

Effectiveness of Peer Education Program-A Pre and Post Test Analysis

By

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She comes across as a committed, sincere & diligent person who has a
strong drive and zeal for learning

We wish her all the best for future endeavors

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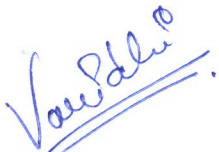
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Abstract

Introduction:

With 356 million 10-24 year olds, India has world's largest Youth Bridget, despite having the smaller population than China. India hence, would be able to see its economic soar, provided it invests healthily in the youth's education, health and protect their rights. Thus India to make any remarkable and sustainable progress, capacity building of the youth i.e. the 10-24 year olds holds utmost importance.

In order to enable adolescents fulfil their potential, substantial investments must be made in education, health, development and other areas. Investments in adolescents will have an immediate, direct and positive impact on India's health goals and on the achievement of the Sustainable Development Goals (SDGs), at the same time it will enhance economic productivity, effective social functioning and overall population development.

Background of the Study:

Peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. Peer education typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies.

Objectives of Study:

1. To determine the existing knowledge of young people (10-19 years) on various health themes like Communicable Diseases, Sexual Health, Menstrual and Personal Hygiene etc.
2. To assess the effectiveness of training delivered by peer educators on improving knowledge level of young people (10-19 years).

Methods:

A pretest and posttest study design with Systematic Random Sampling was undertaken; sample size of

214 was selected using 5% Margin of error, Confidence Level 95%, from a population of 480 adolescents visiting HIC, the probability of efficacy of Peer Education was taken as 50% (literature Review). Structured questionnaires were prepared which consist of 52 closed ended questions addressing the objectives of the study.

Results:

This study apart from highlighting the current situation of healthcare and disease burden in India, will also explain key issues such as youth education, health promotion and youth empowerment as sustainable measures in overall development of the country. For addressing these, Peer Education, Health Information Centers (HIC) and collaboration with CSR wings of various educational and technical institutions have been found out to be effective approaches in the capacity building of young people.

P values shows Pre vs. Post test results are Statistically Significant and there is a definite improvement in knowledge of all the health issues under study.

Conclusion:

Pretest on various health issues should be conducted at regular intervals and if the results shows that the knowledge is inadequate than it becomes necessary to conduct training module so that the knowledge and attitude of the adolescents and young people towards their own health and hence of the community is raised.

Peer Education should be used rigorously and carefully as a means of health promotion. And the locus should not primarily be in training workshops but in Peer Networks.

Keywords:

Adolescents, Young People, Peer Educators, Empowerment, Capacity building.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AZ-YHP	AstraZeneca Young Health Program
ARSH	Adolescent Friendly Health Services
AFHS	Adolescent Friendly Health Services
BCC	Behavior Change Communication
CSR	Corporate social Responsibility
DOTS	Directly Observed Treatment, Short-course
HIC	Health Information Centre
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goals
NHM	National Health Mission
NCD	Non-Communicable Diseases
NFHS	National Family Health Survey
PEP	Peer Education Program
PE	Peer Educator
RMNCH+A	Reproductive Maternal Newborn Child Adolescent Health
RKSK	Rashtriya Kishor Swasthya Karyakram
RTA	Road Traffic Accident
SDG	Sustainable Development Goals
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNGASS	United Nations General Assembly Special Session
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Introduction

The global healthcare sector is on the cusp of a tipping point and it is more evident in developing countries like India, as these countries grapple within key issues such as rapidly aging population, Non-Communicable Disease(NCDs) epidemics, and steady rise in healthcare cost due to raise in out of pocket expenditure.

There are an estimated 358 million young people (aged 10–24 years) in India today (2011). Young people aged 10–24 comprise almost one-third (31 percent), and those aged 10–19 almost one-quarter (22 percent) of the nation's population (Office of the Registrar General and Census Commissioner, India, 2006).

Thus, more than half the population is younger than 25. (1)

Despite the fact that adolescents represent almost one quarter of the Indian population, their Health needs are poorly understood and ill served. (2)

Today, 1.2 billion adolescents stand at the crossroads between childhood and the adult world. Around 243 million of them live in India. As they stand at these crossroads, so do societies at large – the crossroads between losing out on the potential of a generation or nurturing them to transform society. (3).

