SDGs)**.

METHODOLOGY

This policy paper has provided various dimensions of child and adolescent health in India. We began by establishing a clear understanding of "child and adolescent health" within a global context, aligning with SDG targets. Following this, we analysed the demographic context of India, emphasizing the specific significance of its adolescent population and the criticality of investing in early childhood development and the health of under-five and school-going age groups. This paper articulates a robust rationale for prioritizing these specific age cohorts.

This paper intends to demonstrate how early childhood interventions in their developmental stages act as a strategy to enhance future productivity, social progress and economic development for India. The following are the methodology followed for this policy paper to make it a compelling case for policy interventions and resource allocation that strategically prioritize child and adolescent health in India's journey towards a sustainable growth.

Stakeholder Consultation: Stakeholder consultations involved semi-structured discussions with including:

- **Policymakers:** From the Ministry of Health and Family Welfare and state health departments.
- **Program Managers:** Implementing national child and adolescent health programs at national and state levels.
- **Clinicians and Public Health Experts:** Working in primary healthcare, adolescent health clinics, and community health settings.
- **NGO Representatives:** Organizations working directly with adolescents and communities on health and development issues.
- Consultations focused on understanding program implementation challenges, identifying best practices on the ground, barriers and challenges and gathering expert opinions on policy gaps and potential solutions were identified.

Literature Review: A comprehensive literature review was conducted using electronic databases such as PubMed, Cochrane Library, and Google Scholar. Search terms included combinations of keywords like 'child health', 'adolescent health', 'India', 'programs', 'interventions', 'National Health Mission', 'nutrition', 'mental health', 'communicable diseases', 'sexual health', 'reproductive health', 'policy', and 'best practices'. We prioritized peer-reviewed articles published in reputable journals and policy documents from international organizations like WHO and UNICEF and guidance documents of various national health programs focussing child and adolescent health in India.



Secondary Data: Secondary data was primarily sourced from publicly accessible datasets and government reports, including:

- **National Family Health Survey (NFHS):** For comprehensive data on child and adolescent health indicators, nutrition, and health service utilization. (NFHS-V)
- **Sample Registration System (SRS):** For vital statistics like IMR, NMR, and U5MR.
- **Health Management Information System (HMIS):** For program implementation data and service delivery statistics.
- **Program Evaluation Reports:** Government reports evaluating specific national programs like RKSK, RBSK, and POSHAN Abhiyaan. (NITI Aayog reports, Ministry of Health and Family Welfare reports like Annual Health Survey, UNFPA document on adolescent health, National Crime Records Bureau Reports and Press Information Bureau)

Critical Analysis: We critically assessed program effectiveness by considering:

- **Equity:** Whether programs are reaching the most vulnerable and marginalized populations.
- **Effectiveness:** Resource utilization and cost-effectiveness of interventions.
- **Sustainability:** Long-term viability and integration into the health system.
- **Relevance:** Alignment of programs with the evolving health needs of children and adolescents in India.
- **Coverage:** Extent of program reach, and quality of services delivered.



01

**Current Health Status
Challenges: Landscape
and Regional Disparities**



Nutrition

India has made steady progress in addressing malnutrition, with national surveys showing measurable improvements over the past decade. Between NFHS-4 (2015–16) and NFHS-5 (2019–21), stunting reduced from 38.4% to 35.5%, wasting declined from 21% to 19.3%, and underweight prevalence fell from 35.7% to 32.1%. These gains demonstrate the impact of large-scale government programmes, particularly POSHAN Abhiyaan and its continuation under Poshan 2.0, which have strengthened convergence, improved monitoring, and placed nutrition at the centre of policy discussions.

At the same time, progress has been gradual, and data highlight the importance of consolidating and accelerating these efforts. The POSHAN Tracker (2023–24) indicates that out of 85.7 million children under six, 36% are stunted, 17% underweight, and 6% wasted, consistent with national survey reports. Such chronic malnutrition is driven by deprivation, food insecurity, and poor dietary diversity, compounded by gaps in healthcare access. Urgent, multisectoral strategies—especially those improving maternal health and early childhood development—are needed to address these inequities.

Regional experiences illustrate both challenges and opportunities. States such as Uttar Pradesh (46.4%), Lakshadweep (46.3%), Maharashtra (44.6%), and Madhya Pradesh (41.6%) continue to report higher levels of child stunting. Acute malnutrition (wasting) peaks in Lakshadweep (13.2%), followed by Bihar (9.8%) and Gujarat (9.2%). Underweight prevalence is greatest in Madhya Pradesh (26.2%) and Dadra & Nagar Haveli and Daman & Diu (26.4%). By contrast, Goa (stunting 5.8%, wasting 0.9%, underweight 2.2%), Sikkim, and Ladakh have achieved far lower rates. This variation highlights the value of sharing and scaling successful state-level practices, while tailoring interventions to address local socio-economic contexts.

Adolescence is a second window of opportunity for growth and nutrition. Yet nutritional challenges during this stage remain persistent and complex. Anemia continues to be highly prevalent among Indian adolescents, especially girls, largely due to iron deficiency and menstrual blood loss. According to NFHS-5 (2019–21), over 59% of adolescent girls aged 15–19 years are anaemic, reflecting both dietary insufficiencies and gaps in health education and service delivery.¹⁶ Anemia impairs growth, cognitive ability, and increases risks in pregnancy, perpetuating multi-generational disadvantage.¹⁶ Simultaneously, adolescents especially in urban areas face rising overweight and obesity due to sedentary lifestyles and processed foods, exposing them to the “dual burden” of malnutrition – presenting a significant threat to public health and places considerable strain on India's healthcare system.



This dual burden fuels an increase in non-communicable diseases such as type-2 diabetes and cardiovascular conditions, while also damaging immune and cognitive development further eroding educational and lifetime economic potential.

The economic impact is significant: While malnutrition alone is estimated to reduce GDP by 8–10% in certain global contexts, India incurs an estimated loss of approximately 4%, a figure that may rise further with the emerging challenges of obesity-related disorders. Research suggests that \$1 spent on nutritional interventions in India could generate \$34.1 to \$38.6 in public economic returns - three times more than the global average.¹⁷ These figures underscore the value of sustained investment in nutrition.

The way forward is to build on existing gains through integrated, life-course nutrition strategies.¹⁸ The complex interplay of genetic predisposition and environmental influences further complicates prevention and intervention efforts. Strengthening maternal health, expanding dietary diversity, improving early childhood services, and addressing adolescent nutrition—including anemia prevention and healthy lifestyle promotion—will help ensure that progress achieved so far translates into lasting gains for future generations.

Communicable Diseases

Adolescents continue to face a disproportionate burden of communicable diseases, despite declining national trends in infections overall. HIV, sexually transmitted infections (STIs), tuberculosis (TB), hepatitis, and respiratory infections remain key contributors to adolescent morbidity and school absenteeism. According to HIV Estimations 2017, prevalence among adolescents (10–19 years) is estimated at 0.22%, a figure that closely parallels adult rates (0.25% for males and 0.19% for females), and highlights the persistence of new infections in the adolescent population despite declining national trends (MoHFW, 2017). TB and viral hepatitis similarly continue to contribute to adolescent morbidity, while acute respiratory infections remain a leading cause of clinic visits and absenteeism in this demographic.¹⁹

Government programmes have created a strong platform for action. RKSK and its associated Adolescent Friendly Health Clinics (AFHCs) are central to the national strategy for HIV/STI prevention and care among adolescents, providing confidential counseling, testing, and referral services. The National Tuberculosis Elimination Programme (NTEP) increasingly prioritizes early case detection and awareness-building in adolescents, leveraging both school- and community-based interventions. The School Health and Wellness Programme under Ayushman Bharat and the National Strategic Plan for HIV/AIDS and STI (2017–2024) further broaden the base of adolescent outreach through literacy campaigns, peer educators, and routine screenings.



However, service uptake and coverage remain below potential. Utilisation of AFHCs for HIV and STI testing is consistently lower than projected, and awareness of TB symptoms and treatment pathways is uneven, particularly in rural and marginalised communities. Constraints stem from limited provider training, shortages in resources, and stigma that prevents adolescents from seeking timely care.

The next step is to strengthen both systems and communities. On the systems side, investment in provider capacity, reliable diagnostics, and supply chains will be critical. On the community side, reducing stigma, expanding peer-led outreach, and engaging families will help create an enabling environment. Public-private partnerships can complement these efforts by extending reach and coverage.

Robust monitoring of measurable indicators will ensure accountability and progress. Tracking adolescent HIV testing rates, TB screening completion, and STI clinic attendance will provide actionable insights to adapt interventions quickly. With stronger implementation and deeper engagement, India can consolidate its gains and accelerate the reduction of communicable disease risks among adolescents.

Early Child Development

The first 1,000 days are decisive for lifelong health and productivity, and India has embedded this window as a national priority. The launch of POSHAN Abhiyaan (2018) and its consolidation into Mission Poshan 2.0 (2021) has reinforced focus on high-burden districts, community mobilisation, and accountability. By merging with Supplementary Nutrition under ICDS, the initiative has expanded coverage and brought greater visibility to early childhood nutrition. The programme has also actively driven participatory “Jan Andolans” at the grassroots, mobilising communities to adopt better nutrition and care practices (MoWCD, 2022). Complementary efforts such as Anemia Mukt Bharat and Surakshit Matritva Aashwasan (SUMAN) strengthen maternal and newborn health.

A historic innovation has been the launch of the Anganwadi Protocol for Divyang Children (PIB 2023). For the first time in India's policy landscape, Anganwadi workers have been formally empowered to enhance nutritional care through early identification of developmental delays and disabilities in children. This step not only expands the scope of community-based care but also signals a new era of inclusivity in early childhood development.

Service reach has improved, but quality and equity challenges remain. Regional disparities in malnutrition, last-mile delivery barriers, and workforce capacity constraints continue to undermine effectiveness (MoWCD, 2023; NFHS-5). The next step is to strengthen delivery while sustaining gains. To fully realize the potential of these flagship interventions, urgent reforms are needed to address inter-state inequities, strengthen frontline worker training, and guarantee universal integrated early childhood services—thereby sustaining child health gains, improving cognitive outcomes, and breaking the cycle of intergenerational poverty (NFHS-5).

Adolescent Sexual and Reproductive Health

Adolescent pregnancy remains a pressing challenge with implications for maternal and child health. Accounting for over 7% of all births nationwide and contributing to maternal mortality rates that are significantly higher for adolescent mothers than adults; infants born to these mothers face increased risks of stillbirth and early mortality (MoHFW, 2021). The primary drivers are high child marriage prevalence, low contraceptive knowledge, and incomplete sexuality education. For example, fewer than 20% of adolescents demonstrate comprehensive knowledge of contraception, while more than a quarter of Indian women are married before age 18 (NFHS-5).

