Exploring Implementation of the Peer Education Programme for Improving Adolescent Health in India's National Adolescent Health Strategy

i-Saathiya Study Report 2023

Health Promotion Division
Public Health Foundation of India (PHFI)
431A, 4th Floor Rectangle No.1 Behind Saket Sheraton Hotel,
Commercial Complex D4, Saket, New Delhi 110017
Phone: +91-124-4781400 | Fax: +91-124-4781601
www.phfi.org | contact@phfi.org
Table of Contents

01 Acknowledgements 07
02 Background 09
03 Study Overview 10
04 Key Findings 13
05 Recommendations 24
06 References 26
Abbreviations

AEPs - Adolescent Enrolled under Peer Educators
ASHA - Accredited Social Health Activist
ANM - Auxiliary Nurse Midwifery
AFHCs - Adolescent Friendly Health Clinics
AFC - Adolescent Friendly Club
AHWDs - Adolescent Health and Wellness Days
CHO - Community Health Officer
CCE - Continuous and Comprehensive Evaluation
FGDs - Focus Group Discussions
HR - Human resource
IDIs - In-Depth Interviews
MoHFW - Ministry of Health and Family Welfare
MO - Medical Officer
NCDs - Non Communicable Diseases
NHM - National Health Mission
NGO - Non-Governmental Organization
PEs - Peer Educators
RKSK - Rashtriya Kishor Swasthya Karyakram
SRH - Sexual and Reproductive Health
WHO - World Health Organization
<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEPs</td>
<td>Adolescent Enrolled under Peer Educators</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwifery</td>
</tr>
<tr>
<td>AFHCs</td>
<td>Adolescent Friendly Health Clinics</td>
</tr>
<tr>
<td>AFC</td>
<td>Adolescent Friendly Club</td>
</tr>
<tr>
<td>AHWDs</td>
<td>Adolescent Health and Wellness Days</td>
</tr>
<tr>
<td>CHO</td>
<td>Community Health Officer</td>
</tr>
<tr>
<td>CCE</td>
<td>Continuous and Comprehensive Evaluation</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>HR</td>
<td>Human resource</td>
</tr>
<tr>
<td>IDIs</td>
<td>In-Depth Interviews</td>
</tr>
<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>NCDs</td>
<td>Non Communicable Diseases</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>PEs</td>
<td>Peer Educators</td>
</tr>
<tr>
<td>RKSK</td>
<td>Rashtriya Kishor Swasthya Karyakram</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Acknowledgements

Prof. Monika Arora
Vice President Research and Health Promotion
Public Health Foundation of India
New Delhi, India

Ms. Shalini Bassi
Senior Research Scientist
Public Health Foundation of India
New Delhi, India

Dr. Sarit Kumar Rout
Additional Professor
Indian Institute of Public Health
Bhubaneshwar
Public Health Foundation of India
Bhubaneshwar, Odisha, India

Ms. Heeya Maity
Senior Research Assistant
Public Health Foundation of India
New Delhi, India

Prof. Amanda Mason Jones
Associate Professor
Global Public Health
Department of Health Sciences
University of York, York

Dr. Deepika Bahl
Senior Research Associate
Public Health Foundation of India
New Delhi, India

Dr. Ambarish Dutta
Additional Professor
Indian Institute of Public Health
Bhubaneshwar
Public Health Foundation of India
Bhubaneshwar, Odisha, India

Dr. Priya Amrit
Consultant
Public Health Foundation of India
New Delhi, India

Ms. Gayatri Nayak
Consultant
Public Health Foundation of India
New Delhi, India

Dr. Stefanie Dringus
Independent Global Health Consultant
London, United Kingdom

Dr. Nishibha Thapliyal, Consultant
Mr. Suresh K, Manager Administration
Mr. Shubajit Aluni, Assistant Manager Finance
Ms. Ranjana Sharma, Project Officer

Study Team
India Team Members
UK Team Members
Coordinators at Public Health Foundation of India (PHFI)
Acknowledgements

Study Team

India Team Members

Prof. Monika Arora
Vice President Research and Health Promotion
Public Health Foundation of India
New Delhi, India

Ms. Shalini Bassi
Senior Research Scientist
Public Health Foundation of India
New Delhi, India

Dr. Sarit Kumar Rout
Additional Professor
Indian Institute of Public Health
Bhubaneswar
Public Health Foundation of India
Bhubaneswar, Odisha, India

Ms. Heeya Maity
Senior Research Assistant
Public Health Foundation of India
New Delhi, India

Dr. Deepika Bahl
Senior Research Associate
Public Health Foundation of India
New Delhi, India

Dr. Ambarish Dutta
Additional Professor
Indian Institute of Public Health
Bhubaneswar
Public Health Foundation of India
Bhubaneswar, Odisha, India

Dr. Priya Amrit
Consultant
Public Health Foundation of India
New Delhi, India

Ms. Gayatri Nayak
Consultant
Public Health Foundation of India
New Delhi, India

UK Team Members

Prof. Amanda Mason Jones
Associate Professor
Global Public Health
Department of Health Sciences
University of York, York

