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

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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

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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).

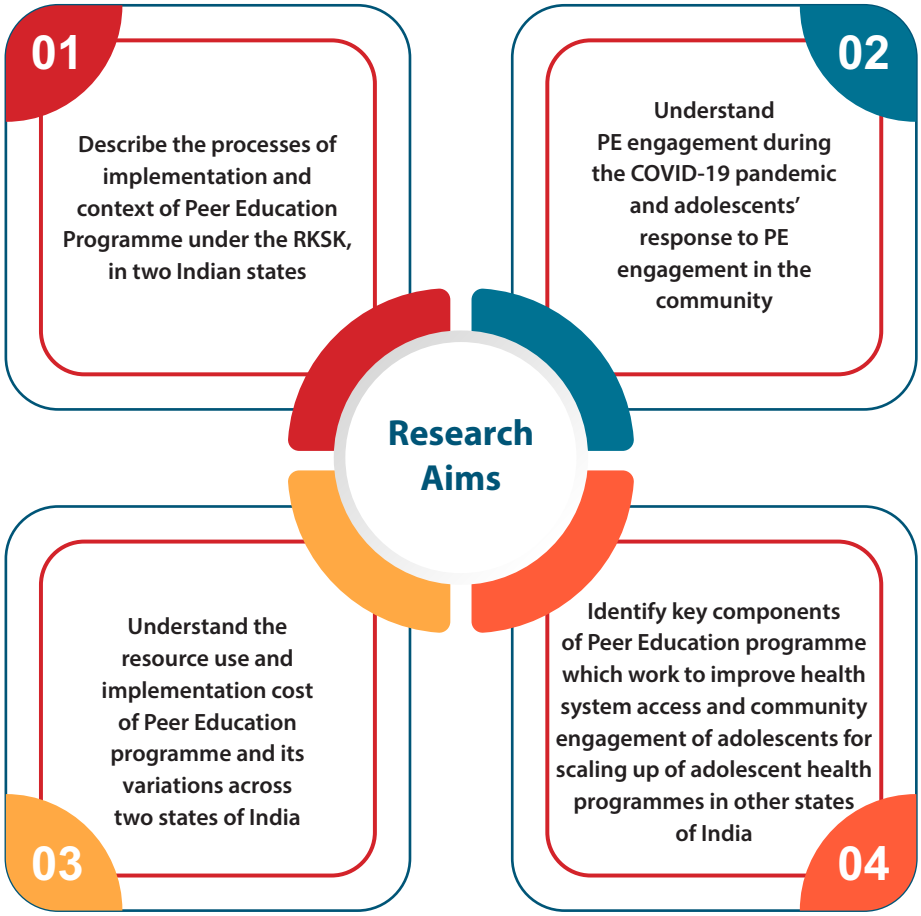
Recognising the importance of protecting and investing in adolescents' health and well-being, the Ministry of Health and Family Welfare, Government of India (MoHFW, GoI), launched the National Adolescent Health Strategy (i.e. Rashtriya Kishor Swasthya Karyakram or RKSK) in 2014 to improve adolescents' 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:

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.