Targeted programmes have achieved measurable impact. The Menstrual Hygiene Scheme (MHS) demonstrated a 42% rise in school attendance among menstruating girls in Maharashtra. Similarly, the RSKS peer educator model (Saathiyas) currently reaches over six million adolescents annually, delivering SRH information, subsidized sanitary pads, and confidential counselling through Adolescent Friendly Health Clinics (AFHCs) and community platforms (MoHFW, 2023; MoE, 2022). The UDAAN initiative embeds life-skills based SRH education in schools across several states, fostering positive norms and informed choices.

However, gaps limit progress. Provider training is inconsistent, social stigma inhibits care-seeking, and curriculum integration remains incomplete. The priority ahead is to normalise adolescent SRH services and education. Embedding age-appropriate SRH modules in all school curricula, expanding AFHC reach in underserved areas, and using digital platforms for confidential outreach will reduce adolescent pregnancy and safeguard sexual and reproductive rights (UNICEF, 2021).

Adolescent Mental Health

Mental health conditions are widespread among adolescents, yet remain under-diagnosed and under-treated. Globally, 10–20% of adolescents have diagnosable mental health conditions, and in India, suicide is a significant contributor to mortality among ages 10–19 (WHO; NCRB, 2023). Meta-analytic evidence documents similar rates of depression and anxiety among rural female and male adolescents, with elevated social anxiety in girls—a pattern that should inform gender-responsive and context-tailored interventions (Mathew et al., 2022).

Policy frameworks provide a strong base but remain underutilised. The National Mental Health Programme (NMHP) and its District Mental Health Programme (DMHP) extend specialist services to districts. Tele-MANAS offers 24/7 multilingual tele-counselling, and Manodarpan provides psychosocial support to students. In addition, school-based health and wellness initiatives under Ayushman Bharat have created platforms for awareness and early identification. Collectively, these programmes reflect strong policy intent to mainstream adolescent mental health.



Despite these initiatives, delivery and uptake remain limited. Coverage under DMHP is uneven, with many districts lacking adolescent-specific modules. Referral pathways from schools to formal mental health services are incomplete, and utilisation of Tele-MANAS is low, particularly due to limited adolescent-focused content and awareness. Stigma continues to discourage help-seeking, especially in rural areas and among girls.

The way forward is to align scale with need. India must expand school-based mental health programmes, formally integrate digital platforms with peer-led and community outreach, and require suicide prevention protocols in all adolescent health services. Only then can the mental health crisis and its long-term social and economic consequences be systematically addressed.

Adolescent Substance Use

Early substance use among adolescents is rising, increasing long-term risks of dependence and ill-health. About 8.5% of Indian students aged 13–15 report current tobacco use, with rising early exposure to alcohol and psychoactive drugs—a trend that increases risk for persistent dependence, psychiatric disorders, and violence (GYTS, 2019; AIIMS/MoHFW, 2019). Early substance use is a major amplifier of adolescent NCD, mental health, and injury burden.

India’s policy response has broadened significantly. National policy responses include Nasha Mukta Bharat Abhiyaan (NMBA), now active in 272 high-burden districts, and the COTPA Amendment Rules (2020), banning loose cigarette sale near schools. The National Action Plan for Drug Demand Reduction (NAPDDR) and Ayushman Bharat’s school health modules further broaden outreach and awareness training (MoSJE, 2023).

Yet adolescent-specific services remain limited. Few age-appropriate rehabilitation services, patchy screening at adolescent clinics, and persistent stigma reduce both early detection and continuity of care.

The way forward is to integrate adolescent substance-use prevention into mainstream health systems. Scaling adolescent-centric rehab facilities, integrating substance-use screening into all AFHCs, and embedding credible prevention and harm reduction modules in the School Health and Wellness Programme will be critical. Adequate, ring-fenced budget allocations, routine monitoring, and destigmatization campaigns are needed to realize meaningful, sustained reductions in youth substance abuse and its consequences.



Injuries and Violence

Injuries and violence constitute significant yet often under-addressed contributors to adolescent morbidity and mortality in India. Road traffic injuries remain a prominent cause of death among adolescents, linked to underage driving, limited use of helmets and seatbelts, and weak enforcement of safety laws. Gender-based violence (GBV) disproportionately affects adolescent girls, with UNICEF data indicating significant prevalence of partner violence and sexual coercion among those aged 15–19. These risks have long-term implications for physical health, psychosocial wellbeing, and educational attainment.

India has taken strong steps to address these issues. The One Stop Centre (OSC) Scheme, launched in 2015 by the Ministry of Women and Child Development, provides integrated medical, legal, psychosocial, and shelter support to women and girls affected by violence. Currently, 812 centres have been operationalised nationwide (PIB, 2025), with growing efforts to ensure adolescent-friendly access and confidentiality. Complementing this, the Childline 1098 helpline offers 24/7 emergency assistance for children in distress, facilitating immediate rescue, referral, and protection, including for victims of abuse and trafficking (MoWCD, 2025)

The School Health and Wellness Programme, introduced under Ayushman Bharat (2018), incorporates health promotion modules on safe behaviour, injury prevention, and emotional well-being. Delivered by trained Health and Wellness Ambassadors, the programme addresses issues such as bullying, violence, and road safety within the school environment, fostering awareness and early intervention.

Efforts to reduce adolescent injury and violence in India must be multi-pronged. Combining legal enforcement, public awareness, school-based education, psychosocial services, and community mobilisation. Strengthening existing frameworks such as RKSK, OSCs, and Call 1098, while integrating restorative justice approaches and adolescent-friendly reporting mechanisms, is crucial. Equally important is the need for **integrated multi-sectoral collaboration** among health, education, and law enforcement agencies to address the root causes of violence and provide responsive support systems for affected adolescents.



02

Impact of Child and Adolescent Health Challenges: Measure of Public Health Indicators



India's child and adolescent health indicators show clear progress, but disparities remain. The infant mortality rate (IMR) currently stands at 26.6 per 1,000 live births in urban areas and 38.4 in rural regions, reflecting a significant rural–urban divide (NFHS-5, 2021). While national surveys indicate overall declines in IMR, progress is uneven across states, with lagging improvements in populous regions such as Maharashtra and Bihar. The differential is rooted in uneven healthcare access, service quality, and social determinants, underscoring the need for tailored interventions targeting rural and underserved populations.

Among adolescents, the disease burden remains substantial. Among adolescents aged 10–19, the disease burden measured by Disability-Adjusted Life Years (DALYs) is substantial and comparable between sexes, with a slight increase in older adolescents (15–19 years) (GBD India, 2019). Crucially, a large share of this burden arises from Years of Life Lost (YLL) due to premature mortality rather than Years Lived with Disability (YLD). Leading causes of adolescent YLL include injuries—particularly road traffic crashes, drowning, and self-harm—and communicable diseases such as diarrhoea, respiratory infections, tuberculosis, and hepatitis.

Policy frameworks provide a strong starting point but could be more closely aligned with the burden profile. Current programmatic focus under the Integrated Adolescent Health Strategy (IAHS) and the network of Adolescent Friendly Clinics (AFHCs) primarily addresses sexual and reproductive health (SRH) and nutrition. However, these domains are more aligned with reducing YLD, leaving a substantive gap in interventions tackling the major causes of adolescent death (YLL). For instance, injuries constitute a predominant portion of adolescent YLL but receive disproportionately low attention within IAHS and AFHC service delivery frameworks, which are yet to sufficiently incorporate injury prevention and management or comprehensive communicable disease control.

The broader consequences extend beyond health outcomes. They impose significant economic strain through high out-of-pocket expenditures (OOPE) and productivity losses, estimated to cost India a notable percentage of GDP annually (World Bank, 2020). Additionally, poor child and adolescent health exacerbate social inequities, perpetuating intergenerational cycles of poverty and limiting human capital development crucial for workforce readiness and national competitiveness aligned with Sustainable Development Goals (SDGs).

The way forward is to build on existing successes while broadening scope. National health policy must realign program scope and investment priorities to comprehensively target leading causes of adolescent mortality alongside disability. Emphasizing cross-sector collaboration, scaling injury prevention, enhancing communicable disease interventions, and integrating equity-focused measures are imperative steps. Such a strategy promises not only reductions in YLL and YLD but also disruption of the poverty–ill-health cycle fundamental to India's inclusive development trajectory.



Category	Age Group	Sex	Total DALYs (approx.)	% of DALYs from YLLs	Major Contributors to YLLs	Focus of IAHS/AFHC	Gaps in IAHS/AFHC	Data Gap in HMIS
Overall Disease Burden	10-14 years	Female	6.75 million	~ 39%		Primarily SRH & Nutrition	Under-addresses fatal conditions	No age/sex disaggregated cause of death data
	10-14 years	Male	6.71 million	~ 42%		Primarily SRH & Nutrition	Under-addresses fatal conditions	No age/sex disaggregated cause of death data
	15-19 years	Female	9.25 million	~ 44%		Primarily SRH & Nutrition	Under-addresses fatal conditions	No age/sex disaggregated cause of death data
	15-19 years	Female	9.65 million	~ 41%		Primarily SRH & Nutrition	Under-addresses fatal conditions	No age/sex disaggregated cause of death data
Leading YLL Causes	15-19 years	Male	-	65.9% of YLLs	Injuries: Road Injuries, Self-harm	Limited Injury Focus	Significant Gap: Injuries (Road,others), Communicable/ NCDs (Diarrhea, LRIs, Malaria, TB etc.)	No age/sex disaggregated cause of death data
	15-19 years	Male	-	45.3% of YLLs	Injuries:	Limited Injury Focus (Self-harm & GBV only)	Significant Gap: Injuries (Road,others), Communicable/ NCDs (Diarrhea, LRIs, Malaria, TB etc.)	No age/sex disaggregated cause of death data
	10-14 years	Male	-	40.8% of YLLs	Injuries: Drowning, Road Injuries	Limited Injury Focus	Significant Gap: Injuries (Drowning, Road, other), Communicable/ NCDs (Diarrhea, LRIs, Malaria, TB etc.)	No age/sex disaggregated cause of death data



03

Policy Framework and Program Implementation

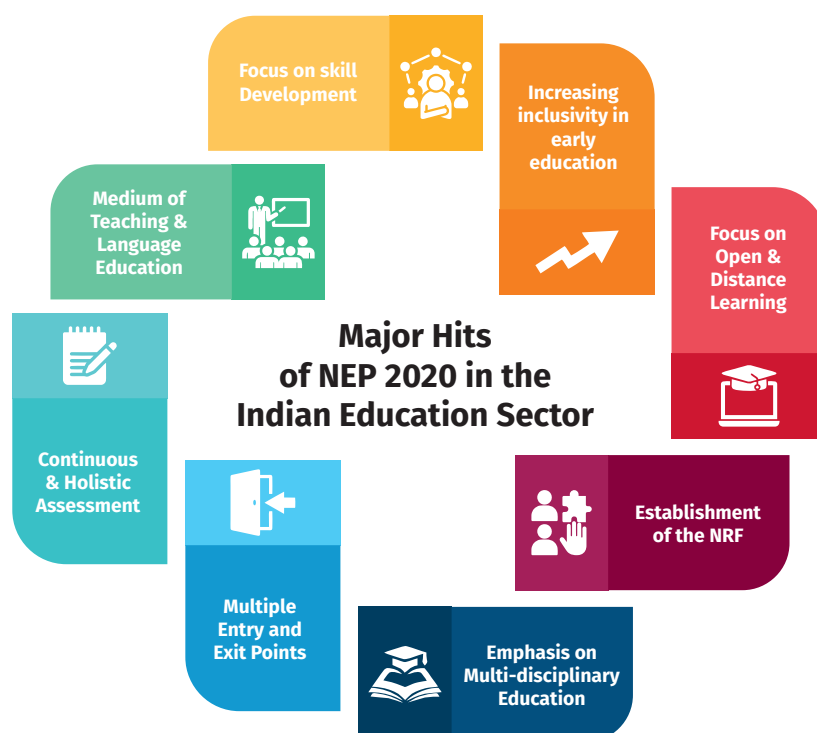


National Health Policy (2017) and National Education Policy (2020)

Together, the National Health Policy (NHP) 2017 and the National Education Policy (NEP) 2020 provide a comprehensive framework for advancing child and adolescent health and development in India. Together, they underscore a multisectoral, life-course approach to child and adolescent development. They recognise health and education as interdependent pillars—essential for preparing India's youth to meet future societal and economic challenges.