Dr. Stefanie Dringus
Independent Global Health Consultant
London, United Kingdom

Coordinators at Public Health Foundation of India (PHFI)

Dr. Nishibha Thapliyal, Consultant
Mr. Suresh K, Manager Administration
Mr. Shubajit Aluni, Assistant Manager Finance
Ms. Ranjana Sharma, Project Officer
Acknowledgements

Independent Project Steering Committee (IPSC)

**Prof. David Ross**  
Institute for Life Course  
Health Research  
University of Stellenbosch

**Dr. Harish Pemde**  
Professor and Director  
Department of Pediatrics  
Kalawati Saran Children’s Hospital Lady Hardinge  
Medical College  
New Delhi, India

**Prof. Robert Blum**  
Professor  
Population, Family & Reproductive Health  
Johns Hopkins Bloomberg School of Public Health  
Baltimore, United States

**Dr. Caroline Harris**  
Programme Manager for Global Health Strategy  
Medical Research Council, United Kingdom

**Dr. Zoya Ali Rizvi**  
Deputy Commissioner (Adolescent Health)  
National Health Mission  
Ministry of Health and Family Welfare  
Government of India, New Delhi, India

**Prof. Monika Arora**  
Vice President Research and Health Promotion  
Public Health Foundation of India  
New Delhi, India

**Prof. Amanda Mason Jones**  
Associate Professor  
Global Public Health  
Department of Health Sciences  
University of York, York
Background

India is a young country with the largest ever adolescent and youth population (378 million) [MoHFW, 2023]. This demographic dividend holds the potential to contribute significantly to the nation’s ambitious role of becoming a US $ 5 trillion economy (Ministry of Commerce & Industry, 2018). Thus, underscores the need to invest in adolescent health.

Investing in the health of adolescents can help prevent an estimated 1.4 million deaths that occur globally every year due to road traffic injuries, violence, suicide, human immunodeficiency virus (HIV) and pregnancy-related causes. It can also improve the health and well-being of millions of adolescents who experience health problems such as depression, anaemia or HIV infection. Investing in health promotion activities among adolescents now, such as anti-smoking and healthy eating initiatives, could yield huge returns in reducing the occurrence of non-communicable diseases such as lung cancer and diabetes in later life. Additionally, it can prevent problems in the next generation such as prematurity and low birth weight in infants born to very young mothers (Chandra-Mouli, 2013).

Recognising the importance of protecting and investing in adolescents' health and well-being, the Ministry of Health and Family Welfare, Government of India (MoHFW, GoI), launched the National Adolescent Health Strategy (i.e. Rashtriya Kishor Swasthya Karyakram or RKSK) in 2014 to improve adolescents’ health. The RKSK is a comprehensive and the largest programme in terms of adolescent outreach. The core programming principles for RKSK are health promotion and a community-based approach covering six thematic areas:

1. Sexual and Reproductive Health (SRH)
2. Non-communicable diseases (NCDs)
3. Nutrition
4. Mental health
5. Substance misuse
6. Injuries, and violence

The programme encompasses a holistic approach including community and school-based health promotion and prevention along with strengthening of preventive, diagnostic, and curative services across health facilities. A unique and central component of the RKSK is the community-based Peer Education Programme. This involves the selection of Peer Educators (PEs), training of selected PEs, formation of a group of 15-20 boys and girls by PEs from their community and conducting weekly one
to two-hour participatory sessions on RKSK’s six thematic areas. The sessions aim to increase adolescents’ knowledge, attitudes, health behaviours and life-skills and increase their engagement and access to health services. Global literature on the effectiveness of Peer Education is mixed (Mason-Jones A, 2023; Dodd et al. 2022; Siddiqui et al. 2020; Chandra -Mouli, 2015; Perry et al. 2009), thus underscoring the need for understanding the differences by context and health themes. Peer Education programme has not been formally evaluated for its effectiveness on intended outcomes among adolescents related to all six health themes of RKSK in India. With this background, under the guidance of the Ministry of Health and Family Welfare-Government of India, the Public Health Foundation of India (PHFI) conducted an implementation science research, i-Saathiya (2020-2023), to address this gap in the literature and explored the implementation of the Peer Education Programme for improving adolescent health in India’s National Adolescent Health Strategy.

### Study Overview

The i-Saathiya study funded by the Medical Research Council (MRC)-United Kingdom was conducted in two states (Madhya Pradesh and Maharashtra) of India. The process of Peer Education implementation was explored in i-Saathiya study using MRC’s process evaluation framework (Moore, 2015). An Independent Project Steering Committee (IPSC) was formulated as part of the study which guided the research activities and helped revise the research questions during the COVID-19. The Committee included independent academic members, senior officials from the Adolescent Health Division-MoHFW, GoI, Adolescent Health experts and key investigators from the study team.
Study Methodology

**Study Design:** Cross-sectional with process evaluation

**Study Duration:** February 2020-August 2023

**Study Location: States and Districts**

- **Madhya Pradesh** (72 villages)
  - Panna
  - Damoh
- **Maharashtra** (40 villages)
  - Nashik
  - Yavatmal