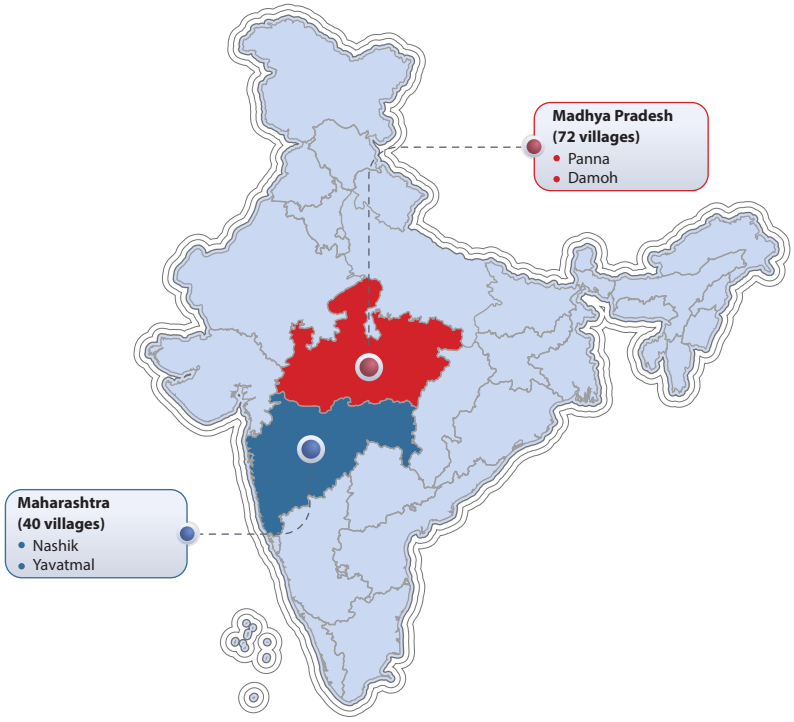


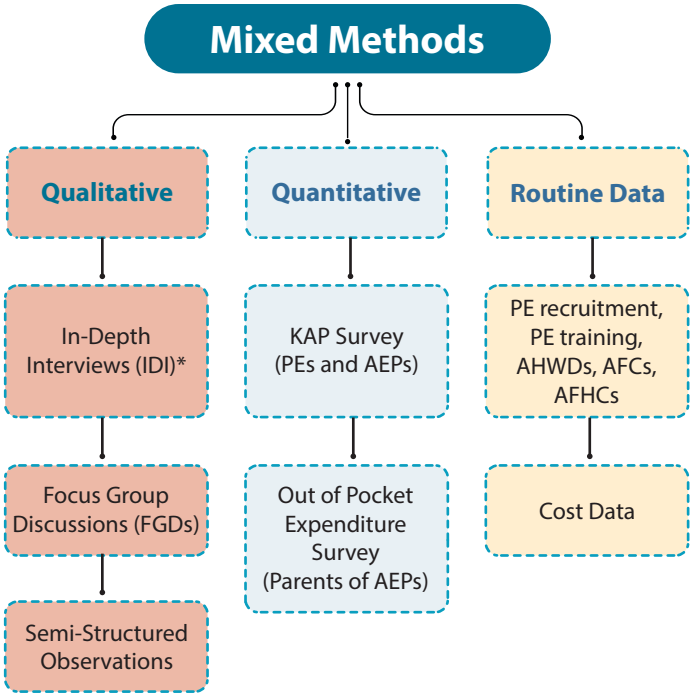
Study Methodology

Study Design: Cross-sectional with process evaluation

Study Duration: February 2020-August 2023

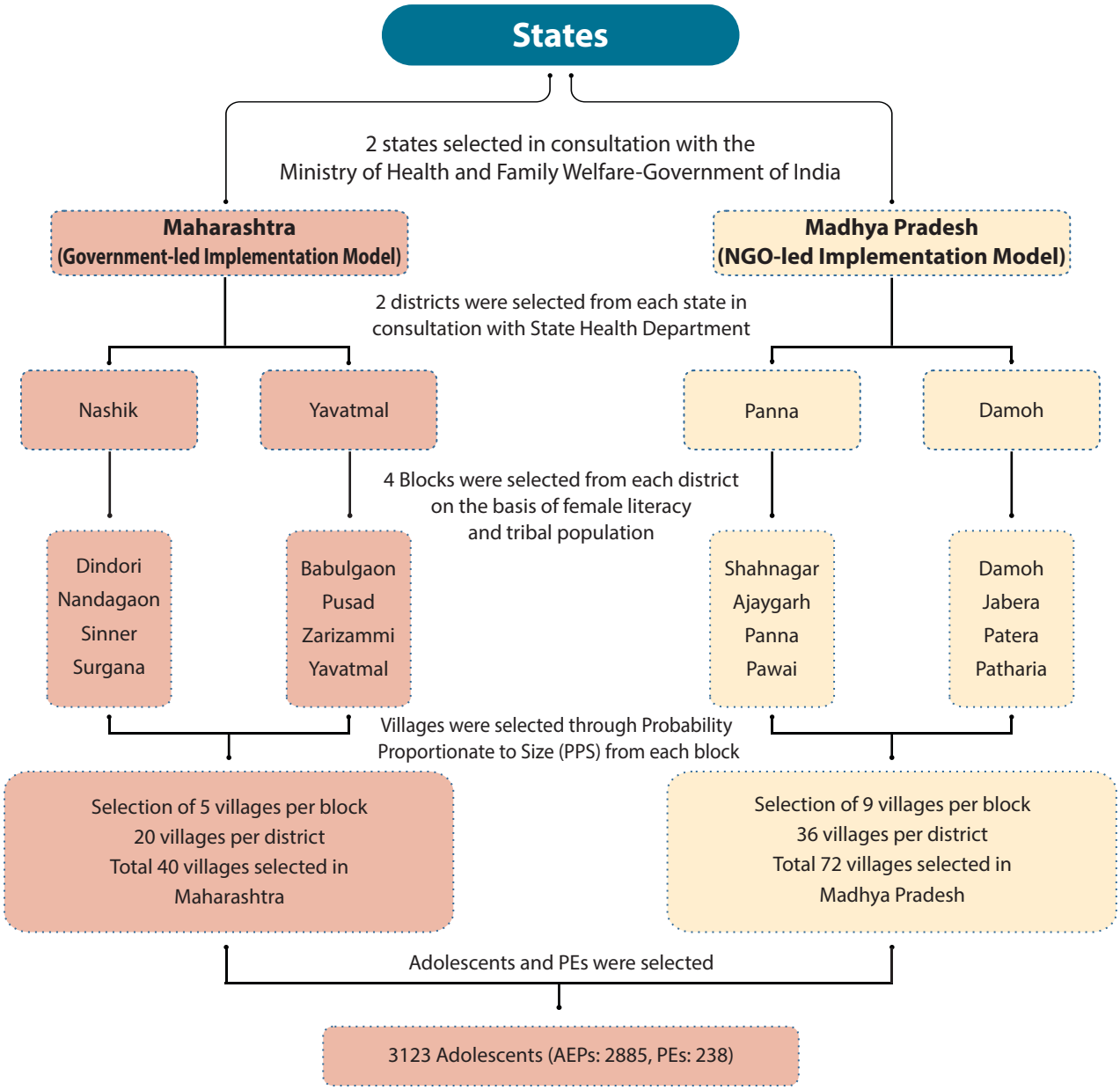
Study Location: States and Districts





**Repeat qualitative assessment*

Sample Selection



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

Findings: Survey

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

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

State Disaggregated Knowledge , Attitudes and Behaviour scores of Adolescents (PEs +AEPs)

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

	Madhya Pradesh (N=1480)	Maharashtra (N=1643)	Total (N=3123)
Behaviour (Possible score is 0-10, 10 being the most appropriate behaviour)			
Mean (SD)	4.02 (2.24)	4.90 (2.10)	4.48 (2.21)
Sexual and Reproductive Health			
Knowledge (Possible score is 0-30, 30 being most appropriate knowledge)			
Mean (SD)	5.59 (5.24)	11.93 (8.96)	8.93 (8.08)
Attitudes (Possible score 0-8, 8 being the most favourable score)			
Mean (SD)	6.50 (5.79)	5.05 (2.11)	5.74 (2.01)
Menstrual Hygiene Management (n=1706 girls)			
Inappropriate hygiene	290 (39.2%)	187 (22.0%)	477 (30.0%)
Appropriate hygiene but inappropriate disposal	328 (44.4%)	592 (69.7%)	920 (57.9%)
Both appropriate	121 (16.4%)	70 (8.3%)	191 (12.1%)