The NHP 2017, formulated after extensive stakeholder consultations, responds to India's evolving socio-economic, technological, and epidemiological context by prioritizing preventive and promotive healthcare, with a commitment to increasing public health expenditure to 2.5% of GDP by 2025 (MoHFW, 2017). It aims to enhance health outcomes for children and adolescents through strengthening primary care infrastructure—transforming Primary Health Centres (PHCs) into Health and Wellness Centres (HWCs)—and integrating health education within schools. The policy explicitly supports the focus areas including nutrition, sexual and reproductive health, mental health, injury prevention, and substance misuse.

Complementing these objectives, NEP 2020 introduces transformative educational reforms emphasizing holistic development from early childhood onward (Ministry of Education, 2020). It promotes social-emotional learning (SEL), mental health support, and life skills education within an inclusive and adaptive curriculum framework, thereby addressing critical determinants of adolescent health and wellbeing. NEP's focus on equity includes prioritizing access for girls, disabled children, and socio-economically disadvantaged groups, while leveraging technology and culturally sensitive pedagogy to enhance reach and impact, especially in rural and tribal areas.



NEP 2020 Focus Area	Policy Provisions	Impact on Health Outcomes
Social-Emotional Learning (SEL)	Integration of SEL into curriculum through value-based education, life skills, and experiential learning	Improves emotional regulation, reduces anxiety and behavioural issues, lowers risk of adolescent substance use and violence
Mental Health and Well-being	Establishment of school-based support systems for early identification and care of emotional/psychological concerns	Enables timely intervention for mental health issues; reduces long-term risks like depression, self-harm, and adolescent pregnancy
Holistic Development	Focus on physical, emotional, ethical, and cognitive growth	Builds resilience and empathy; improves interpersonal relationships at home and in school; contributes to better hygiene, nutrition, and health-seeking behaviour
Equity and Inclusion	Prioritises access to education for girls, children with disabilities, and socio-economically disadvantaged groups	Delays early marriage, improves menstrual and reproductive health awareness, reduces gender-based health disparities
Life Skills Education	Curriculum includes stress management, communication, decision-making, and conflict resolution	Equips adolescents to handle peer pressure, avoid risky behaviour, and take informed health decisions
Parental and Community Engagement	Encourages stronger collaboration between schools, families, and local communities	Reinforces positive parenting; improves uptake of immunisation, hygiene practices, and child nutrition
Multilingual and Culturally Sensitive Learning	Promotes learning in local languages and culturally relevant contexts	Enhances engagement and learning retention, particularly in tribal and rural areas—contributing to inclusive health literacy
Technology for Equity	Use of digital tools to ensure continued learning and outreach	Maintains educational continuity in crisis; supports adolescent mental health and access to health information



EARLY CHILDHOOD DEVELOPMENT (ECD)

Rashtriya Bal Swasthya Karyakram (RBSK)

The Rashtriya Bal Swasthya Karyakram (RBSK), launched under the National Health Mission, is India's flagship programme for early identification and intervention in children from birth to 18 years. The programme addresses the 4Ds—Defects at birth, Diseases, Deficiencies, and Developmental delays including Disabilities—through community-based screening and facility-based management.

By focusing on timely detection and care, RBSK contributes significantly to improving survival, growth, learning, and quality of life in children and adolescents. It plays a vital role in **reducing long-term health complications**, preventing disability, and enabling early school-readiness and socio-emotional development, thereby aligning with broader goals of child and adolescent health and well-being.

RBSK: 4Ds and Interventions

Category (4Ds)	Description	Examples	Key Interventions
Defects at Birth	Congenital anomalies identified early in life	Neural tube defects, cleft lip/palate, clubfoot, Down syndrome	Newborn and early childhood screening, referral to District Early Intervention Centres (DEICs), corrective surgery or therapy
Diseases in Children	Detectable and treatable childhood illnesses	Otitis media, skin infections, rheumatic heart disease, dental issues	Regular health check-ups in schools and Anganwadis, early diagnosis, linkage with primary/secondary healthcare
Deficiencies	Nutritional shortfalls impacting health and development	Anemia, vitamin A deficiency, iodine deficiency, malnutrition	Micronutrient supplementation (IFA, vitamin A), deworming, nutrition counseling, referral for SAM/MAM
Developmental Delays and Disabilities	Delays in physical, cognitive, or sensory development	Hearing/visual impairment, speech delay, autism, cerebral palsy	Milestone monitoring, early stimulation, therapy and rehabilitation via DEICs, caregiver training

Rashtriya Kishor Swasthya Karyakram (RKSK)

Launched in 2014 under the National Health Mission, the Rashtriya Kishor Swasthya Karyakram (RKSK) is India's flagship adolescent health programme. It provides a comprehensive, preventive, and promotive health framework for young people aged 10–19, reaching both in-school and out-of-school adolescents.

By recognising adolescence as a decisive phase in the life course, RKSK aims to equip youth with the knowledge, skills, and access to services required for informed decision-making about their health and wellbeing. The programme addresses sexual and reproductive health, nutrition, mental health, and life skills, while also fostering gender equality and supporting educational and long-term health outcomes.

Strategic priorities	Objectives
Enable Sexual and Reproductive Health	Improve knowledge, attitude and behaviour in relation to menstrual hygiene. Reducing teenage pregnancies. Improve birth preparedness and complications readiness. Provide parenting support for adolescent parents.
Improve Nutrition	Reduce prevalence of malnutrition and Iron deficiency anemia.
Address non-communicable diseases	Promote behaviour change in adolescents to prevent NCDs.
Prevent Substance misuse	Increase adolescent awareness on the adverse effects of substance abuse.
Prevent Injuries and violence	Promote favourable behaviour and attitudes for preventing injuries and violence including gender-based violence.
Enhance Mental health	Improve knowledge and skills on mental health issues of adolescents among health workers.

The programme is implemented through a peer educator model (two trained peer educators (one male, one female) per village/1000 population act as change agents); Adolescent Friendly Health Clinics (AFHCs) – to provide confidential counselling and services through health facilities; and school- and community-based interventions in coordination with education, WCD, and youth departments.



OTHER IMPORTANT POLICY INITIATIVES

Beti Bachao, Beti Padhao (BBBP)

India has made visible progress in addressing gender imbalance, with BBBP acting as a national platform to promote girls' survival, protection, and education. The programme has demonstrated the power of coordinated advocacy and inter-ministerial action in driving behavioural change and measurable outcomes.

Launched in January 2015, Beti Bachao, Beti Padhao (BBBP) is a tri-ministerial initiative by the Ministries of Women and Child Development, Health and Family Welfare, and Education, aimed at addressing India's declining Child Sex Ratio (CSR) and promoting girls' education and empowerment through coordinated advocacy, community mobilization, and intersectoral convergence (MoWCD, 2023). Initially targeting 100 gender-critical districts, BBBP employs multi-pronged strategies including mass media campaigns, incentive schemes like Sukanya Samridhi Yojana, and education sector engagement to shape gender norms and improve sex ratios and school enrolment rates. As of 2023, over 422 districts reported improvements in CSR, with secondary education enrolment for girls increasing in states such as Haryana (NFHS-5, 2022).

Looking ahead, BBBP can further consolidate these gains by deepening community-level engagement and ensuring stronger district-level convergence between health, education, and protection services. Monitoring should focus on education participation, delayed age of marriage, and access to entitlements as near- to medium-term indicators of progress, while CSR improvements continue to be tracked through NFHS and Census. Embedding gender budgeting into district plans would also enhance accountability and ensure sustained investments in girls' empowerment.



Strengthening Adolescent Health Platforms for Greater Impact

Adolescents often face health needs that fall between paediatric and adult systems, leading to under-detection of reproductive, nutritional, and mental health concerns.

India has built a dedicated service architecture that now spans schools, communities, and health facilities, reflecting a strong commitment to closing this gap.

Adolescent-centered healthcare in India is delivered through various facility-based services, including the School Health and Wellness Programme (SHWP), Adolescent Friendly Health Clinics (AFHCs), and the Menstrual Hygiene Scheme (MHS). AFHCs, operational at Community Health Centres (CHCs) and higher facilities, provide comprehensive services spanning screening, reproductive and sexual health, nutrition, non-communicable disease management, mental health support, substance abuse counseling, and health education (MoHFW, 2023). Sub-centre level Health and Wellness Centres offer accessible, walk-in adolescent care, supported by trained staff and aligned with community needs.

The School Health and Wellness Programme, launched in 2020 as part of Ayushman Bharat, synergizes with these initiatives by embedding health education and screening within the school environment, addressing physical, mental, and reproductive health holistically (MoE & MoHFW, 2023).

The Menstrual Hygiene Scheme (MHS) adopts a multisectoral framework focused on advocacy through mass media alongside administrative interventions. It aims to enhance menstrual hygiene awareness, improve access to quality sanitary products, and promote safe, sustainable disposal practices among adolescent girls aged 10–19, primarily in rural areas, with gradual scale-up to urban contexts (MoWCD, 2023). MHS complements infrastructure-driven programs by fostering behavior change and facilitating programmatic convergence.

Together, these programs represent a comprehensive, multi-layered response to adolescent health, combining infrastructure expansion, service delivery, education, and social norm transformation. Future efforts should emphasize integration across sectors, expanded coverage in underserved areas, digital monitoring, and community engagement to optimize outcomes for adolescent girls' health and empowerment.



Strategic Priority Driven

Nutrition and Micronutrient Deficiencies: A Multisectoral Convergence Approach

Addressing malnutrition and micronutrient deficiencies among adolescents is central to India's public health and economic agenda. These conditions shape lifelong health, cognitive development, and workforce productivity, making their reduction a national priority.