**Mixed Methods**

- **Qualitative**
  - In-Depth Interviews (IDI)*
  - Focus Group Discussions (FGDs)
  - Semi-Structured Observations

- **Quantitative**
  - KAP Survey (PEs and AEPs)
  - Out of Pocket Expenditure Survey (Parents of AEPs)

- **Routine Data**
  - PE recruitment, PE training, AHWDs, AFCs, AFHCs
  - Cost Data

*Repeat qualitative assessment
### Key Findings

Success of Peer Education Programme

- PEs looked upon as change agents for adolescents and community
- Increased knowledge of PEs and AEPs on six thematic areas of RKSK
- Enhanced communication skills of PEs
- Acted as leaders (PEs and AEPs) in handling health, social and development issues
- Successfully linked adolescents to the health services by referring them to Adolescent Friendly Health Clinics (AFHCs)
- Provided support to Accredited Social Health Activists (ASHAs) in the implementation of many national health programmes and campaigns, like Maternal and Child Health Programme, Anaemia Mukt Bharat, Pulse Polio campaign, Deworming Day campaign
- PEs created an identity for themselves as "Green Commandos" (in Madhya Pradesh)
- Recognition during the Republic Day Parade (in Madhya Pradesh)
- Additional scores to PEs through Continuous and Comprehensive Evaluation (CCE) (in Madhya Pradesh)
- PEs created pathways for their future employment as NGO Mentor Trainer (in Madhya Pradesh)
- PEs stepped up as innovators, communicators, and bridged the gap between the health system and community by providing prevention messages, distributing masks, sanitizers, and essential materials (groceries, medicines, etc.) to adolescents and communities at their doorstep
- Sensitised the community on COVID-19 Appropriate Behaviours and vaccinations through a contextual community involvement approach, including rallies, wall paintings, nukkad natak (street plays), folk songs, and traditional practices (offering yellow rice)
- To overcome vaccine hesitancy, PEs acted as role models by taking the first dose of the COVID-19 vaccine and motivated community members for the same
- Generated employment for families by providing opportunities for mask making

### Sample Selection

#### States

- **Maharashtra** (Government-led Implementation Model)
  - 2 states selected in consultation with the Ministry of Health and Family Welfare-Government of India
  - 2 districts were selected from each state in consultation with State Health Department
  - 4 Blocks were selected from each district on the basis of female literacy and tribal population
  - Villages were selected through Probability Proportionate to Size (PPS) from each block
  - Selection of 5 villages per block
  - 20 villages per district
  - Total 40 villages selected in Maharashtra

- **Madhya Pradesh** (NGO-led Implementation Model)
  - 2 states selected in consultation with the Ministry of Health and Family Welfare-Government of India
  - 2 districts were selected from each state in consultation with State Health Department
  - 4 Blocks were selected from each district on the basis of female literacy and tribal population
  - Villages were selected through Probability Proportionate to Size (PPS) from each block
  - Selection of 9 villages per block
  - 36 villages per district
  - Total 72 villages selected in Madhya Pradesh

#### Adolescents and PEs were selected

- **Maharashtra** (Government-led Implementation Model)
  - Total 36 villages selected
  - 18 villages per district
  - Total 360 adolescents (AEPs: 302, PEs: 58)

- **Madhya Pradesh** (NGO-led Implementation Model)
  - Total 72 villages selected
  - 36 villages per district
  - Total 360 adolescents (AEPs: 288, PEs: 72)
Key Findings

Success of Peer Education Programme

CHANGE AGENTS

PEs looked upon as change agents for adolescents and community

- Improved behaviour of adolescents (use of hygienic menstrual products, no use of alcohol and tobacco cessation)
- Contributed in preventing cases of child marriages, teenage pregnancies in community
- Helped school dropout adolescents to continue their education
- Improved coverage of pulse polio immunization (100% children received polio dose in Madhya Pradesh)

EMPOWERMENT

- Increased knowledge of PEs and AEPs on six thematic areas of RKSK
- Enhanced communication skills of PEs
- Acted as leaders (PEs and AEPs) in handling health, social and development issues

HEALTH SYSTEM STRENGTHENING

- Successfully linked adolescents to the health services by referring them to Adolescent Friendly Health Clinics (AFHCs)
- Provided support to Accredited Social Health Activists (ASHAs) in the implementation of many national health programmes and campaigns, like Maternal and Child Health Programme, Anaemia Mukt Bharat, Pulse Polio campaign, Deworming Day campaign

RECOGNITION AND APPRECIATION

- PEs created an identity for themselves as “Green Commandos” (in Madhya Pradesh)
- Recognition during the Republic Day Parade (in Madhya Pradesh)
- Additional scores to PEs through Continuous and Comprehensive Evaluation (CCE) (in Madhya Pradesh)
- PEs created pathways for their future employment as NGO Mentor Trainer (in Madhya Pradesh)

