



## Exploring the 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, 4<sup>th</sup> 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](http://www.phfi.org) | [contact@phfi.org](mailto:contact@phfi.org)



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# Abbreviations

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





# 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

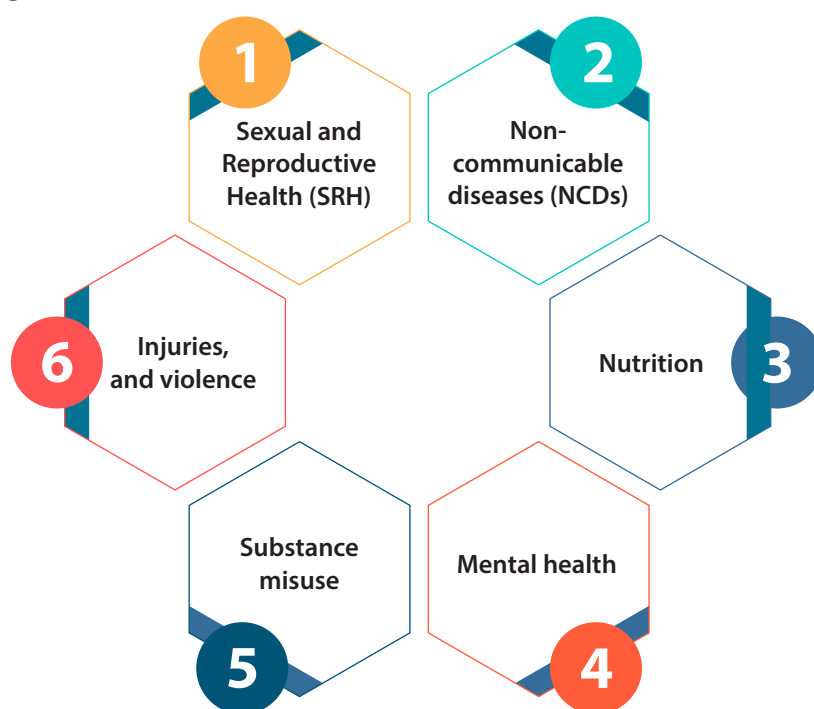


## Background

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; and promote the adoption of healthy behaviours that can prevent health problems that occur later in life, such as cardiovascular diseases and lung cancer resulting from physical inactivity and tobacco use initiated during adolescence. 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:

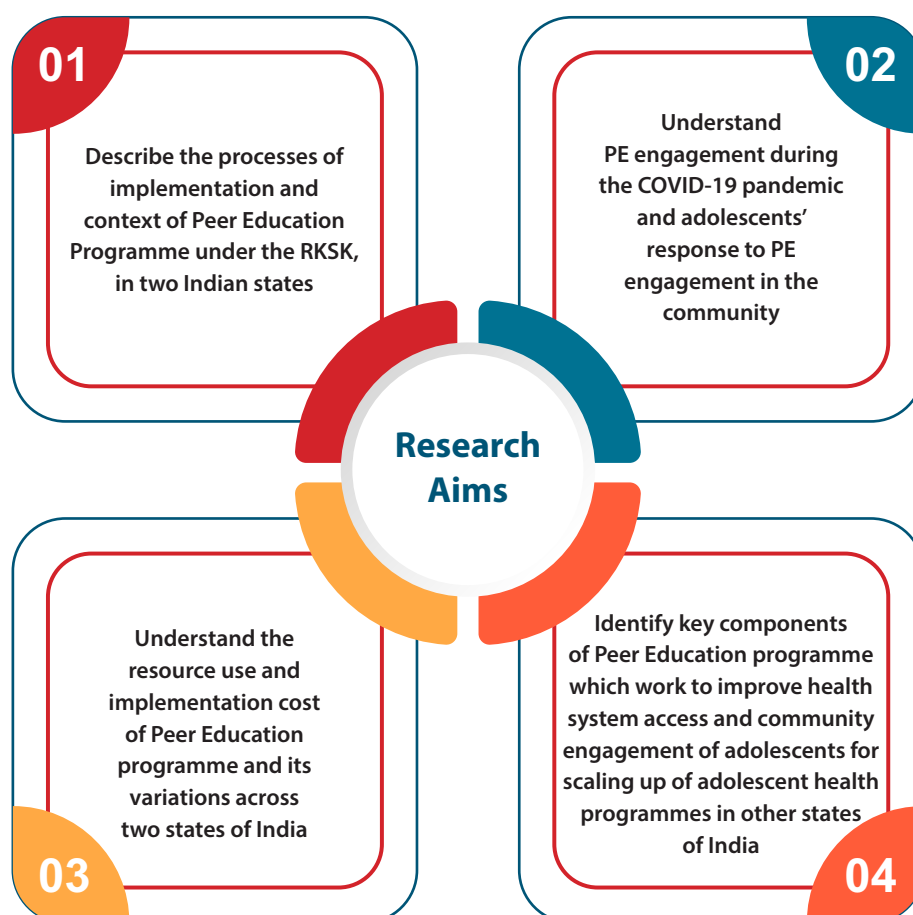


The programme encompasses a holistic approach including community and school-based health promotion and prevention along with strengthening of preventive, diagnostic, and curative services across health facilities. A unique and central component of the RKSK is the community-based Peer Education Programme. 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, 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

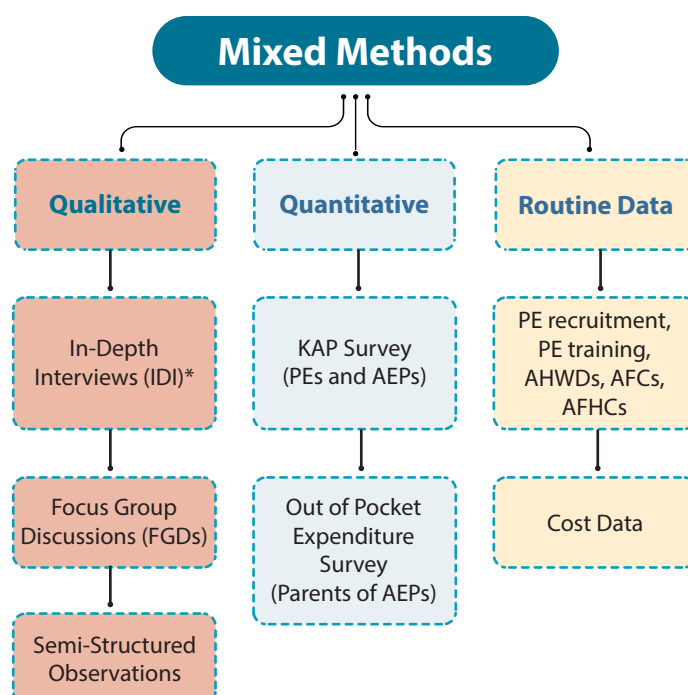
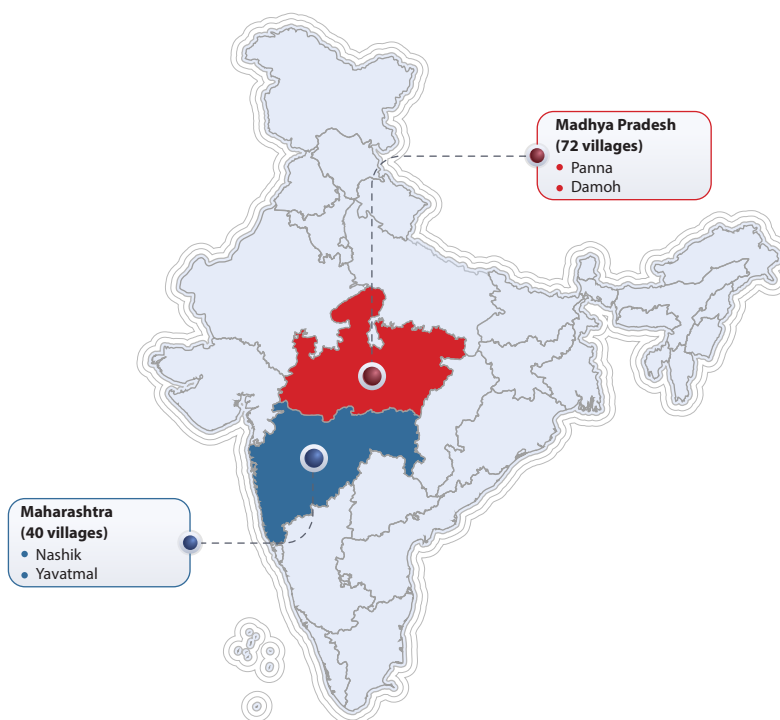
The i-Saathiya study funded by the Medical Research Council (MRC)-United Kingdom was conducted in two states (Madhya Pradesh and Maharashtra) of India. The process of Peer Education implementation was explored in i-Saathiya study using MRC's process evaluation framework (Moore, 2015). An Independent 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 Design:** Cross-sectional with process evaluation