The Anemia Mukht Bharat (AMB) strategy, launched in 2018 by the Ministry of Health and Family Welfare (MoHFW), exemplifies India's multisectoral approach. Targeting approximately 450 million beneficiaries across six prioritized population groups with a comprehensive intervention mix—including weekly iron and folic acid supplementation (WIFS), biannual deworming, and intensified behaviour change communication (MoHFW, 2023).

Implementation involves coordination among multiple ministries:

1. The Ministry of Education oversees WIFS delivery to 118 million students in grades 6–12.
2. The Ministry of Women and Child Development (MWCD) facilitates outreach to out-of-school adolescent girls via 1.38 million Anganwadi Centres, leveraging frontline workers such as ASHAs and AWWs for mobilization and adherence monitoring.
3. Digital health tools, including hemoglobinometers and the nationwide Poshan Tracker platform, enhance screening accuracy, supply tracking, and performance oversight (MWCD, 2023).

Food fortification and infrastructure programmes complement AMB. The Food Safety and Standards Authority of India (FSSAI) advances nutritional supplementation via large-scale food fortification, notably the rollout of iron-fortified rice to 291 districts through the mid-day meal and Public Distribution System (PDS). Complementary initiatives—such as sanitation improvements under Swachh Bharat Mission and water access via Jal Jeevan Mission—address underlying infection-related contributors to anemia, reinforcing the integrated nature of India's nutrition strategy.

Despite these advances, challenges remain in sustaining last-mile impact. Ensuring uninterrupted supply chains, achieving behaviour change amidst cultural barriers (e.g., menstruation-related taboos and IFA misconceptions), and reducing absenteeism at service platforms constrain impact.

The next phase requires sharper execution and accountability. Institutionalizing frontline capacity building, embedding performance-linked incentives, and utilizing real-time data analytics are critical for accelerating progress. Furthermore, establishing a unified cross-ministry dashboard to track supply, service delivery, and compliance will enable timely course corrections and accountability.

Strategically, targeted interventions in high-burden districts with district-specific plans, coupled with formalized partnerships engaging the private sector and civil society, can strengthen last-mile delivery and foster innovation (MoHFW, 2023).

In summary, AMB and complementary interventions represent a well-calibrated, multi-ministerial effort. By embedding a life-course approach and integrating health, education, food systems, and community engagement, India is laying the groundwork to improve adolescent nutrition and strengthen its human capital for the future.

Nutritional programme for adolescents

Nutrition Programme	Implementing Ministry/Agency	Key Points
Anemia Mukta Bharat (AMB)	Ministry of Health & Family Welfare (MoHFW)	Launched 2018 with a 6x6x6 model; expanded fortified rice distribution via TPDS, ICDS, PM Poshan; digital monitoring dashboards; ₹805.9 Cr allocated for FY 2024-25 (MoHFW)
National Deworming Day (NDD)	MoHFW	Held bi-annually; Albendazole provided to 1–19 year olds, including pregnant women via ANC
POSHAN 2.0	Ministry of Women & Child Development (MWCD)	Integrates Supplementary Nutrition Programme & SAG; extends AWW coverage to recruit out-of-school adolescents
Scheme for Adolescent Girls (SAG, formerly Kishori Shakti)	MWCD	Universalised by 2021, covers all districts; supports nutrition, life skills, health education, IFA supplementation
Mid-Day Meal Scheme	Ministry of Education (MoE)	Strengthened food fortification with micronutrient-rich grains under FSSAI Eat Right Initiative; linked with school-level health modules
School Health & Wellness Programme (Ayushman Bharat)	MoHFW & MoE (Joint)	Includes anemia screening, deworming, and nutrition education via Health & Wellness Ambassadors in schools
Iodine Deficiency Disorders Control Programme	MoHFW	Continues universal iodized salt provision and monitoring through IDD surveys and fortification testing labs
Special Nutrition Programme	MWCD	Incorporated under POSHAN 2.0; targets high-burden districts with supplements for children 6–6 years, pregnant, lactating women & adolescents
Food Fortification Resource Centre (FFRC)	Food Safety and Standards Authority of India (FSSAI)	Large-scale fortification of rice, wheat flour, edible oil, and milk (Vitamin A, D, iron, folic acid, B12) through PDS, ICDS, and PM POSHAN
Rashtriya Kishor Swasthya Karyakram (RKSK) – Nutrition Component	MoHFW	Provides adolescent nutrition counselling, IFA supplementation, and referrals through Adolescent Friendly Health Clinics (AFHCs)

MALNUTRITION

Poshan Abhiyaan – Anemia Mukt Bharat – PM Poshan

India has prioritised malnutrition reduction through one of the world’s largest, multisectoral nutrition delivery systems. The launch of POSHAN Abhiyaan (2018) created a convergence model linking health, women and child development, education, sanitation, and consumer affairs. (MoHFW, 2021).

In 2021, this architecture was consolidated into Mission Poshan 2.0, which integrated the Supplementary Nutrition Programme and placed renewed focus on 112 high-burden districts. The shift emphasised decentralised planning, enhanced monitoring, and stronger inter-ministerial collaboration, marking an evolution from programme expansion to targeted delivery and accountability (MoHFW, 2021). The programme integrates schemes such as Integrated Child Development Services (ICDS), AMB, PM POSHAN, Weekly Iron Folic Acid Supplementation (WIFS), and National Deworming Day to ensure continuity of care (PIB, 2022).

Key innovations include:

1. Jan Andolan campaigns and annual POSHAN Maah, promoting awareness on nutrition, hygiene, deworming, and adolescent health. Over 100 crore nutrition-centric sensitisation activities were reported during these awareness campaigns under various themes in the 7th Rashtriya Poshan Maah in 2024 (PIB, 2023)
2. **Poshan Tracker** deployment across 13.5 lakh Anganwadi Centres (AWCs) has enabled real-time monitoring of service delivery and beneficiary coverage. The application’s role in digital governance was recognised through the Prime Minister’s Award for Excellence in Public Administration 2024 (Innovation Category) (PIB, 2024) as well as the National Award for e-Governance (PIB, 2025, March 15)
3. Over 4.37 lakh Poshan Vatikas (nutrition gardens) established to boost dietary diversity (PIB, 2022).
4. Large-scale food fortification, led by FSSAI, now covering 291 districts (MoHFW, 2023).

Complementary programmes reinforce this framework. AMB targets approximately 240 million beneficiaries, emphasizing adolescent and maternal anemia control through integrated interventions across schools, AWCs, and health facilities, thereby complementing adolescent health programs like RKSK and School Health and Wellness (MoHFW, 2022).

The PM POSHAN scheme reaches about 118 million children, providing fortified meals in government and aided schools up to grade 8, integrating local sourcing, nutritional diversity, hygiene promotion, and health screenings to address hidden hunger and support educational outcomes (MoE, 2022).

Together, these programmes represent a comprehensive, life-course approach to nutrition. They combine community mobilisation, digital monitoring, dietary diversification, and fortification at scale.

The priority now is to sustain momentum and deepen impact. Continued investment in behaviour-change communication, stronger support and incentives for frontline workers, and greater interoperability across digital platforms (such as the Poshan Tracker, AMB monitoring tools, and fortification databases) would further improve coordination, enable timely course corrections, and enhance accountability. Strengthened partnerships with the private sector and civil society can also drive innovation and improve last-mile delivery.

6X6X6 strategy of Anemia Mukht Bharat

6 Beneficiaries	6 Interventions	6 Institutional Mechanisms
<ul style="list-style-type: none"> • Children (6-59 Months) • Children (5-9 Years) • Adolescents (10-19 Years) • Pregnant Women • Lactating Women • Women in reproductive age (15-49 Years) 	<ul style="list-style-type: none"> • Prophylactic Iron and Folic Acid supplementation • Deworming • Intensified year-round behavior change communication campaign • Testing and treatment of anemia, using digital methods and point of care treatment • Mandatory provision of Iron and Folic Acid fortified foods • Intensifying non-nutritional causes of anemia in endemic pockets 	<ul style="list-style-type: none"> • Intra-ministerial coordination • National Anemia Mukht Bharat Unit • National Centre of Excellence • Convergence with other Ministries • Strengthening supply chain and Logistics • Anemia Mukht Bharat Dashboard and Digital Portal-one stop shop on Anemia



COMMUNICABLE DISEASES

Universal Immunization Programme (UIP)

The Universal Immunization Programme (UIP) serves as the backbone of India's vaccine-preventable disease control efforts, providing immunization to approximately 26 million newborns and 29 million pregnant women annually (MoHFW, 2023; NFHS-5). Established in 1978 as the Expanded Programme on Immunization and rebranded in 1985, UIP has expanded nationwide under the National Health Mission.

India's immunization milestones have been globally recognised. Notable milestones include the eradication of polio by 2014, elimination of maternal and neonatal tetanus by 2015, and significant progress in measles-rubella (MR) elimination, with a 73% decline in measles cases and 291 districts achieving zero cases of MR by early 2025 (MoHFW, 2024). The programme also earned international recognition, such as the Measles & Rubella Champion Award (PIB, 2024 March 10)

Coverage expansion has been supported by innovation and system strengthening. The government's intensified initiatives—Mission Indradhanush (2014) and subsequent Intensified Mission Indradhanush (IMI, 2017 to present), employ data-driven microplanning to target high-risk and underserved districts. Advanced tools such as the Electronic Vaccine Intelligence Network (eVIN) provide real-time cold chain and vaccine inventory management. The Universal Vaccine Intelligence Network (U-WIN) aids beneficiary tracking, session mapping, and self-registration (MoHFW, 2023). Geographic Information Systems (GIS), artificial intelligence-driven microplanning, and drone-based vaccine delivery pilots facilitate efficient last-mile coverage, especially in challenging terrain.

At the same time, challenges persist. Official HMIS data indicate 93.5% full immunization compared to 76.1% coverage per NFHS, highlighting data quality and outreach gaps that also impedes precise monitoring. Significant challenges persist with zero-dose prevalence remaining high in states like Uttar Pradesh, Madhya Pradesh, and Bihar, necessitating focused interventions within IMI 4.0 to enhance microplans and outreach (NFHS-5). Socioeconomic, geographic, and cultural barriers contribute to inequities, accentuated by vaccine hesitancy fuelled by misinformation. Migrant and mobile populations remain difficult to track and serve, underscoring the need for robust digital platforms to ensure continuity of care.

Rather than treating them as conflicting, triangulating HMIS with NFHS and other population-based surveys would provide a more accurate picture of coverage and drop-outs. Integrated data review platforms at national and state levels, where HMIS and NFHS trends are systematically compared, with flagged discrepancies triggering targeted validation and corrective action, can make this triangulation practicable.

Furthermore, the priority should now be to close these last-mile gaps.

1. Leveraging GIS-enabled mapping to identify underserved pockets
2. Scaling digital platforms like U-WIN and eVIN for supply chain and demand-side management
3. Enhancing community engagement via targeted communication campaigns to counter hesitancy
4. Fostering public-private partnerships for innovative delivery mechanisms such as drones.
5. Strengthening provider training and ensuring equitable resource allocation are critical.