ENGAGEMENT DURING COVID-19

- PEs stepped up as innovators, communicators, and bridged the gap between the health system and community by providing prevention messages, distributing masks, sanitizers, and essential materials (groceries, medicines, etc.) to adolescents and communities at their doorstep
- Sensitised the community on COVID-19 Appropriate Behaviours and vaccinations through a contextual community involvement approach, including rallies, wall paintings, nukkad natak (street plays), folk songs, and traditional practices (offering yellow rice)
- To overcome vaccine hesitancy, PEs acted as role models by taking the first dose of the COVID-19 vaccine and motivated community members for the same
- Generated employment for families by providing opportunities for mask making

States

2 states selected in consultation with the Ministry of Health and Family Welfare-Government of India

Madhya Pradesh

Panna

Damoh

Shahnagar

Ajaygarh

Panna

Pawai

Damoh

Jabera

Patera

Patharia

States

3123 Adolescents (AEPs: 2885, PEs: 238)

Adolescents and PEs were selected

Villages were selected through Probability Proportionate to Size (PPS) from each block

2 districts were selected from each state in consultation with State Health Department

4 Blocks were selected from each district on the basis of female literacy and tribal population

Maharashtra

Nashik

Yavatmal

Dindori

Nandagaon

Sinner

Surgana

Babulgaon

Pusad

Zarizammi

Yavatmal

States

Selection of 5 villages per block

20 villages per district

Total 40 villages selected in Maharashtra

Nashik

Yavatmal

Dindori

Nandagaon

Sinner

Surgana

Babulgaon

Pusad

Zarizammi

Yavatmal
## Distribution of Socio-Demographic characteristics of Adolescents (PEs and AEPs) across states

<table>
<thead>
<tr>
<th>Age group (in years)</th>
<th>Madhya Pradesh (N=1480)</th>
<th>Maharashtra (N=1643)</th>
<th>Total (N=3123)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 yrs</td>
<td>279 (18.9%)</td>
<td>598 (36.6%)</td>
<td>877 (28.2%)</td>
</tr>
<tr>
<td>15-19 yrs</td>
<td>1097 (74.2%)</td>
<td>886 (54.2%)</td>
<td>1983 (63.7%)</td>
</tr>
<tr>
<td>Above 19 yrs</td>
<td>102 (6.9%)</td>
<td>151 (9.2%)</td>
<td>253 (8.1%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>741 (50.1%)</td>
<td>794 (48.3%)</td>
<td>1535 (49.2%)</td>
</tr>
<tr>
<td>Female</td>
<td>739 (49.9%)</td>
<td>849 (51.7%)</td>
<td>1588 (50.8%)</td>
</tr>
<tr>
<td>Caste</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST</td>
<td>61 (4.1%)</td>
<td>688 (41.9%)</td>
<td>749 (24.0%)</td>
</tr>
<tr>
<td>SC</td>
<td>211 (14.2%)</td>
<td>197 (12.0%)</td>
<td>408 (13.1%)</td>
</tr>
<tr>
<td>OBC</td>
<td>926 (62.6%)</td>
<td>449 (27.3%)</td>
<td>1375 (44.0%)</td>
</tr>
<tr>
<td>None of these</td>
<td>207 (14.0%)</td>
<td>288 (17.5%)</td>
<td>495 (15.8%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>75 (5.1%)</td>
<td>21 (1.3%)</td>
<td>96 (3.1%)</td>
</tr>
<tr>
<td>Socio- Economic Status (SES)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest Tertile</td>
<td>725 (49.0%)</td>
<td>319 (19.4%)</td>
<td>1044 (33.4%)</td>
</tr>
<tr>
<td>Intermediate Tertiile</td>
<td>501 (33.8%)</td>
<td>538 (32.8%)</td>
<td>1039 (33.3%)</td>
</tr>
<tr>
<td>Richest Tertile</td>
<td>254 (17.2%)</td>
<td>786 (47.8%)</td>
<td>1040 (33.3%)</td>
</tr>
</tbody>
</table>
## State Disaggregated Knowledge, Attitudes and Behaviour scores of Adolescents (PEs +AEPs)