An adolescent is defined as an individual aged 10-19 by the UN. The vast majority of the world's adolescents – 88 per cent – live in developing countries. The least developed countries are home to roughly 16 per cent of all adolescents. Adolescents represent only 12 per cent of people in the industrialized world. In contrast, they account for more than 1 in every 5 inhabitants of sub-Saharan Africa, South Asia and the least developed countries. Adolescents today face a unique set of challenges, including an uncertain global economic outlook and high levels of youth unemployment, an increasing number of humanitarian crises and conflicts, climate change and environmental degradation, and rapid urbanization. The severity of challenges is expected to worsen over the next decade (4).

Current Scenario of adolescents in India today

- 30% of India's population (327 million individuals) is in the age group of 10-24 years (WHO, 2007)
- Youth are vulnerable to sexually transmitted infections, including Human Immunodeficiency Virus, and account for 31% of AIDS burden in the country (NACO, 2007)
- Though age at marriage is increasing; data from NFHS-3 (National Family Health Survey 3) shows that 27% young women and 3% young men in the age group of 15-19 year were married at the time of the survey (2005-06)
- 30% women in the age group of 15-19 years have had a live birth by the age of 19 years (Source: NFHS 3)
- 7% married and 9% unmarried girls reported current use of modern contraceptive methods (Source: NFHS 3)
- 60% girls in the age group 15-19 were found to be anemic (Source: NFHS-3). Anemia is a contributing cause of increased age-specific mortality among female adolescents
- The sex ratio in the age group of 10-19 years is 882 females per 1000 males, and is lower than the sex ratio of 927 females per 1000 males in the age group of 0-6 years
- Among the 15-19 years old, 25% of adolescents in rural areas and 10% in urban areas are illiterate. Gender disparities persist in the education sector despite improved school enrolment rates. Girls account for less than 50% of enrolment at all stages of schooling. Rural girls are the most disadvantaged. The male-female differences grow with each level of education.
- Largest proportion of estimated 3 million drug abusers and 0.6 million drug dependents in India are in the age group of 16 -35 (Source: UNODC & Ministry of Social Justice & Empowerment, 2004)
- Among 12,447 children surveyed across 13 states in India, 50% reported some form of sexual abuse. 53% victims were boys. A majority of nonconsensual sexual experiences (eve teasing, abduction) go unreported. Extreme poverty, low status of women and lack of law enforcement has led to an increase in sex work. Human trafficking and clandestine movement of young girls has also increased within the country and across international borders. (Source: Study on Child Abuse, Ministry of Women and Child Development, 2007)

Global commitments to adolescent health

To uphold the adolescent's health and rights, national governments have endorsed several global commitments during the last 20 years. These include:

- The 1989 Convention on the Rights of the Child includes human rights of children and adolescents. Freedom from discrimination, abuse and exploitation; participation in decisions affecting their lives; access to education, health information and services for their well-being are a part of the commitment.
- In 1994, several governments pledged to address the reproductive needs and rights of adolescents at the International Conference on Population and Development (ICPD).
- In 1995, at the Fourth World Conference on Women in Beijing, several governments reaffirmed this commitment and placed special emphasis on the girl child.
- The Millennium Summit in 2000 identified the Millennium Development Goals (MDGs) and identified targets for young people (10-24 years). Those relevant to adolescents include the following:
 - Eradicate extreme poverty and hunger (MDG 1)
 - Achieve universal primary education (MDG 2)
 - Promote gender equality and empower women (MDG 3)
 - Improve child health (MDG 4)
 - Improve maternal health, including universal access to sexual and reproductive Health (MDG 5)
 - Combat HIV/AIDS, and other diseases (MDG 6)
- Recognizing the vulnerabilities of young people to HIV/AIDS, the United Nations General Assembly Special Session on HIV/AIDS (2001), outlined a number of goals and targets focusing on young people (including adolescents). The targets in UNGASS include the following:

- By 2010 ensure that 95% of young people (15-24 years) have access to the information they need to reduce their vulnerability to HIV.

- By 2010 ensure that 95% of young people have access to skills they need to reduce their vulnerability to HIV.