- 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

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

	Maharashtra	Madhya Pradesh
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	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	ASHA in consultation with ANM/CHO/ASHA facilitator/Medical officer	NGO Trainer Mentor in consultation with ASHA
COVERAGE OF ADOLESCENTS UNDER THE PROGRAMME	Maharashtra with 4 PEs had 38.8% of younger population (10-15 years) in their adolescent group	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	Non-financial incentives, travel allowance for PE training, training completion certificate, additional scores to PEs through Continuous and Comprehensive Evaluation (CCE)
REASONS FOR ATTRITION	Female PEs getting married, impact on education, inadequate information about their role in the programme, parents' hesitancy	Lack of incentives, relocation of PEs for higher education, relocation of family, parents' hesistancy

**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	Madhya Pradesh
PEs TRAINED (%)	
88.8% of selected PEs were trained	76.0% of selected PEs were trained
TRAINING PROCESS	
Flexible days (4-5-days), flexible timings (not full day), conducted by Master Trainers/health workers, information disseminated was not standardised	Structured (6 days), fixed timings (10am-4pm), conducted by NGO Trainer Mentor (dedicated HR), delivery of standardised content
INTEGRATION OF RESOURCES FROM OTHER HEALTH PROGRAMMES	
Limited use of RKSK resources due to their unavailability, leveraging resources from other programmes like ARSH manual, relied on experiences of the Master Trainers	Use of RKSK manuals, posters, innovative RKSK resources like comic books, videos and leveraging resources from other programmes like School Health Programme under Ayushman Bharat
PRE-POST TRAINING ASSESSMENTS	
No Pre-Post training Assessment	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
BARRIERS TO ATTENDANCE	
Inadequate access to public transportation, inappropriate weather conditions, conflict of training schedule with school's activities	Inadequate access to public transportation, remote training location, inappropriate weather conditions
INCENTIVES	
Travel allowance for PE s	Travel allowance for PEs, Certificate of completion for the training

Formation of Adolescent Group/Brigade*

Maharashtra	Madhya Pradesh
GROUP CONSTITUTION	
5-25 adolescents under each PE	12-14 adolescents under each PE
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

Maharashtra	Madhya Pradesh
IMPLEMENTATION STATUS	
Ongoing but at reduced scale	On hold since March 2020 due to COVID-19 and budgetary constraints

Village Level Sessions by PEs

	Maharashtra	Madhya Pradesh
FREQUENCY AND DURATION	**Frequency:** Monthly to Quaterly **Duration:** 45 to 60 minutes	**Frequency:** Monthly **Duration:** 30 to 90 minutes
ADOLESCENT ATTENDANCE	24-49 (Male: 11-30; Female: 13-19)	19-48 (Male: 11-24; Female: 8-24) *
SUPPORTIVE SUPERVISION	Supportive supervision provided by ASHA to PEs and occassionally PEs conduct alone	Sessions conducted by PEs in the presence of NGO Trainer Mentors with reporting through App
RESOURCES	Heavily relied on knowledge, notes, and Google for information due to limited number of printed resources	Use of comic books, videos, Kranti Bhranti cards and play-way methods like role plays and case studies
SESSION AWARENESS	Low awareness about the PE sessions among parents of both PEs and adolescents, and teachers	Low awareness about the PE sessions among parents of PEs and adolescents
BARRIERS FOR CONDUCTING SESSIONS BY PEs	PEs hesitant to conduct sessions on sensitive topics e.g. SRH and lack of full understanding of issues like violence	PEs hesitant to conduct sessions on sensitive topics e.g SRH and lack of full understanding of issues like violence
MOST LIKED AND LEAST LIKED SESSIONS	Most liked: Personal hygiene, menstruation (among girls), community sanitation and hygiene (boys) Least Liked: child marriage, gender identity	Most liked: Personal hygiene, menstruation (among girls), undernutrition and anaemia Least Liked: Pubertal changes
ATTENDANCE BARRIERS	Inconvenient timing, lack of incentives, less engaging strategies, gender of the health worker (mostly females) and embarrassment discussing SRH-related issues	Inconvenient timings, parents unwillingness and lack of incentives for the brigade members

* PE Sessions also attended by adolescents who are not part of the Peer Education programme