<table>
<thead>
<tr>
<th></th>
<th>Madhya Pradesh (N=1480)</th>
<th>Maharashtra (N=1643)</th>
<th>Total (N=3123)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition and NCDs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge</strong> (Possible score is 0-7, 7 being most appropriate knowledge)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.20 (1.32)</td>
<td>4.48 (1.76)</td>
<td>3.88 (1.69)</td>
</tr>
<tr>
<td><strong>Attitudes</strong> (Only obese adolescents should exercise)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>510 (34.5%)</td>
<td>621 (37.8%)</td>
<td>1131 (36.2%)</td>
</tr>
<tr>
<td>Agree</td>
<td>463 (31.3%)</td>
<td>608 (37.0%)</td>
<td>1071 (34.3%)</td>
</tr>
<tr>
<td>Not Sure</td>
<td>360 (24.3%)</td>
<td>19 (1.2%)</td>
<td>379 (12.1%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>50 (3.4%)</td>
<td>208 (12.7%)</td>
<td>258 (8.3%)</td>
</tr>
<tr>
<td><strong>Nutritional behaviour</strong> (Possible score is 0-12, 12 being most appropriate/good practice)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>8.55 (1.54)</td>
<td>8.06 (1.70)</td>
<td>8.29 (1.64)</td>
</tr>
<tr>
<td><strong>Physical activity related behaviour</strong> (Number of days age appropriate exercises undertaken per week)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>2.87 (0.70)</td>
<td>2.54 (1.25)</td>
<td>2.70 (1.04)</td>
</tr>
<tr>
<td><strong>Substance Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge</strong> (Possible score is 0-5, 5 being the most appropriate knowledge)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.28 (1.17)</td>
<td>4.26 (0.92)</td>
<td>3.80 (1.15)</td>
</tr>
<tr>
<td><strong>Attitude</strong> (Possible score is 2-6, 2 being least positive and 6 being most positive attitude)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>5.7 (0.2)</td>
<td>5.8 (0.12)</td>
<td>5.8 (0.17)</td>
</tr>
<tr>
<td><strong>Prevalence</strong> (any form of substance abuse related behaviour)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>81 (5.5%)</td>
<td>22 (1.3%)</td>
<td>103 (3.3%)</td>
</tr>
<tr>
<td><strong>Injury and Violence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge</strong> (Possible score is 0-10, with 10 being most appropriate knowledge)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>1.64 (2.14)</td>
<td>1.45 (2.18)</td>
<td>1.54 (2.16)</td>
</tr>
<tr>
<td><strong>Attitudes</strong> (Possible score is 0-4, 4 being the most positive attitude)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>1.40 (1.05)</td>
<td>2.28 (1.04)</td>
<td>1.86 (1.13)</td>
</tr>
<tr>
<td><strong>Experience of Violence</strong> (Possible score is 0-5, 0 being someone who has not experienced any form of violence)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>0.58 (0.77)</td>
<td>0.36 (0.55)</td>
<td>0.46 (0.67)</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Knowledge</strong> (Possible score is 0-9, 9 being most appropriate knowledge)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>4.31 (1.69)</td>
<td>4.60 (2.15)</td>
<td>4.46 (1.95)</td>
</tr>
<tr>
<td><strong>Mental health status</strong> (Using SDQ scale)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>304 (20.5%)</td>
<td>1190 (72.4%)</td>
<td>1494 (47.8%)</td>
</tr>
<tr>
<td>Borderline</td>
<td>372 (25.2%)</td>
<td>212 (12.9%)</td>
<td>584 (18.7%)</td>
</tr>
<tr>
<td>Abnormal</td>
<td>804 (54.3%)</td>
<td>241 (14.7%)</td>
<td>1045 (33.5%)</td>
</tr>
</tbody>
</table>
Qualitative Findings: In-depth interviews, Focus Group Discussions and Semi-structured Observations

Selection, Recruitment, and Attrition of Peer Educators (PEs)

<table>
<thead>
<tr>
<th>Maharashtra (N=1643)</th>
<th>Madhya Pradesh (N=1480)</th>
<th>Total (N=3123)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour (Possible score is 0-10, 10 being the most appropriate behaviour)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>4.90 (2.10)</td>
<td>4.48 (2.21)</td>
</tr>
<tr>
<td>Sexual and Reproductive Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge (Possible score is 0-30, 30 being most appropriate knowledge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>11.93 (8.96)</td>
<td>8.93 (8.08)</td>
</tr>
<tr>
<td>Attitudes (Possible score 0-8, 8 being the most favourable score)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>5.05 (2.11)</td>
<td>5.74 (2.01)</td>
</tr>
<tr>
<td>Menstrual Hygiene Management (n=1706 girls)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate hygiene</td>
<td>187 (22.0%)</td>
<td>477 (30.0%)</td>
</tr>
<tr>
<td>Appropriate hygiene but inappropriate disposal</td>
<td>592 (69.7%)</td>
<td>920 (57.9%)</td>
</tr>
<tr>
<td>Both appropriate</td>
<td>70 (8.3%)</td>
<td>191 (12.1%)</td>
</tr>
</tbody>
</table>

- Knowledge on injury and violence (mean score being 1.544 in a possible range of 0-10) was deficient and experience of violence was minimum
- Average knowledge on Nutrition, NCDs and Mental Health was in the middle of their respective ranges
- Knowledge on SRH was significantly deficient (mean score being 8.9 in a possible range of 0-30)
- Favourable practices to maintain positive mental health was only 4.6 on an average (possible score ranging 0-10)
- Menstrual Hygiene Management Practice for disposal was inappropriate among 57.9% adolescent girls
Qualitative Findings: In-depth interviews, Focus Group Discussions and Semi-structured Observations

Selection, Recruitment, and Attrition of Peer Educators (PEs)

**Maharashtra**

**ELIGIBILITY CRITERIA**
Selection of four PEs (two from 10-14 years and two from 15-19 years), leadership skills, communication skills, friendly, knowledgeable, and responsible.