- By 2010 ensure that 95% of young people have access to the services they need to reduce their vulnerability to HIV.

- By 2010, HIV prevalence among young people to be reduced by 25%. In the recently (10 June 2011) adopted Resolution the UN General Assembly has expressed grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day, and noted that most young people still have limited access to good quality sexual and reproductive health program. The Assembly recognizes that the deadlines for achieving key targets and goals set out in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS have now expired and that many countries have been unable to fulfill their pledges to achieve them. The resolution has stressed the urgent need to recommit to those targets and goals and commit to new, ambitious and achievable targets and goals.

- **Sustainable Development Goals (2016-2030): The 2030 agenda for Sustainable Development**

Goal 3: Ensure healthy lives and promote well-being for all at all ages

This goal calls for achieving universal access to sexual and reproductive health care, reducing global maternal death rates, and ending the AIDS epidemic by 2030.

Reproductive health problems are a Leading cause of Ill Health and Death for women and girls of childbearing age in developing countries.

Impoverished women suffer disproportionately from unintended pregnancies, unsafe abortion, maternal death and disability, sexually transmitted infections (STIs), and related problems.

Young people are also extremely vulnerable, facing disproportionately high HIV rates as well as barriers to reproductive health information and care.

Some Targets under SDG vouching Young People's Health are as follows:

- 1) By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 2) By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- 3) Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 4) By 2020, halve the number of global deaths and injuries from road traffic accidents
- 5) By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.
- 6) Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- 7) By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- 8) Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
- 9) Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and Small Island developing States

10) Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Reproductive rights of adolescents

The idea of reproductive rights is inherent to the definition of reproductive health, and these rights are integral to globally recognized human rights. In 1994, in Cairo, the International Conference on Population and Development's (ICPD) Program of Action urged governments and health systems to establish, expand or adjust health programs to meet adolescents' reproductive and sexual health (ARSH) needs, to respect their rights to privacy and confidentiality, and to ensure that the attitudes of healthcare providers do not restrict adolescents' access to information and services. Within the framework of human rights established and accepted by the global community, certain rights are particularly relevant to adolescents and the opportunities and risks they face. These include gender equality and the rights to education and health, including ARSH information and services appropriate to their age, capacity and circumstance. Actions to ensure implementation of these rights can have tremendous practical benefits: empowering individuals, ensuring well-being, stemming the HIV/AIDS pandemic, alleviating poverty and improving socio-economic prospects. (5)

Policy Environment in India

- The National Youth Policy (2003) visualizes active participation of youth, including adolescents, at all levels of social enterprise. It recommends youth empowerment through education, nutrition, leadership development and equal opportunity.
- The National Health Policy (2002) has recognized the nutritional needs of adolescent girls as well as the necessity of implementing school health program.
- The National Population Policy (2000) and the National Policy for the Empowerment of Women (2001) both recognize adolescents as an underserved and vulnerable population group with special sexual and reproductive health needs.

- The National AIDS Prevention and Control Policy (2000) recognize street children and sex workers as vulnerable groups and recommend the inclusion of HIV/AIDS issues in population education.
- The National Policy on Education (1986, modified in 1992) aims to equalize education opportunities in the 15–35 years age group, implement free and compulsory elementary education for all children up to 14 years and imparts functional literacy to adult illiterates. It recognizes the role of adolescents in population stabilization and parenthood.
- The Rastriya Kishor Swasthaya Karikram (RKSK) launched in (2014) aims at achieving optimal health of adolescents between (10-19) years through preventive and promotive approach towards health. The RKSK focuses on adolescent, reproductive and sexual health (ARSH), Non Communicable Diseases (NCDs), Substance Misuse etc.
- The Reproductive Maternal Neonatal Child Health+ Adolescent Health (RMNCH+A) was launched in 2013 and it essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services. The RMNCH+A strategic approach has been developed to provide an understanding of ‘continuum of care’ to ensure equal focus on various life stages. The RMNCH+A appropriately directs the States to focus their efforts on the most vulnerable population and disadvantaged groups in the country. It also emphasizes on the need to reinforce efforts in those poor performing districts that have already been identified as the high focus districts.