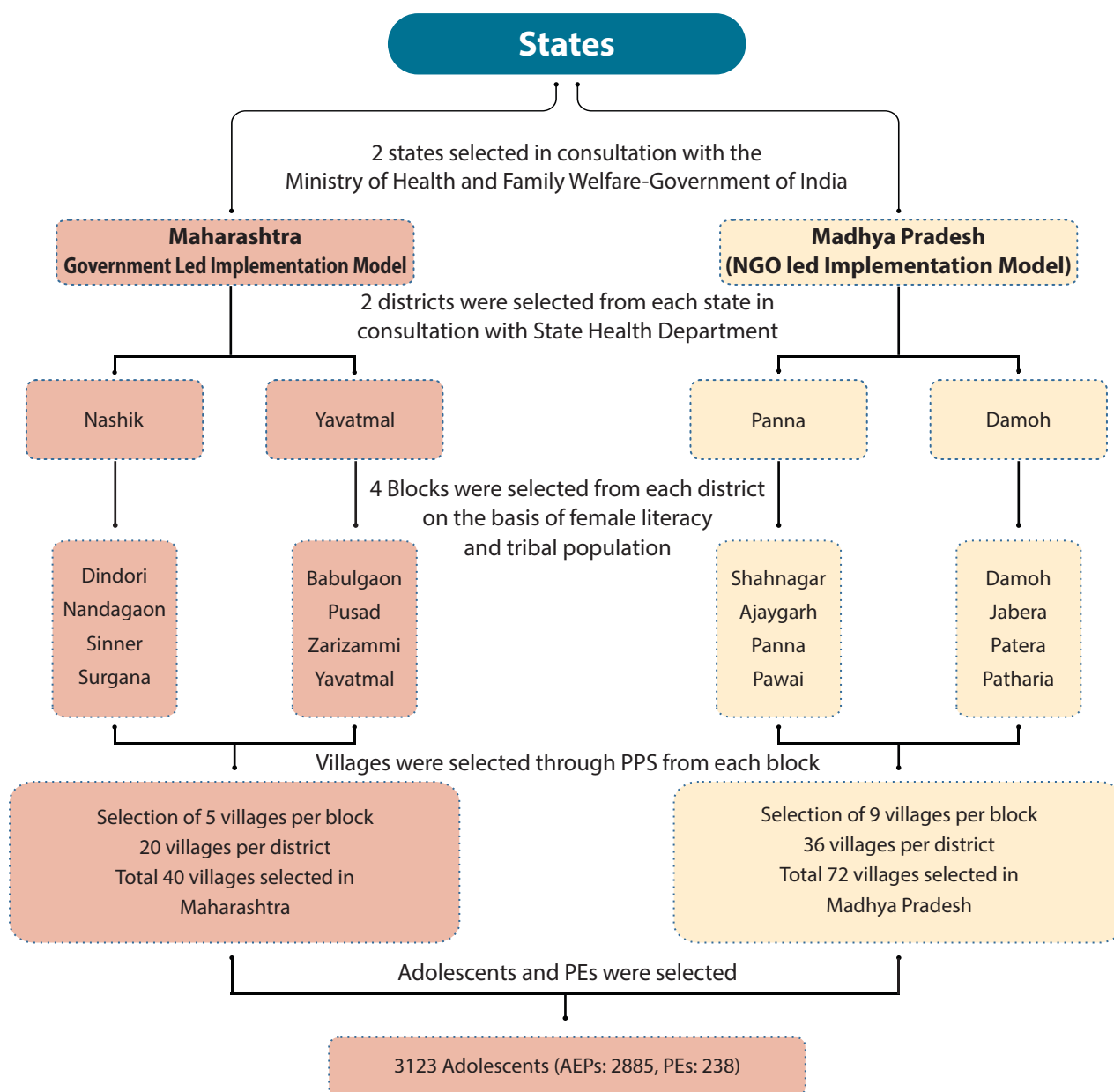
**Study Duration:** February 2020-August 2023

## Study Location: States and Districts



*\*Repeat qualitative assessment*

# Sample Selection





## Success of Peer Education Programme



### CHANGE AGENTS

#### PEs looked upon as change agents for adolescents and community

- Improved healthy behaviour of adolescents (use of hygienic menstrual products, no use of tobacco and alcohol)
- Contributed in reducing 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 and development issues