**MULTI-LEVEL SELECTION PROCESS**
ASHA in consultation with ANM/CHO/ASHA facilitator/Medical officer

**COVERAGE OF ADOLESCENTS UNDER THE PROGRAMME**
Maharashtra with 4 PEs had 38.8% of younger population (10-15 years) in their adolescent group

**INCENTIVES**
Non-financial incentives, travel allowance for PE training

**REASONS FOR ATTRITION**
Female PEs getting married, impact on education, inadequate information about their role in the programme, parents' hesitancy

**Madhya Pradesh**

**ELIGIBILITY CRITERIA**
Selection of two PEs (15+ years) and two Shadow Peers *(10-14 years), leadership skills, communication skills, high motivation, sympathetic, not taking any substances, PE should not have any familial relation with the community health worker

**MULTI-LEVEL SELECTION PROCESS**
NGO Trainer Mentor in consultation with ASHA

**COVERAGE OF ADOLESCENTS UNDER THE PROGRAMME**
Madhya Pradesh with 2 PEs had 20% of younger population (10-15 years) in their adolescent group

**INCENTIVES**
Non-financial incentives, travel allowance for PE training, training completion certificate, additional scores to PEs through Continuous and Comprehensive Evaluation (CCE)

**REASONS FOR ATTRITION**
Lack of incentives, relocation of PEs for higher education, relocation of family, parents' hesitancy

*Shadow Peers: Shadow peer, aged between 10-14 years, provides support to the trained Peer Educator by accompanying them in all peer-led activities*
## Peer Educator (PE) Training

### Maharashtra

<table>
<thead>
<tr>
<th>PEs TRAINED (%)</th>
<th>88.8% of selected PEs were trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING PROCESS</td>
<td>Flexible days (4-5 days), flexible timings (not full day), conducted by Master Trainers/health workers, information disseminated was not standardised</td>
</tr>
<tr>
<td>INTEGRATION OF RESOURCES FROM OTHER HEALTH PROGRAMMES</td>
<td>Limited use of RSKS resources due to their unavailability, leveraging resources from other programmes like ARSH manual, relied on experiences of the Master Trainers</td>
</tr>
<tr>
<td>PRE-POST TRAINING ASSESSMENTS</td>
<td>No Pre-Post training Assessment</td>
</tr>
<tr>
<td>BARRIERS TO ATTENDANCE</td>
<td>Inadequate access to public transportation, inappropriate weather conditions, conflict of training schedule with school’s activities</td>
</tr>
<tr>
<td>INCENTIVES</td>
<td>Travel allowance for PEs</td>
</tr>
</tbody>
</table>

### Madhya Pradesh

<table>
<thead>
<tr>
<th>PEs TRAINED (%)</th>
<th>76.0% of selected PEs were trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING PROCESS</td>
<td>Structured (6 days), fixed timings (10am-4pm), conducted by NGO Trainer Mentor (dedicated HR), delivery of standardised content</td>
</tr>
<tr>
<td>INTEGRATION OF RESOURCES FROM OTHER HEALTH PROGRAMMES</td>
<td>Use of RSKS manuals, posters, innovative RSKS resources like comic books, videos and leveraging resources from other programmes like School Health Programme under Ayushman Bharat</td>
</tr>
<tr>
<td>PRE-POST TRAINING ASSESSMENTS</td>
<td>Pre-post training assessment showed improvement in knowledge; Panna - 9.6 (pre-training) to 19.9 (post-training); Damoh - 7.7 (pre-training) to 14.5 (post-training) out of 20</td>
</tr>
<tr>
<td>BARRIERS TO ATTENDANCE</td>
<td>Inadequate access to public transportation, remote training location, inappropriate weather conditions</td>
</tr>
<tr>
<td>INCENTIVES</td>
<td>Travel allowance for PEs, Certificate of completion for the training</td>
</tr>
</tbody>
</table>

* Adolescent groups are called a Brigade in Madhya Pradesh

Adolescent Health and Wellness Days

On hold since March 2020 due to COVID-19 and budgetary constraints
## Formation of Adolescent Group/Brigade*

<table>
<thead>
<tr>
<th>Maharashtra</th>
<th>Madhya Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP CONSTITUTION</strong></td>
<td></td>
</tr>
<tr>
<td>5-25 adolescents under each PE</td>
<td>12-14 adolescents under each PE</td>
</tr>
</tbody>
</table>

| **SUPPORTIVE SUPERVISION** | |
| ASHA and sometimes teachers support the formation of Adolescent Group | ASHA and NGO Trainer Mentors support the brigade formation |

| **ACCEPTABILITY** | |
| Adolescent Group formed by the PEs usually consists of friends of PEs. Acceptance of PE by the group. | Adolescent Group formed by the PEs usually consists of friends of PEs. Acceptance of PE by the group. |

* Adolescent groups are called a Brigade in Madhya Pradesh

---

## Adolescent Health and Wellness Days

<table>
<thead>
<tr>
<th>Maharashtra</th>
<th>Madhya Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMPLEMENTATION STATUS</strong></td>
<td></td>
</tr>
<tr>
<td>Ongoing but at reduced scale</td>
<td>On hold since March 2020 due to COVID-19 and budgetary constraints</td>
</tr>
</tbody>
</table>