Adolescent Friendly Club Meetings

	Maharashtra	Madhya Pradesh
IMPLEMENTATION STATUS	Ongoing	On hold since March 2020 till April 2022 (resumed in May 2022)
AIM	Provided handholding to PEs who were untrained during COVID-19 by ANM	Handholding was provided by the ANM and NGO Trainer Mentor for conducting future sessions
RESOURCES	No specific RKSK resources used but ANM and CHO used other national programme resources (eg. Mental Health Programme)	Used RKSK Comic books and Role plays

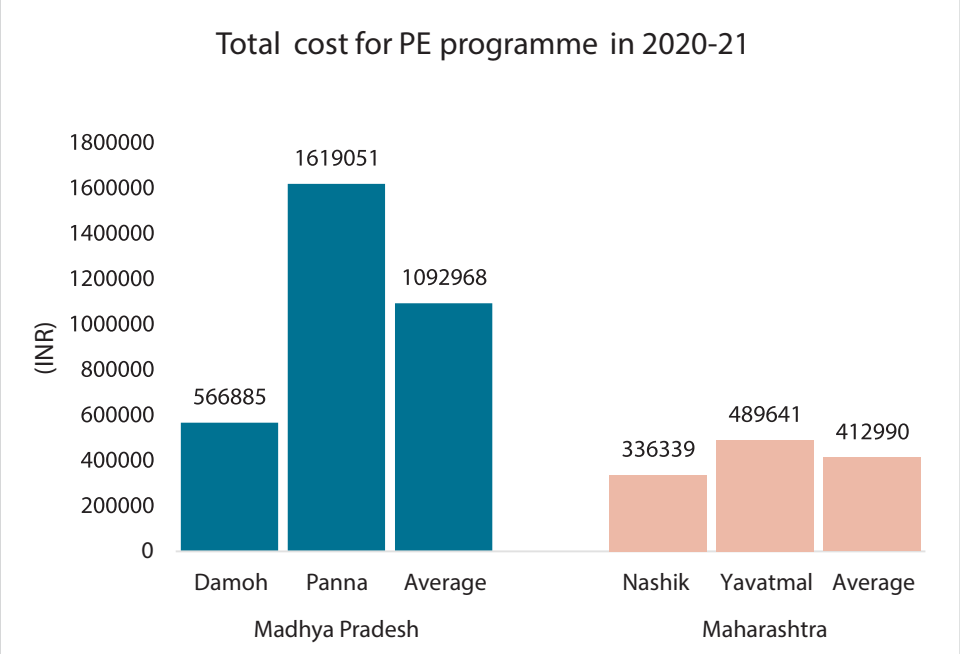
Adolescent Friendly Health Clinics (AFHCs)

	Maharashtra	Madhya Pradesh
AFHC AWARENESS	PEs: 79.1%; AEPs: 57.5% Majority of parents and school teachers were unaware of AFHCs	PEs : 53.8%; AEPs: 17.5% Majority of parents were unaware of AFHCs
BARRIERS TO ACCESS	Hesitation to go alone, transport, parents' hesitation, low awareness and gender of counsellors in AFHCs	Embarrassment, distance, and lack of awareness
SOURCE OF INFORMATION ABOUT AFHCs	64% AEPs received information from PEs; 88.7% of aware PEs received information from ANM	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	Counsellors expressed the need for digital resources (app or toolkit) for managing adolescent clients