### CONTRIBUTION TO THE HEALTH SYSTEM

- 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 Mukh 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 accepted well among adolescent members and the community workers like ASHA, ANM and MO
- 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 CABs 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 to make masks

## Distribution of Socio-demographic characteristics of Adolescents Enrolled under Peer Educators (AEPs) and Peer Educators (PEs) across states

	AEPs			PEs		
	Madhya Pradesh (N=1480)	Maharashtra (N=1643)	Total (N=3123)	Madhya Pradesh (N=104)	Maharashtra (N=134)	Total (N=238)
<b>Age group (in years)</b>						
10-14	279 (18.9%)	598 (36.6%)	877 (28.2%)	3 (2.9%)	16 (11.9%)	19 (8.0%)
15-19	1097 (74.2%)	886 (54.2%)	1983 (63.7%)	83 (79.8%)	96 (71.7%)	179 (75.2%)
Above 19	102 (6.9%)	151 (9.2%)	253 (8.1%)	18 (17.3%)	22 (16.4%)	40 (16.8%)
<b>Gender</b>						
Male	741 (50.1%)	794 (48.3%)	1535 (49.2%)	55 (52.9%)	65 (48.5%)	120 (50.4%)
Female	739 (49.9%)	849 (51.7%)	1588 (50.8%)	49 (47.1%)	69 (51.5%)	118 (49.6%)
<b>Caste</b>						
ST	61 (4.1%)	688 (41.9%)	749 (24.0%)	2 (2.0%)	47 (35.4%)	49 (21.0%)
SC	211 (14.2%)	197 (12.0%)	408 (13.1%)	13 (13.0%)	25 (18.8%)	38 (16.4%)
OBC	926 (62.6%)	449 (27.3%)	1375 (44.0%)	61 (61.0%)	39 (29.3%)	100 (42.9%)
None of these	207 (14.0%)	288 (17.5%)	495 (15.8%)	24 (24.0%)	22 (16.5%)	46 (19.7%)
Don't know	75 (5.1%)	21 (1.3%)	96 (3.1%)	0	0	0
<b>Socio-Economic Status (SES)</b>						
SES-1	725 (49.0%)	319 (19.4%)	1044 (33.4%)	23 (22.1%)	21 (15.7%)	45 (18.9%)
SES-2	501 (33.8%)	538 (32.8%)	1039 (33.3%)	26 (25.0%)	42 (31.3%)	75 (31.5%)
SES-3	254 (17.2%)	786 (47.8%)	1040 (33.3%)	55 (52.9%)	71 (53%)	118 (49.6%)
<b>Employment Status</b>						
Not Employed	1281 (93.1%)	1426 (94.5%)	2707 (93.8%)	86 (82.7%)	118 (88.1%)	204 (85.7%)
Employed	95 (6.9%)	83 (5.5%)	178 (6.2%)	18 (17.3%)	16 (11.9%)	34 (14.3%)

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

	Madhya Pradesh (N=1480)	Maharashtra (N=1643)	Total (N=3123)
<b>Nutrition and NCDs</b>			
<b>Knowledge</b> (Possible score is 0-7, 7 being most appropriate knowledge)			
Mean (SD)	3.20 (1.32)	4.48 (1.76)	3.88 (1.69)
<b>Attitudes</b> (Only obese adolescents should exercise)			
1(strongly agree)	510 (34.5%)	621 (37.8%)	1131 (36.2%)
2(agree)	463 (31.3%)	608 (37.0%)	1071 (34.3%)
3(not sure)	360 (24.3%)	19 (1.2%)	379 (12.1%)
4(disagree)	50 (3.4%)	208 (12.7%)	258 (8.3%)
<b>Nutritional behaviour</b> (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)
<b>Physical activity related behaviour</b> (Number of days age appropriate exercises undertaken per week)			
Mean (SD)	2.87 (0.70)	2.54 (1.25)	2.70 (1.04)
<b>Substance Use</b>			
<b>Knowledge</b> (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)
<b>Attitude</b> (Possible, score: 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)
<b>Behaviours</b> (any form of substance abuse)	81 (5.5%)	22 (1.3%)	103 (3.3%)
<b>Injury and Violence</b>			
<b>Knowledge</b> (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)
<b>Attitudes</b> (Possible score: 0-4, 4 being the most positive attitude)			
Mean (SD)	1.40 (1.05)	2.28 (1.04)	1.86 (1.13)
<b>Experience of Violence</b> (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)
<b>Mental Health</b>			
<b>Knowledge</b> (Possible score is 0-9, 9 being most appropriate knowledge)			
Mean (SD)	4.31 (1.69)	4.60 (2.15)	4.46 (1.95)
<b>Attitudes/Mental health status</b>			
Normal	304 (20.5%)	1190 (72.4%)	1494 (47.8%)
Borderline	372 (25.1%)	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)
<b>Behaviour</b> (Possible score 0-10, 10 being the most appropriate behaviour)			
Mean (SD)	4.02 (2.24)	4.90 (2.10)	4.48 (2.21)
<b>Sexual and Reproductive Health</b>			
<b>Knowledge</b> (Possible score is 0-30, 30 being most appropriate knowledge)			
Mean (SD)	5.59 (5.24)	11.93 (8.96)	8.93 (8.08)
<b>Attitudes</b> (Possible score 0-8, 8 being the most favourable score)			
Mean (SD)	6.50 (5.79)	5.05 (2.11)	5.74 (2.01)
<b>Menstrual Hygiene Management (n=1706)</b>			
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 (8.2%)	191 (12.0%)