---

*Adolescent Health and Wellness Days are on hold since March 2020 due to COVID-19 and budgetary constraints.*
## Village Level Sessions by PEs

### Maharashtra

<table>
<thead>
<tr>
<th>FREQUENCY AND DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency:</strong> Monthly to Quarterly</td>
</tr>
<tr>
<td><strong>Duration:</strong> 45 to 60 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADOLESCENT ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-49 (Male: 11-30; Female: 13-19)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORTIVE SUPERVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive supervision provided by ASHA to PEs and occasionally PEs conduct alone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavily relied on knowledge, notes, and Google for information due to limited number of printed resources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SESSION AWARENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low awareness about the PE sessions among parents of both PEs and adolescents, and teachers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BARRIERS FOR CONDUCTING SESSIONS BY PEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEs hesitant to conduct sessions on sensitive topics e.g. SRH and lack of full understanding of issues like violence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOST LIKED AND LEAST LIKED SESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most liked: Personal hygiene, menstruation (among girls), community sanitation and hygiene (boys)</td>
</tr>
<tr>
<td>Least liked: child marriage, gender identity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ATTENDANCE BARRIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconvenient timing, lack of incentives, less engaging strategies, gender of the health worker (mostly females) and embarrassment discussing SRH-related issues</td>
</tr>
</tbody>
</table>

### Madhya Pradesh

<table>
<thead>
<tr>
<th>FREQUENCY AND DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency:</strong> Monthly</td>
</tr>
<tr>
<td><strong>Duration:</strong> 30 to 90 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADOLESCENT ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-48 (Male: 11-24; Female: 8-24) *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORTIVE SUPERVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sessions conducted by PEs in the presence of NGO Trainer Mentors with reporting through App</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of comic books, videos, Kranti Bhranti cards and play-way methods like role plays and case studies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SESSION AWARENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low awareness about the PE sessions among parents of PEs and adolescents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BARRIERS FOR CONDUCTING SESSIONS BY PEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEs hesitant to conduct sessions on sensitive topics e.g. SRH and lack of full understanding of issues like violence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOST LIKED AND LEAST LIKED SESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most liked: Personal hygiene, menstruation (among girls), undernutrition and anaemia</td>
</tr>
<tr>
<td>Least liked: Pubertal changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ATTENDANCE BARRIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconvenient timings, parents unwillingness and lack of incentives for the brigade members</td>
</tr>
</tbody>
</table>

* PE Sessions also attended by adolescents who are not part of the Peer Education programme
### Adolescent Friendly Health Clinics (AFHCs)

#### Maharashtra

- **AFHC AWARENESS**
  - PEs: 79.1%; AEPs: 57.5%
  - Majority of parents and school teachers were unaware of AFHCs

- **BARRIERS TO ACCESS**
  - Hesitation to go alone, transport, parents’ hesitation, low awareness and gender of counsellors in AFHCs

- **SOURCE OF INFORMATION ABOUT AFHCs**
  - 64% AEPs received information from PEs; 88.7% of aware PEs received information from ANM

- **DIGITISATION OF RESOURCES**
  - Counsellors expressed the need for digital resources (app or toolkit) for managing adolescent clients

#### Madhya Pradesh

- **AFHC AWARENESS**
  - PEs: 53.8%; AEPs: 17.5%
  - Majority of parents were unaware of AFHCs

- **BARRIERS TO ACCESS**
  - Embarrassment, distance, and lack of awareness

- **SOURCE OF INFORMATION ABOUT AFHCs**
  - 62.6% of AEPs received information about the clinics from PEs; 75% of the aware PEs received information from ASHAs

- **DIGITISATION OF RESOURCES**
  - Counsellors expressed the need for digital resources (app or toolkit) for managing adolescent clients

---

### Adolescent Friendly Club Meetings

<table>
<thead>
<tr>
<th>Maharashtra</th>
<th>Madhya Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMPLEMENTATION STATUS</strong></td>
<td>On hold since March 2020 till April 2022 (resumed in May 2022)</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>Handholding was provided by the ANM and NGO Trainer Mentor for conducting future sessions</td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
<td>Used RKSK Comic books and Role plays</td>
</tr>
</tbody>
</table>

---

**Note:** PE Sessions also attended by adolescents who are not part of the Peer Education programme.
Findings: Cost of PE Programme in Madhya Pradesh and Maharashtra

Health system cost entails the cost borne by the provider to deliver various services. This further helps in price negotiation for purchasing services from the private sector and budgeting. Overall, this is critical for resource allocation decisions in the health system. However, there are limited studies on the cost of delivering various services by the health system of the country. In this context, this study attempts to estimate the resource use and implementation cost of the Peer Education programme in the two states of India (Madhya Pradesh and Maharashtra). We used the micro-costing approach (bottom-up costing), where all relevant resources used for the PE programme were identified and the cost was estimated accordingly.