Multi-Ministerial Approach to Vaccination in India			
Ministry/ Department	Role in Immunization	Key Programs/ Interventions	Convergence/ Partnerships
Ministry of Health and Family Welfare (MoHFW)	Lead agency for policy, program implementation, vaccine procurement, training, and surveillance	<ul style="list-style-type: none"> • Universal Immunization Programme (UIP) • Mission Indradhanush & Intensified MI • Anemia Mukt Bharat • eVIN, U-WIN platform • Adverse Events Following Immunization (AEFI) surveillance 	Coordinates with WCD, Education, MeitY, Panchayati Raj, Defence, and development partners (UNICEF, WHO, GAVI)
Ministry of Women and Child Development (MoWCD)	Mobilization of pregnant women and children; supplementing services through Anganwadis	<ul style="list-style-type: none"> • Integrated Child Development Services (ICDS) • Anganwadi-based IFA supplementation • Community mobilization = for immunization sessions • Tracking out-of-school adolescent girls for Td and MR vaccines 	AWWs collaborate with ANMs, ASHAs for session delivery and mobilization under UIP and AMB
Ministry of Education (MoE)	School-based immunization delivery and awareness through curriculum and campaigns	<ul style="list-style-type: none"> • School Health and Wellness Programme (SHWP) • WIFS (Iron Folic Acid) • De-worming Day • School-based MR & Td campaigns 	Partners with MoHFW for session planning and delivery; Health & Wellness Ambassadors facilitate awareness
Ministry of Panchayati Raj	Local governance, community mobilization, and support for cold chain infrastructure	<ul style="list-style-type: none"> • IEC/BCC campaigns at panchayat level • Oversight on immunization microplans and VHNDs 	Facilitates last-mile access, local grievance redressal, and community awareness

Multi-Ministerial Approach to Vaccination in India			
Ministry/ Department	Role in Immunization	Key Programs/ Interventions	Convergence/ Partnerships
Ministry of Defence	Immunization access in border and difficult terrains; special camps for armed forces families	<ul style="list-style-type: none"> • Military hospitals and mobile health units offer UIP vaccines • Support in logistics for hard-to-reach areas 	Coordinates with MoHFW in inaccessible zones and disaster/ emergency settings
Ministry of Electronics and IT (MeitY)	Development and deployment of digital immunization platforms	<ul style="list-style-type: none"> • CoWIN (COVID-19) • U-WIN (routine immunization) • Digital identity linking, beneficiary self-registration, e-certificates 	Works with MoHFW and NIC to strengthen real-time data, analytics, and beneficiary tracking
Indian Council of Medical Research (ICMR)	Operational research, piloting innovations, vaccine safety studies	<ul style="list-style-type: none"> • Research on drone-based vaccine delivery • Seroprevalence studies • AEFI safety surveillance studies 	Supports MoHFW through evidence generation for policy refinement and innovation
Ministry of Information & Broadcasting (MoI&B)	Public awareness, combating misinformation, and communication campaigns	<ul style="list-style-type: none"> • Mass media campaigns • COVID-19 vaccine awareness • MR and Polio IEC materials 	Partners with MoHFW, UNICEF, PIB for coordinated communication across platforms
Ministry of Finance	Budgetary allocations, external financing coordination	<ul style="list-style-type: none"> • Financial support through National Health Mission (NHM) • GAVI and World Bank-supported vaccine programs 	Enables fiscal planning, program sustainability, and donor alignment



MENTAL HEALTH

India's approach to adolescent mental health has evolved incorporating multisectoral policies and integration with education and primary healthcare systems. The National Mental Health Programme (NMHP), established in 1982 and revised in 2003, focuses on community-based mental healthcare, with the District Mental Health Programme (DMHP) operational in over 700 districts as of 2024 (MoHFW, 2024). DMHP prioritizes early identification, school mental health programs, suicide prevention, and counseling, though implementation quality varies interstate.

To expand access, Tele-MANAS—launched in 2022 by MoHFW and NIMHANS—operates through a tiered helpline, offering primary support via counselors and advanced care through psychiatrists and psychologists (MoHFW, 2024). By June 2024, Tele-MANAS processed over 520,000 calls across all states and union territories, with adolescents constituting a significant proportion.

The School Health and Wellness Programme (SHWP) under Ayushman Bharat, is India's first structured effort to embed mental health within the education system. Employing Health and Wellness Ambassadors to deliver weekly sessions on emotional wellbeing, stress management, peer pressure, bullying, empathy, and suicide ideation recognition (MoHFW & MoE, 2023). Supported by student Health and Wellness Messengers, these interventions utilize participatory learning to foster peer engagement. By 2023, SHWP operates in over 200 districts, though scale-up faces challenges such as inconsistent teacher training, weak convergence with health services, limited monitoring, and persistent stigma around mental health discussions (Ayushman Bharat Review, 2023).

Systemic constraints remain significant. Service integration and follow-up in platforms like Tele-MANAS require strengthening, particularly to ensure continuity of care. At the system level, funding for mental health remains below 1% of the total health budget, the child psychiatrist density is just 0.75 per 100,000 population, and intersectoral coordination is fragmented. These gaps collectively constrain access, quality, and sustainability of adolescent mental health services (MoHFW, 2023).

Strengthening SHWP is critical to establishing schools as safe and responsive environments for early mental health intervention. Expanding clinical support linkages, integrating digital tools, and involving families and communities more actively would reinforce its impact. Over time, institutionalising SHWP at scale with regular mental health screening and stronger frontline capacity can help position schools as the foundation for adolescent wellbeing. Furthermore, integrating digital platforms like Tele-MANAS with peer and community outreach will be essential to make adolescent mental health a cornerstone of India's demographic dividend.



SUBSTANCE ABUSE

Nasha Mukt Bharat Abhiyan (NMBA, 2020)

Substance use among adolescents is a growing public health concern in India. The Nasha Mukt Bharat Abhiyan (NMBA) is the first nationwide programme to tackle this challenge at scale. Launched in October 2020 by the Ministry of Social Justice and Empowerment, NMBA targets substance abuse prevention, particularly among youth in 372 high-burden districts identified by the 2019 National Survey on Extent and Pattern of Substance Use (AIIMS & MoSJE, 2019). Since August 2023, it has been expanded to all the districts in the country. So far it has reached more than 13.57 crore people, with participation of more than 3.85 lakh educational institutions (MoHFW, 2025 - Rajya Sabha Unstarred Question No. 1884)

The programme implements awareness campaigns in educational and community settings, offers counseling and de-addiction services, builds capacity of educators and frontline workers for early detection, and deploys digital tools such as mobile applications and e-counseling platforms. NMBA's focus on children and adolescents addresses early initiation of tobacco, alcohol, and drug use, which are key risk factors for long-term dependence, mental illness, and risky behaviors.

The programme has created unprecedented awareness but faces challenges in sustaining age-appropriate interventions, integrating more deeply with schools, and ensuring convergence between health, education, and social justice ministries. Scaling rehabilitation services and embedding prevention modules in the School Health and Wellness Programme will be critical to reducing early initiation of substance use.

Injuries and Violence: Child Protection and Welfare Framework

Injuries and violence remain under-recognised drivers of adolescent morbidity and mortality. India's protection framework, anchored in One Stop Centres and Child Welfare Committees, is expanding access to safety, rehabilitation, and care.

India's legal and service architecture has expanded in response. The One Stop Centre (OSC) Scheme has supported more than 10 lakh survivors of violence, while Child Welfare Committees (CWCs) provide statutory rehabilitation under the Juvenile Justice Act. However, adolescent-specific services—such as paediatric mental health support, confidential reporting, and safe facilities—remain limited. Gaps remain in child-friendly infrastructure, availability of trained pediatric mental health professionals, and inter-sectoral coordination, which must be addressed to enhance adolescent health and safety outcomes.

Implementation Challenges and Systemic Barriers

India has built one of the world's most extensive programmatic architectures for child and adolescent health. Yet, across nutrition, communicable disease control, early childhood development, sexual and reproductive health, mental health, substance use, and injury prevention, common systemic barriers continue to limit impact.

1. **Geographic inequities in outcomes.** National progress masks sharp disparities between and within states. Nutrition outcomes in Uttar Pradesh and Madhya Pradesh contrast starkly with those in Goa and Sikkim; zero-dose immunisation and anemia prevalence remain concentrated in high-burden districts; and adolescent SRH uptake varies widely depending on local norms and service delivery capacity. These contrasts highlight that large-scale programmes deliver impact unevenly, with local governance, capacity, and social context playing an important role in ensuring success.
2. **Workforce and frontline delivery gaps.** Coverage has expanded, but the quality and consistency of service delivery is uneven. RBSK screenings often do not result in referrals to DEICs, IFA supplementation under AMB suffers from poor adherence, and AFHCs—though established in nearly every district—record low adolescent utilisation. Teacher-led health promotion under SHWP or Tele-MANAS counselling show wide variability. This reflects the gap between programme design and frontline execution capacity, particularly in rural and underserved regions.
3. **Fragmented care pathways. India's programmes offer strong entry points but referral and follow-up are inconsistent.** Children screened under RBSK may not complete the pathway to intervention, and Tele-MANAS calls often lack structured continuity into offline clinical care. Weak linkage across touchpoints leads to episodic engagement rather than sustained care, especially in mental health, disability, and adolescent SRH.
4. **Data fragmentation and lack of adolescent-sensitive metrics.** Investments in systems like the Poshan Tracker, eVIN, and U-WIN have transformed monitoring and accountability. Yet, discrepancies between administrative data (HMIS) and surveys (NFHS) complicate interpretation of coverage levels and programme performance. Furthermore, routine systems rarely disaggregate adolescent-specific indicators on mental health, substance use, or injury morbidity, limiting the ability to design tailored interventions for this age group.
5. **Convergence gaps at the delivery level.** Flagship programmes - RSK, Mission Poshan 2.0, AMB, SHWP, and PM POSHAN, are all conceived as multisectoral initiatives. At the national level, intent has been clear: the Ministry of Education's decision to rebrand the Mid-Day Meal scheme as PM POSHAN signalled alignment of education and nutrition under the broader Mission Poshan 2.0 framework, bringing coherence of purpose across ministries. Yet, on the ground, convergence is less consistent. SHWP sessions do not always link to AFHC referrals, and frontline workers such as AWWs and ASHAs still function through parallel structures. The opportunity now is to reinforce national alignment with mechanisms for joint planning and shared accountability at state and district levels, so that convergence of objectives translates into integrated outcomes for children and adolescents.