Findings: Cost of PE Programme in Madhya Pradesh and Maharashtra

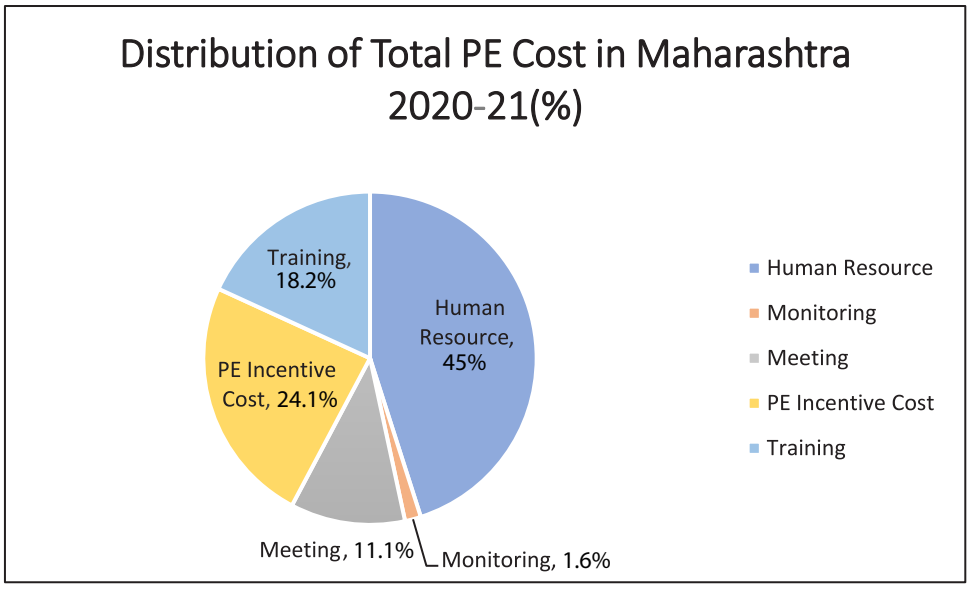
Health system cost entails the cost borne by the provider to deliver various services. This further helps in price negotiation for purchasing services from the private sector and budgeting. Overall, this is critical for resource allocation decisions in the health system. However, there are limited studies 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.

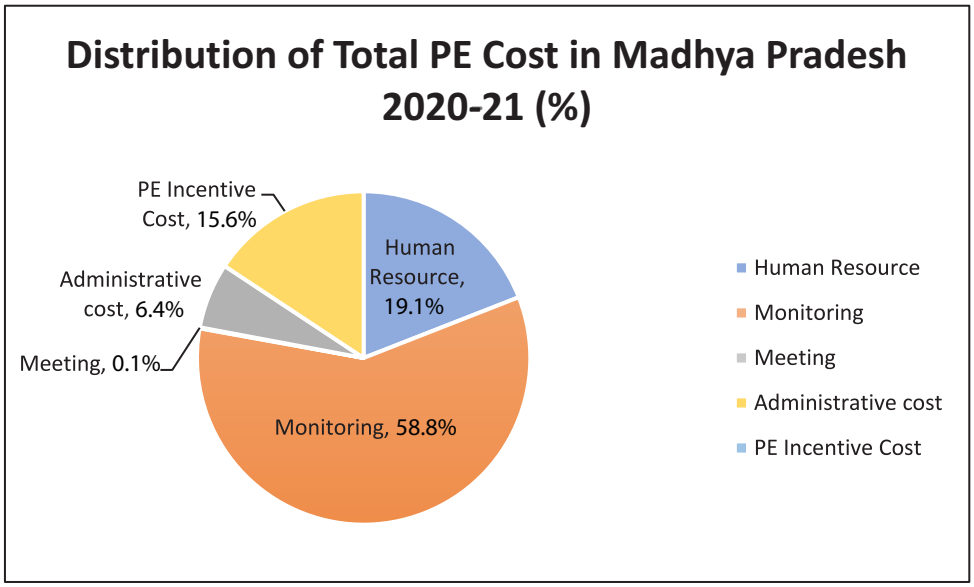
The findings suggested that in Maharashtra, the total Peer Education programme cost on average was INR 412990 (95% CI: 246728-579251) whereas, this was INR 1092968 (95% CI: 608344 - 1577592) in Madhya Pradesh.



Total cost of Peer Education Programme in Madhya Pradesh and Maharashtra (FY2020-21)

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

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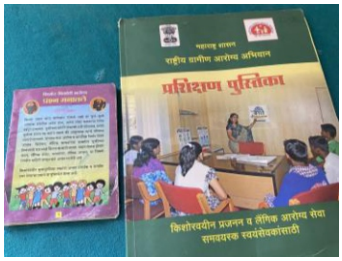
Glimpses from the Field













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