The findings suggested that in Maharashtra, the total Peer Education programme cost on average was INR 412990 (95% CI: 246728-579251) whereas, this was INR 1092968 (95% CI: 608344 - 1577592) in Madhya Pradesh.

<table>
<thead>
<tr>
<th>State</th>
<th>Total Cost (INR)</th>
<th>Distribution (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madhya Pradesh</td>
<td>1092968</td>
<td></td>
</tr>
<tr>
<td>Maharashtra</td>
<td>412990</td>
<td></td>
</tr>
</tbody>
</table>

While examining the share of different components in the total cost, it was observed that in Maharashtra, the share of human resource cost was the highest (45%) followed by PE incentives cost (24.1%), training cost of the PEs (18.2%), meeting cost (11.1%), and monitoring cost (1.6%). In Madhya Pradesh, the monitoring cost formed the highest share (58.8%) in the total Peer Education programme cost followed by the cost incurred for human resources (19.1%), incentives for the PEs (15.6%), administrative cost (6.4%) and meeting cost (0.1%).
Overall, the per unit cost of creating a PE in Madhya Pradesh was INR 2935/ against INR 1818/ in Maharashtra in 2020-21. Similarly, the per unit cost of adolescents enrolled under PE in the year 2020-21 was INR 262/ in Madhya Pradesh and this was INR 168/ in Maharashtra. The cost data analysis showed that there were variations in the cost of delivering PE services in both the states of India and between the districts in a state. The variations ought be explained in proper perspective. The cost variation is due to differences in the implementation strategies between the states. The two states included in this study are diverse in terms of implementation modalities – Madhya Pradesh, with an NGO-led model and Maharashtra, with a government-led model. In the case of Madhya Pradesh, the cost is higher because of monitoring and administrative cost related to NGO engagement.
Recommendations

Selection, Recruitment, and Attrition of Peer Educators

- Community-level sensitisation programmes can be organised through AHWDs or similar platforms at the village level to raise awareness about Peer Education programme, RKSK and AFHCs
- Additional scores through CCE or skill training and other context appropriate incentives can be provided to motivate PEs to overcome attrition
- Additional eligibility criteria for PEs selection can include not using any kind of substances (tobacco, alcohol or any other substance) as PEs are seen as role model
- Select 4 PEs (10-14 years: 2; 15-19 years:2) to provide representative coverage of adolescent population

Peer Educator Training

- Booster training at regular intervals can be organised for PEs to refresh their knowledge and skills. AFC meetings can be used for these booster trainings
- PE training to be structured with defined days, timings, topics for discussion, provision of kits and digital resources to PEs
- Schedule training time and days in consultation with PEs, parents and teachers
- Pre-Post training assessment should be conducted with the PEs to assess the effectiveness of training
- Skills assessment of PEs can be conducted at regular interval either through rating survey or qualitatively
- Formal training of health workers can help in delivering standardised information during PE trainings
- It is important to have in-depth discussions with the PEs on topics like injuries and violence to ensure they understand the issues and comprehend the associated challenges appropriately
- PEs to be trained on environment-friendly methods of disposing sanitary napkins

Peer Educator Sessions

- Increase frequency of sessions with supportive supervision from ASHA/NGO Mentor for sensitive issues like SRH, injuries and violence
- Meaningful engagement of PEs and adolescents in the co-creation of digital resources with updated content for all themes and especially to enhance the acceptability and skills to handle issues like SRH, injuries and violence
- Involvement of male health workers or Community Health Officers can help address the hesitancy of male adolescents in attending PE sessions. This inclusion may encourage their active participation and engagement
Adolescent Friendly Health Clinics

- The newly developed Information, Education and communication (IEC) and digital resources to be provided at AFHCs for improving access to these facilities
- Outreach sessions by counsellors can generate awareness in the schools and community about AFHC
- IEC can be displayed at various places in the village to generate awareness about the AFHCs
- AFHC services can be made part of the Citizen’s Charter of the facility located at all level of health system
- Popularizing counseling services in every possible RKSK forum through deployment of trained counsellors

Adolescent Friendly Club Meetings

- A digital resource library can be created at the AFC to empower PEs with knowledge and skills

Adolescent Health and Wellness Days

- Scale of AHWDs can be resumed to improve community and parent engagement and also to sensitise adolescents and PEs
- AHWDs should be used as a continuous platform in the village for community sensitisation about the RKSK, Peer Education programme and existing health services (AFHCs, helplines and Apps) to create an enabling environment for PEs and for the overall sustainability of the programme

Routine RKSK data

- A mobile/online data collection system for PEs and all stakeholders in the health system may be introduced for standardised data collection and maintenance of the routine data for future analysis to understand the process and impact of the programme

Cost data

- Conduct cost-effectiveness analysis for NGO-led and Government-led model to assess effectiveness of strategies comparing costs with outputs
References


Glimpses from the Field
Contact

facebook.com/thePHFI
instagram.com/thePHFI
twitter.com/thePHFI
slideshare.net/thePHFI
youtube.come/PHFIchannel