- 6. Monitoring centred on activities, not outcomes.** Programme performance is tracked mainly through activity counts for instance through tablets distributed, sessions delivered, calls logged, rather than meaningful outcomes. For example, AMB reports on IFA supply but not adherence, SHWP measures the number of sessions rather than behavioural change, and Tele-MANAS emphasises call volumes without follow-up. This activity bias makes it difficult to assess real impact and reduces the system's ability to course-correct in time.
- 7. Continuous alignment with the adolescent burden of disease.** Flagship platforms are most advanced in nutrition and immunisation, reflecting long-standing national priorities. Yet the burden profile for adolescents is shifting, with road injuries, self-harm, and substance use emerging as leading causes of Years of Life Lost. Current service platforms such as AFHCs and RKSK continue to focus predominantly on SRH and nutrition, leaving less structured attention to these high-impact risks. This highlights the importance of embedding mechanisms for continuous burden assessment and programme recalibration, so that policy priorities remain responsive to the health conditions most affecting adolescent survival and wellbeing.
- 8. Adolescent engagement constrained by stigma and social norms.** Adolescents often avoid AFHCs due to confidentiality concerns, while SRH services remain stigmatised and mental health or substance use issues hidden. These individual reservations are reinforced by broader cultural barriers: menstrual taboos undermine hygiene schemes, restrictive gender norms limit girls' mobility, and silence around self-harm prevents disclosure. Together, these factors constrain demand, leaving critical health needs under-addressed despite expanding programme coverage.

Critical review of Some Existing National Health Programmes		
National Health Programmes	Strengths	Challenges
Weekly Iron and Folic Acid Supplementation (WIFS) Programme	<ul style="list-style-type: none"> • Comprehensive coverage targets school-going and out-of-school adolescents • Focuses on preventive approach to anemia • Integrated Health Intervention-Involves school and community platforms, improving reach 	<ul style="list-style-type: none"> • Irregular supply of IFA tablets • Low adherence due to side effects (Vertigo & Nausea) or misinformation • Lack of proper counselling and monitoring mechanisms • Out-of-school adolescents often miss out on coverage • Lack of training of Frontline workers • Lack of coordination with Schools
Universal Immunization Programme (UIP)	<ul style="list-style-type: none"> • One of the largest public health programs globally • Significant success in reducing vaccine-preventable diseases • Introduction of new vaccines (e.g., rotavirus, pneumococcal) • Full Immunization coverage reach up to 93% • Digitalisation through eVIN and UWIN 	<ul style="list-style-type: none"> • Geographic and social inequity in coverage • Cold chain maintenance issues in remote areas • Vaccine hesitancy in some communities • Need for stronger community engagement and follow-up

<p>POSHAN Abhiyaan (National Nutrition Mission)</p>	<ul style="list-style-type: none"> • Brings convergence across ministries (Health, WCD, Water, Sanitation, etc.) • Promotes behaviour change communication and use of technology (e.g., POSHAN Tracker) • Emphasizes growth monitoring, community participation 	<ul style="list-style-type: none"> • Implementation varies widely across states • Anganwadi workers are overburdened with data entry tasks • Limited real-time data use for decision-making • Behaviour changes efforts still limited in impact and reach • Lack of interdepartmental coordination • Lack of monitoring
<p>School-Based Fortification Programme</p>	<ul style="list-style-type: none"> • Targets micronutrient deficiencies through mid-day meals • Uses an existing delivery platform (schools), which enhances sustainability 	<ul style="list-style-type: none"> • Monitoring of food quality and fortification standards is inconsistent • Often no tracking of actual impact on nutritional outcomes • Resistance to taste change or lack of awareness among students/teachers



04+

**Evidence-Based Policy
Recommendations**



India has made significant strides in strengthening child and adolescent health through large-scale programmes and cross-ministerial initiatives. The next phase of progress requires building on this foundation with a clear, evidence-based strategy that translates national ambition into sustainable impact on the ground. Eight mutually reinforcing levers can anchor this approach:

A. Strategic priorities

1. **Prioritise prevention and wellness across the life course.** Shifting focus towards the concept of wellness, preventing illnesses and strengthening public health systems to keep the population healthy, reducing sickness and death rates and ensuring a robust workforce. Prevention must move from being a programme component to a system anchor, with ministries aligning incentives around reductions in preventable disease, anemia, and adolescent YLL.
2. **Reorient measurement towards outcomes. India’s flagship programmes have successfully expanded coverage.** The next step is to align success metrics with outcomes rather than activity counts. A consolidated outcome set—covering adherence to supplementation, referral completion, reduction in zero-dose immunisation, and decline in adolescent anemia and YLL—should be adopted across all flagship schemes. This alignment will enable consistent measurement and course correction.
3. **Institutionalise adolescence as a distinct policy focus.** Developing specific policies that address the unique health needs of adolescents including good nutrition, mental well-being, and sexual and reproductive health, is vital to ensure they become healthy adults. Adolescents should be positioned as partners in programme design and monitoring. Structured platforms such as youth advisory boards, peer-led feedback mechanisms, and digital grievance systems will strengthen service uptake and ensure that interventions are responsive to evolving needs.
4. **Strengthen reproductive health access and education.** Making family planning and reproductive health services more readily available is important to support declining birth rates and the demographic transition. Integrating thorough sexual and reproductive health education into school curriculums is crucial to empower young people with knowledge.
5. **Tailor health programming to urban and rural realities.** Creating focused health programs for cities and rural areas necessary to tackle specific health issues like sanitation, hygiene, and chronic diseases common in urban areas.
6. **Employ a “Child and Adolescent Health in All Policies” strategy.** As gender has been integrated across sectors, child and adolescent health should similarly be embedded in all policy domains. Urban planning can ensure safe mobility and recreation, education can institutionalise health literacy, and digital platforms can prioritise adolescent-friendly services. This cross-sector lens makes health a shared objective and amplifies outcomes across development priorities.

7. **Strengthen convergence and partnerships for delivery.** The priority now is to extend this alignment to state and district levels through joint planning, shared accountability, and integrated delivery. At the same time, structured partnerships with civil society, academia, and the private sector can amplify reach and innovation—whether through digital adolescent outreach, workplace wellness programmes, or private-sector logistics for supply chains. Together, these mechanisms can bridge system gaps and ensure programmes translate into outcomes on the ground.

B. Policy Alignment and Governance Reforms

Effective delivery requires coherence across programmes and sustained governance focus. India's policies—NHP 2017, NEP 2020, Poshan 2.0, RKSK, SHWP—are well aligned at the national level, but state and district execution remains uneven.

Align Policies Across Sectors:

Harmonize national and state policies (Health, Education, Nutrition) to enable integrated delivery and coherent outcomes. Ensure that child and adolescent health priorities are embedded across frameworks.

01

Strengthen Governance and Accountability:

Define clear institutional roles and monitoring structures to track progress. Empower state and district-level mechanisms to adapt strategies based on local needs.

02

Integrate Adolescent Health into Panchayati Raj Institutions (PRI):

Empower PRIs to monitor adolescent health indicators and allocate local resources (e.g., from 15th FC grants) toward community-led health promotion and school retention efforts.

03

Ensure Policy Backing for Health Literacy:

Mandate age-appropriate, evidence-based health literacy (nutrition, hygiene, mental health, SRHR) in school curricula through policy support from both MoE and MoHFW.

04

Effective delivery requires coherence across programmes and sustained governance focus. India's policies—NHP 2017, NEP 2020, Poshan 2.0, RKSK, SHWP—are well aligned at the national level, but state and district execution remains uneven.

C. Strengthening Health Service Delivery

Improving access to child and adolescent-friendly healthcare services requires a comprehensive approach that addresses both supply and demand-side factors. Healthcare facilities should be redesigned to include dedicated spaces for adolescents that ensure privacy, confidentiality, and age-appropriate services. These facilities should integrate physical health, mental health, and nutritional services within a single setting to provide holistic care, reducing the need for multiple visits and improving service utilization.



D. Multi-sectoral Coordination and Partnerships

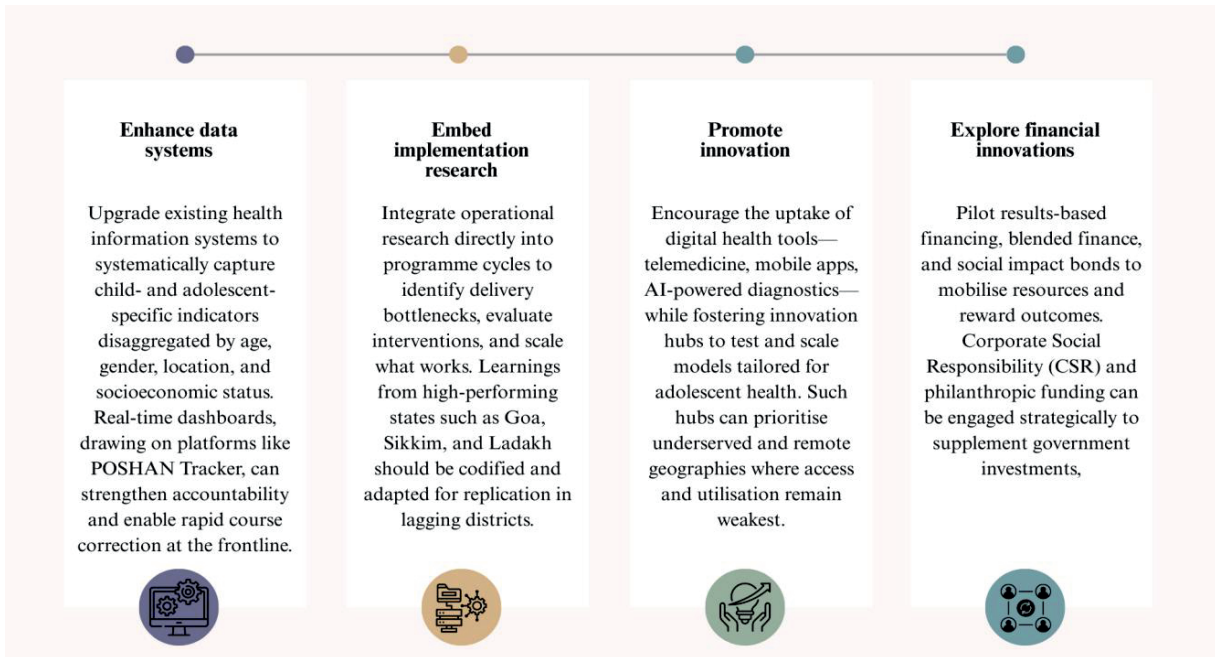
Effectively addressing the multifaceted determinants of child and adolescent health necessitates precise, outcome-oriented collaboration across sectors. Existing government initiatives have established coordination platforms; the priority now is to operationalize these mechanisms with clear accountability and measurable mandates at national, state, and district levels.

- 1. Align cross-sector planning and accountability.** Developing integrated work plans with specified roles, deliverables, and timelines for departments such as Health, Education, Women and Child Development, and Youth Affairs, ensuring cohesive program execution. Furthermore, instituting capacity-building initiatives that foster cross-sector understanding and collaborative competencies among frontline and managerial personnel.
- 2. Create shared data and monitoring systems.** Establishing joint data-sharing protocols and unified monitoring dashboards to enable real-time tracking of coverage and outcomes across sectors. Additionally, Regular joint reviews at national, state, and district levels should explicitly track adolescent health outcomes alongside broader child health indicators, embedding structured feedback loops.
- 3. Formalise partnerships beyond government.** Civil society organisations, academic institutions, and the private sector bring complementary reach and capabilities. Formalising these partnerships through structured frameworks will enable consistent collaboration, filling service gaps, innovating delivery models, and enhancing community engagement.