- 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 8.927 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% of 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 PEs, 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 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

## 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 of 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 activities

Transport, remote training location, inappropriate weather conditions

### INCENTIVES

Travel allowance for PEs

Travel allowance, 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 may support the formation of Adolescent Group

ASHA and NGO Trainer Mentors support the adolescent group/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

## Maharashtra

## Madhya Pradesh

### IMPLEMENTATION STATUS

Ongoing but at reduced scale

On hold since March 2020 (COVID-19 and budgetary constraints)

## 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 comic books and case studies







# Village Level Sessions by PEs

## Maharashtra

## Madhya Pradesh

FREQUENCY AND DURATION	
<b>Frequency:</b> Monthly to Quaterly <b>Duration:</b> 45 minutes to 60 minutes	<b>Frequency:</b> Monthly <b>Duration:</b> 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 sometime 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
SESSIONS 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 full understanding of issues like violence	PEs hesitant to conduct sessions on sensitive topics e.g SRH and lack 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	
Incontinent timing, lack of incentives , less engaging strategies, gender of the health worker and embarrassment discussing SRH-related issues	Parents' unwillingness, inconvenient timings, and lack of incentives for the brigade members





# 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

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 a digital resources (app or toolkit) for managing adolescent clients

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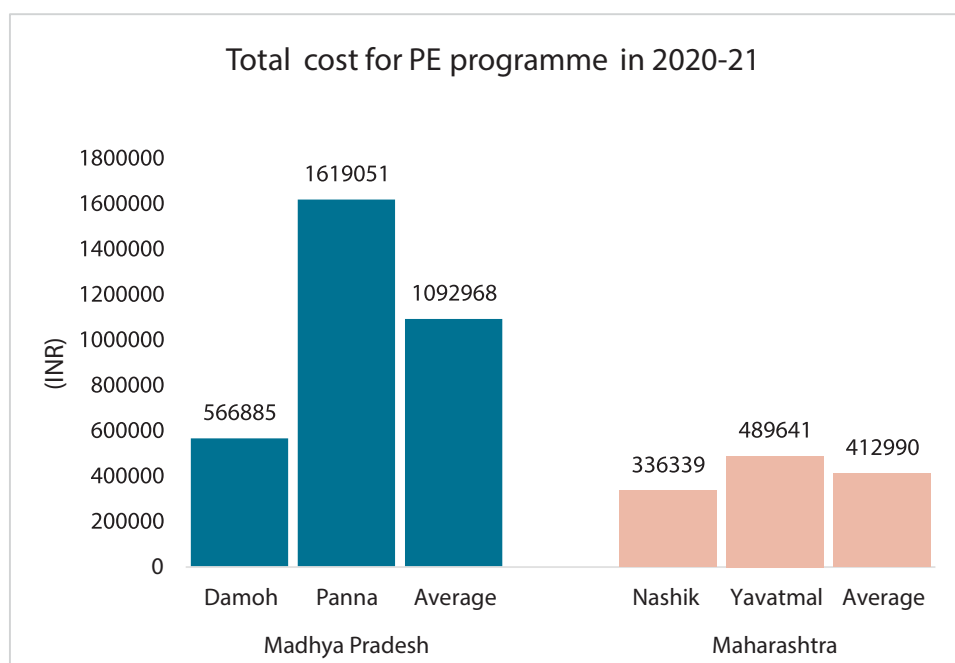




## Findings: Cost of PE Programme in Madhya Pradesh and Maharashtra

Health system costs entail 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 or activity costing), where all relevant resources used for the Peer Education programme were identified and the cost was estimated accordingly.