E. Data Systems, Research, and Innovation

Harnessing data and innovation is critical to making India's adolescent health strategy more adaptive and outcome-oriented. While national surveys like NFHS provide valuable benchmarks, programmatic decision-making requires more frequent, disaggregated, and actionable insights. Building on existing platforms such as the POSHAN Tracker, eVIN, and U-WIN, the focus now must shift from activity counts to outcomes, and from fragmented systems to integrated intelligence. Four reinforcing priorities can anchor this shift:



Conclusion

India's child and adolescent health agenda has evolved into one of the most extensive programmatic architectures globally, spanning nutrition, immunisation, reproductive health, and mental well-being. The intent is clear, the frameworks are in place, and national platforms such as Mission Poshan 2.0, RKSK, and Ayushman Bharat provide a strong foundation. What remains decisive is the system's ability to translate this ambition into consistent outcomes at scale.

The analysis shows that progress is uneven, not because of lack of policy direction, but because delivery remains fragmented, outcome measurement is weak, and services are not yet fully aligned with the shifting burden of adolescent health. Addressing anemia and undernutrition must now be balanced with structured responses to rising obesity, mental health challenges, substance use, and injury prevention.

The opportunity is clear. By embedding prevention as a system anchor, aligning success metrics with outcomes, and institutionalising adolescent participation in design and monitoring, India can move from programmatic expansion to impact at scale. This is not simply a health sector priority; it is central to securing the demographic dividend, strengthening human capital, and sustaining economic growth. The next decade will determine whether India's investments in its children and adolescents deliver the transformative returns its development trajectory demands.



References

1. Ministry of Women and Child Development. Poshan Abhiyaan (National Nutrition Mission). 2021.
2. Ministry of Health and Family Welfare. Intensified Mission Indradhanush. 2020.
3. Ministry of Health and Family Welfare. School Health Programme under Ayushman Bharat. 2021.
4. World Health Organization. Global adolescent health strategy. 2016.
5. United Nations Office on Drugs and Crime. Substance use among adolescents. 2022
6. World Health Organization. Adolescent health in the South-East Asia Region [Internet]. New Delhi: WHO Regional Office for South-East Asia; 2021 [cited 2024 Mar 5]. Available from: <https://www.who.int/southeastasia/health-topics/adolescent-health>
7. [India-Country-Profile-Final-Version.pdf](#)
8. Ministry of Health and Family Welfare, Government of India. Rashtriya Kishor Swasthya Karyakram (RKSK): Operational Framework. New Delhi: MoHFW; 2014.
9. Ministry of Health and Family Welfare, Government of India. National Health Policy 2017. New Delhi: MoHFW; 2017.
10. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-5), 2019-21: India Report. Mumbai: IIPS; 2022.
11. UNICEF India. Early Childhood Development in India: Current Status and Way Forward. New Delhi: UNICEF; 2021.
12. Mathew G, Sharma A, Kurian N, D'Souza R. Prevalence of mental health problems among rural adolescents in India: A meta-analytic review. *J Mental Health Hum Behav.* 2022;27(1):12-24.
13. Ministry of Women and Child Development, Government of India. Poshan Tracker Analytics Report 2023-24. New Delhi: MoWCD; 2024.
14. UNICEF. Adolescent health and well-being: A global priority for sustainable development. New York: UNICEF; 2021
15. Ministry of Women and Child Development, Government of India. Poshan Tracker Analytics Report 2023-24. New Delhi: MoWCD; 2024.
16. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-5), 2019-21: India Report. Mumbai: IIPS; 2022.
17. Saha, S. (2021, April 15). Child malnutrition in India: A systemic failure [Blog post]. Down To Earth. <https://www.downtoearth.org.in/blog/health/child-malnutrition-in-india-a-systemic-failure-76507>
18. World Health Organization. Improving early childhood development: WHO guideline. Geneva: WHO; 2020.

19. Ministry of Health and Family Welfare, Government of India. Rashtriya Bal Swasthya Karyakram (RBSK): Operational Guidelines. New Delhi: MoHFW; 2013.
20. Ministry of Health and Family Welfare, Government of India. Implementation Guide on RSK for State and District Program Managers. New Delhi: MoHFW; 2018.
21. Registrar General of India. Sample Registration System (SRS) Statistical Report 2021. New Delhi: Office of the Registrar General & Census Commissioner; 2022.
22. World Health Organization. Adolescent mental health [Internet]. Geneva: WHO; 2023 Sep 25 [cited 2024 Aug 6]. Available from: <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>
23. Patel V, Ramasundarahettige C, Vijayakumar L, Thakur JS, Gajalakshmi V, Gururaj G, et al. Suicide mortality in India: a nationally representative survey. *Lancet*. 2018;379(9834):2343-51.
24. National AIDS Control Organization. HIV Estimation 2017: Technical Report. New Delhi: Ministry of Health and Family Welfare, Government of India; 2018.
25. Global Youth Tobacco Survey Collaborative Group. Global Youth Tobacco Survey (GYTS): India Fact Sheet 2019. Atlanta: Centers for Disease Control and Prevention; 2020.
26. National Crime Records Bureau. Accidental Deaths and Suicides in India 2022. New Delhi: Ministry of Home Affairs, Government of India; 2023.
27. Ministry of Health and Family Welfare, Government of India. Ayushman Bharat – Health and Wellness Centres: Progress Report. New Delhi: MoHFW; 2023.
28. World Health Organization. Global status report on road safety 2021. Geneva: WHO; 2022.
29. National Drug Dependence Treatment Centre (NDDTC) of the All India Institute of Medical Sciences (AIIMS). Magnitude of Substance Use in India. New Delhi: Ministry of Social Justice and Empowerment; 2019 Feb 18.
30. World Health Organization. Global status report on road safety 2021. Geneva: WHO; 2022.
31. Press Information Bureau, Ministry of Women and Child Development, Government of India. 802 One-Stop Centres (OSCs) operational across India to Support Women in Distress [Internet]. New Delhi: PIB; 2025 Mar 12 [cited 2024 Aug 6]. Available from: <https://www.pib.gov.in/PressReleseDetail.aspx?PRID=2110882>
32. Registrar General of India. Sample Registration System Statistical Report 2021. New Delhi: Office of the Registrar General & Census Commissioner; 2025 May 7.
33. Ministry of Education, Government of India. Programme Approval Board-Pradhan Mantri Poshan Shakti Nirman (PAB-PM POSHAN) Minutes of Meeting 2022-23. New Delhi: MoE; 2022 Apr 21.
34. Press Information Bureau, Ministry of Health and Family Welfare, Government of India. Update on Immunization of Children [Internet]. New Delhi: PIB; 2024 Aug 6 [cited 2024 Aug 6]. Available from: <https://www.pib.gov.in/PressReleseDetailm.aspx?PRID=2042058>

35. Observer Research Foundation. Mind matters: Tech for India's mental health [Internet]. New Delhi: ORF; 2024 Oct 9 [cited 2024 Aug 6]. Available from: <https://www.orfonline.org/expert-speak/mind-matters-tech-for-india-s-mental-health>
36. OGD India Platform. Year-wise Details of Beneficiaries and Funds disbursed under the Pradhan Mantri Matru Vandana Yojana (PMMVY) from 2021-22 to 2024-25 [Internet]. New Delhi: OGD India Platform; 2025 Jul 17 [cited 2024 Aug 6]. Available from: <https://www.data.gov.in/resource/year-wise-details-beneficiaries-and-funds-disbursed-under-pradhan-mantri-matru-vandana>
37. Ministry of Women and Child Development, Government of India. Poshan Tracker Analytics Report 2023-24. New Delhi: MoWCD; 2024.
38. Ministry of Health and Family Welfare, Government of India. Surakshit Matritva Aashwasan (SUMAN) Initiative [Internet]. New Delhi: MoHFW; [cited 2024 Aug 6]. Available from: <https://suman.mohfw.gov.in/>
39. Press Information Bureau, Ministry of Health and Family Welfare, Government of India. Nine years of Pradhan Mantri Surakshit Matritva Abhiyan [Internet]. New Delhi: PIB; 2025 Jun 8 [cited 2024 Aug 6]. Available from: <https://www.pib.gov.in/PressNoteDetails.aspx?id=154588&NotelId=154588&ModuleId=3>
40. Ministry of Women and Child Development. Pradhan Mantri Matru Vandana Yojana – Scheme Guidelines. New Delhi: MoWCD; 2021.
41. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-4), 2015-16: India Report. Mumbai: IIPS; 2017.
42. NITI Aayog. Strategy for New India @75. New Delhi: NITI Aayog, Government of India; 2018.
43. Population Council. Understanding the lives of adolescents and young adults (UDAYA) in Bihar and Uttar Pradesh. New Delhi: Population Council; 2018.
44. Ministry of Women and Child Development, Government of India. Integrated Child Development Services Scheme: Evaluation Report. New Delhi: MoWCD; 2022.
45. Ministry of Education, Government of India. National Education Policy 2020. New Delhi: Ministry of Education; 2020.
46. World Health Organization. Improving early childhood development: WHO guideline. Geneva: WHO; 2020.
47. Population Foundation of India. Peer Education Program for Adolescent Health: Evaluation study. New Delhi: PFI; 2023.
48. Ministry of Health and Family Welfare, Government of India. Anemia Mukh Bharat Strategy: Implementation Guidelines. New Delhi: MoHFW; 2018.
49. Ministry of Health and Family Welfare, Government of India. Weekly Iron and Folic Acid Supplementation (WIFS) Programme: Technical Operational Guidelines. New Delhi: MoHFW; 2018.
50. United Nations Development Programme. Sustainable Development Goals - India: Progress Report 2023. New Delhi: UNDP; 2023.

51. Ministry of Drinking Water and Sanitation, Government of India. Menstrual Hygiene Management: National Guidelines. New Delhi: MDWS; 2022.
52. The Lancet Child & Adolescent Health. Child and adolescent health in India: a journey of hope and optimism. *Lancet Child Adolesc Health*. 2021;5(12):839-40.
53. Ministry of Health and Family Welfare, Government of India. Adolescent Friendly Health Clinics: Operational Framework. New Delhi: MoHFW; 2016.
54. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-4), 2015-16: India Report. Mumbai: IIPS; 2017.
55. https://www.researchgate.net/publication/347254504_Beti_Bachao_Beti_Padhao_Campaign_An_Attempt_to_Social_Empowerment
56. Ministry of Education, Government of India. National Education Policy 2020. New Delhi: Ministry of Education; 2020.
57. World Health Organization. mhGAP Intervention Guide—Version 2.0. Geneva: WHO; 2022.
58. Patel V, et al. Global mental health training partnerships. *Br J Psychiatry*. 2023;222(1):12-18.
59. NIMHANS. Global South Mental Health Consortium Launch Report. Bengaluru: NIMHANS; 2023.
60. <https://pib.gov.in/PressReleasePage.aspx?PRID=2042058>
61. Ministry of Women and Child Development. Pradhan Mantri Matru Vandana Yojana – Scheme Guidelines. New Delhi: MoWCD; 2021.
62. Press Information Bureau. Pradhan Mantri Matru Vandana Yojana – implementation status. 2022. Available from: <https://pib.gov.in/PressReleasePage.aspx?PRID=1777263>
63. Saxena, R. (2021). National Nutrition Mission or Poshan Abhiyaan: Fighting with undernutrition among children. Research Gate. https://www.researchgate.net/publication/357349099_National_Nutrition_Mission_or_Poshan_Abhiyaan_Fighting_with_Undernutrition_among_children
64. National Crime Records Bureau. (2023). Accidental deaths and suicides in India, 2022. Ministry of Home Affairs, Government of India. Accessed on <https://www.ncrb.gov.in/uploads/files/AccidentalDeathsSuicidesinIndia2022v2.pdf>
65. Press Information Bureau. (2023, December 20). Ministry of Home Affairs launches National Action Plan to prevent and reduce substance abuse related deaths. Government of India. Accessed at <https://www.pib.gov.in/PressReleaseFramePage.aspx?PRID=1980609data>
66. Press Information Bureau. (2025, February 1). Over 10.80 lakh women assisted by 812 One-Stop Centres across India under Mission Shakti. Government of India. <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2115240pib>

67. Press Information Bureau. (2022, September 14). Operational guidelines for 'Saksham Anganwadi and Poshan 2.0' issued by Ministry of Women and Child Development. Government of India. <https://www.pib.gov.in/Pressreleaseshare.aspx?PRID=1847548>
68. Press Information Bureau. (2023, January). Jan Andolan: Participation of Pregnant Women and Lactating Mothers in Nutrition Initiatives. Government of India. <https://www.pib.gov.in/PressNoteDetails.aspx?NoteId=153204&ModuleId=3>
69. Press Information Bureau. (2025, March 15). Rashtriya Poshan Maah 2024: A Nationwide Movement for Health and Nutrition. Government of India. <https://www.pib.gov.in/PressReleaselframePage.aspx?PRID=2123319>
70. Press Information Bureau. (2024, December 20). POSHAN Abhiyaan: Progress and Achievements in Improving Nutritional Outcomes. Government of India. <https://www.pib.gov.in/PressReleaselframePage.aspx?PRID=2051650>
71. Press Information Bureau. (2024, March 10). Government of India launches 'Mission Poshan 2.0' to address malnutrition holistically. Government of India. <https://www.pib.gov.in/PressReleaselframePage.aspx?PRID=2012663>
72. Government of India, Ministry of Health and Family Welfare. (2025). Details of beneficiaries under health schemes [Rajya Sabha Unstarred Question No. 1884]. Government of India. https://sansad.in/getFile/annex/266/AU1884_N8jKTO.pdf?source=pqars
73. Ministry of Health and Family Welfare. (n.d.). Rashtriya Bal Swasthya Karyakram (RBSK). Government of India. <https://rbsk.mohfw.gov.in/RBSK/>
74. Ministry of Women and Child Development. (2021). Saksham Anganwadi and Poshan 2.0 is an Integrated Nutrition Support Programme. Press Information Bureau, Government of India. <https://www.pib.gov.in/Pressreleaseshare.aspx?PRID=1847548>



Notes

A series of horizontal dashed lines for writing notes.



Confederation of Indian Industry

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the development of India, partnering Industry, Government and civil society through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organisation, with around 9,700 members from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 365,000 enterprises from 318 national and regional sectoral industry bodies.

For more than 130 years, CII has been engaged in shaping India's development journey and works proactively on transforming Indian Industry's engagement in national development. CII charts change by working closely with the Government on policy issues, interfacing with thought leaders, and enhancing efficiency, competitiveness, and business opportunities for industry through a range of specialised services and strategic global linkages. It also provides a platform for consensus-building and networking on key issues.

Through its dedicated Centres of Excellence and Industry competitiveness initiatives, promotion of innovation and technology adoption, and partnerships for sustainability, CII plays a transformative part in shaping the future of the nation. Extending its agenda beyond business, CII assists industry to identify and execute corporate citizenship programmes across diverse domains, including affirmative action, livelihoods, diversity management, skill development, empowerment of women, and sustainable development, to name a few.

For 2025-26, CII has identified "Accelerating Competitiveness: Globalisation, Inclusivity, Sustainability, Trust" as its theme, prioritising five key pillars. During the year, CII will align its initiatives to drive strategic action aimed at enhancing India's competitiveness by promoting global engagement, inclusive growth, sustainable practices, and a foundation of trust.

With 70 offices, including 12 Centres of Excellence, in India, and 9 overseas offices in Australia, Egypt, Germany, Indonesia, Singapore, UAE, UK, and USA, as well as institutional partnerships with about 250 counterpart organisations in almost 100 countries, CII serves as a reference point for Indian industry and the international business community.

Confederation of Indian Industry

The Mantosh Sondhi Centre
23, Institutional Area, Lodi Road, New Delhi – 110 003 (India)
T: 91 11 45771000
E: info@cii.in • W: www.cii.in

Follow us on



[cii.in/facebook](https://www.facebook.com/cii.in)



[cii.in/twitter](https://twitter.com/cii.in)



[cii.in/linkedin](https://www.linkedin.com/company/cii.in)



[cii.in/youtube](https://www.youtube.com/cii.in)

Reach us via CII Membership Helpline: 1800-103-1244



About The Women's Collective Forum (WCF)

The Women's Collective Forum (WCF) is a pan-sectoral platform focused on equity-led systems transformation through scalable, institutionally grounded models.

Its enterprise initiative, SPARK – The 100K Collective, addresses the “missing middle” of women-led businesses—enterprises that are already established but remain excluded from formal finance, markets, digital systems, and regulatory frameworks. Through bootcamps in 300 locations, SPARK will work with 100,000 women entrepreneurs to strengthen their capacity to engage with capital, platforms, and institutions, ensuring that systems become navigable for those already building.

Beyond enterprise, WCF collaborates with leading health, technology, and management institutions to advance maternal health protocols, disease elimination, and the integration of new health technologies. In law and governance, WCF supports implementation of India's evolving criminal law frameworks with a focus on survivor-centricity and institutional accountability.

WCF also convenes cross-sectoral dialogues to highlight India's leadership in frugal innovation and systems change, engaging with global leaders and national platforms to translate research into policy and practice.

Across all these areas, WCF's model is consistent: build partnerships that connect evidence to institutions, and design approaches that can scale to strengthen systems for equity.

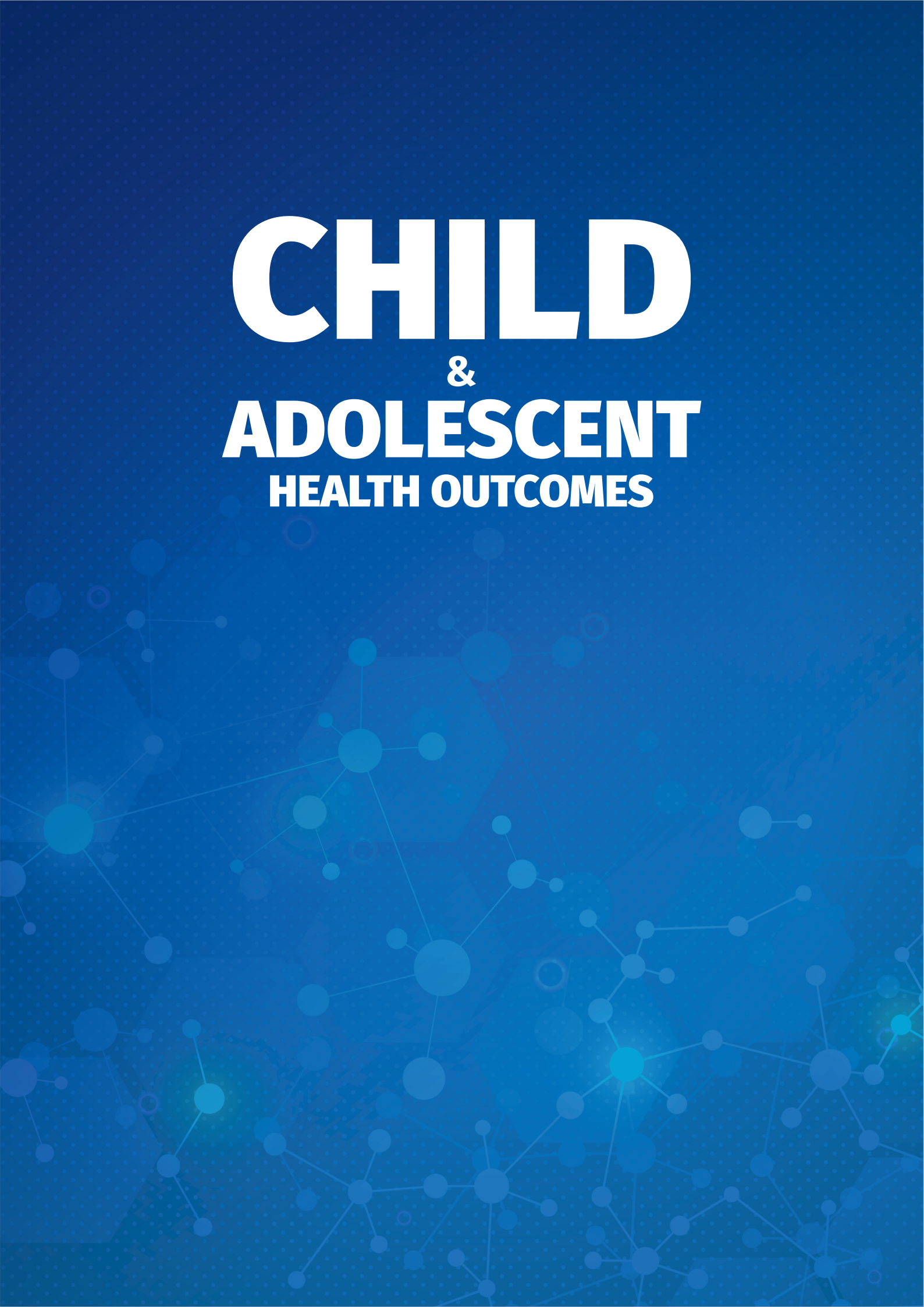


Connect with Us

Website: womenscollectiveforum.org

Email: richa.sharma@womenscollectiveforum.com

womenscollectiveforum@gmail.com

The background of the entire page is a dark blue color with a subtle pattern of small white dots. Overlaid on this is a complex network diagram consisting of numerous blue circles of varying sizes connected by thin, light blue lines. The nodes and lines are scattered across the lower two-thirds of the page, creating a sense of interconnectedness and data flow.

CHILD

&

ADOLESCENT

HEALTH OUTCOMES