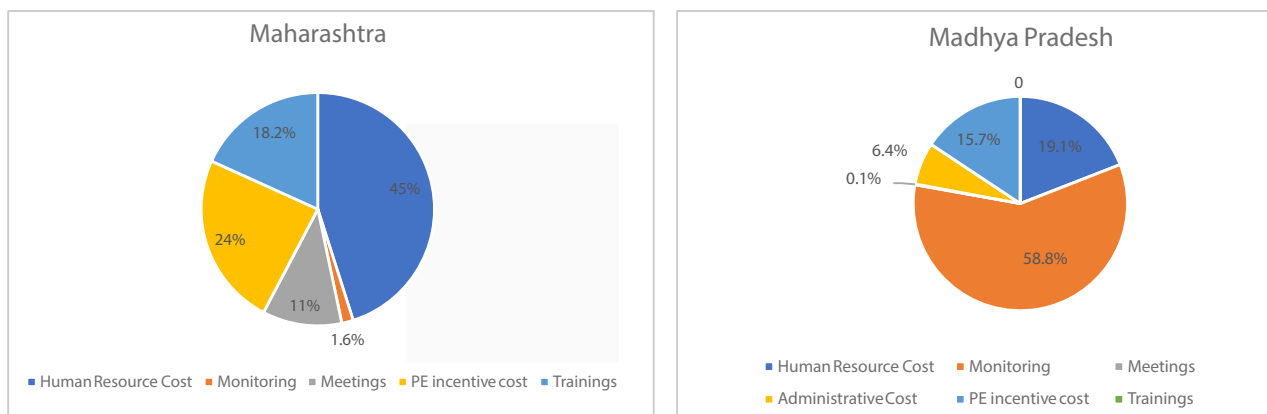
The findings suggested that in Maharashtra, the total programme cost on average was INR 412990 (95% CI: 246728.4-579251.5) whereas, this was INR 1092968 (95% CI: 608344.4 -1577592) in Madhya Pradesh.



### Total cost of the programme in Madhya Pradesh and Maharashtra (FY 2020-21)

While examining the share of different components in the total cost, it was observed that In Maharashtra, the share of human Resource costs was the highest (45%) followed by PE incentives costs (24%), training costs of the PEs (18.2%), meeting's costs (11%), and monitoring cost (1.6%). In Madhya Pradesh, the monitoring costs formed the highest share (58.8%) in the total programme costs followed by the cost incurred for human resources (19.1%), incentives for the PEs (15.7%), administrative costs (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 assisted by 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 also between the districts in a state. The variations ought to be explained in a proper perspective. The cost variation between the two states 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 costs related to NGO engagement.





## Selection, Recruitment, and Attrition of Peer Educators

- Community-level sensitisation programmes can be organised through AHWDs or similar platforms at the village level
- Additional scores through CCE or skill trainings can be provided to motivate PEs to overcome attrition
- Additional eligibility criteria for PEs can include not using any kind of substances (tobacco, alcohol or any other substance) as PEs are seen as role model

## Peer Educator Training

- Booster trainings at regular intervals can be organised for PEs to refresh their knowledge and skills
- PE training can be structured with defined days, timings, topics of discussion and provision of kits and resources to PEs
- Schedule training time and days in consultation with PEs, parents and teachers
- Pre-Post training assessment may be conducted with the PEs to assess the effectiveness of trainings
- Skills assessment of PEs can be conducted at regular interval either through rating survey or qualitatively
- Formal training of health workers can be organised to deliver 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 of 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 to enhance the acceptability and skills to handle like SRH, injuries and violence issues
- 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 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 adolescent health and sensitisation about the existing health services at AFHC
- AHWD should be used as a continuous platform in the village for community sensitisation about the RKSK, Peer Education programme and existing health services (clinics, helplines and Apps) to create an enabling environment for PEs and for the overall sustainability of the programme

### Adolescent Friendly Health Clinics

- Outreach sessions by counsellors can be used as a platform for generating awareness in the schools and community about AFHCs
- Information, Education and Communication (IEC) can be displayed at various places in the village to generate awareness about the AFHCs
- AFHC's 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

### Routine RKSK data

- The routine RKSK data collected as part of the programme lack capturing of important adolescent health indicators example anaemia, undernutrition, overnutrition etc. 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 impact of the programme

### Cost data

- Conduct cost-effectiveness analysis for NGO-led and government-led model to find out effectiveness of strategies comparing costs with outputs



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