Literature Review

Peer education draws on the credibility that young people have with their peers, leverages the power of role modeling, and provides flexibility in meeting the diverse needs of today's youth. Peer education can support young people in developing positive group norms and in making healthy decisions about sex (7).

Boyle, J. et. al. in their article on Peer Education intervention among college students defines Peer Education as an approach to health promotion, in which community members are supported to promote health-enhancing change among their peers. It is the teaching or sharing of health information, values and behavior in educating others who may share similar social backgrounds or life experiences. It has been identified as a more economical way to deliver health training. (8).

A team of peer educators can extend health promotion outreach and be more accessible than paid health professionals.

With and another effort in defining the work of Peer Educators Wiskochil, B et.. al. states that Peer educators help to bridge many of the gaps in service that occur through fear and suspicion of official health care providers, and to facilitate effective communication with community members and professional provider. Engaging youth peer educators helps professionals to extend their outreach of programs and services to ensure their efforts are impactful (9).

Peer education is also associated with efforts to prevent tobacco, alcohol and other drug use among young people. Peer educators can be effective role models for young adolescents by promoting healthy behavior, helping to create and reinforce social norms that support safer behaviors, and also serve as an accessible and approachable health education resource both inside and outside the classroom. Peer education is also useful in promoting healthy eating, food safety and physical activity amongst marginalized populations (10).

Peer educators are typically the same age or slightly older than the group with whom they are working. They may work alongside the teacher, run educational activities on their own, or actually take the lead in organizing and implementing school-based activities. Peer educators can help raise awareness, provide accurate information, and help their classmates develop skills to change behavior.

It has also been highlighted by UNAIDS in 1999 that Peer education derives in part from behavioural theory that asserts that people make changes not because they may assess evidence or closely examine testimony or argument so much as they subjectively trust the judgement of close, trusted peers. (11)

In a study conducted by G.W. Dowsett, L. Turney, G. Woolcock, A. Rance and N. Thomson, Peer Education and Peer Support has been projected as an effective model by various HIV risk reduction and drug user communities in Netherlands, The UK and US and in Australia. (12)

Broadhead et. Al. in their study on drug users and effectiveness of peer education intervention on the same stated that a peer-driven intervention relies on active collaboration with users rather than a 'provider-client' model and is based on the theory of 'group-mediated social control, which works by: altering people's preferences regarding how others should behave. It does this by using rewards and punishments to a group based on the performance of individual members. (13)

Friedman and Friedman et al. in their study for encouraging peer support in HIV/AIDS reduction and going beyond education to mobilise sub cultural changes cited that inside information, knowledge from personal experience and trust are key factors in the success of peer education initiatives (14) (15)

There have been several additional studies reporting the efficacy of peer education in developing countries. Three evaluations of school-based peer education programs in China found significant increases in HIV knowledge among the intervention group. (15) (16) (17)

One of these, a randomized controlled trial involving 1,950 students from 10 senior high schools in Shanghai, found that the increases in HIV knowledge and intention to use condoms were sustained at least one year following the 3-month intervention. (15)

Another study conducted showed significant increase in Consistent condom use with clients (from 28.8% to 70.4%) among female sex workers in a peer-mediated intervention in Mombasa, Kenya. (18) These studies support that peer education interventions can lead to increases in knowledge on health issues and increases in health seeking behaviour and adaptation towards healthy lifestyle within various at-risk populations in developing countries.

Power et. Al. in their article explained that in the peer education model, the focus is also on mobilising peer pressure within user's broader social networks to reinforce health-oriented behaviours. Such networks are characterised by functionally supportive and reciprocal relationships, and peer education

and advocacy generally take place on an informal basis and are often promoted by established members and key figures in social networks (16)

On the effectiveness of Peer Education in health promotion within community, or in other terms why is it considered successful, UNAIDS in 1999 cited that Peer educators can have physical and socio cultural access to intended audiences in their natural environments; they can mutually identify with each other as individuals and as members of a specific socio cultural reality. (11)

In a framework introduced by Australian injecting and illicit Drug Users league for Peer Education (6) its emphasized that best peer education does not happen because organizations are funded to do it or because government want it to be done, but it happens in response to an identified need within user network and among individuals.

Peer education is based on the reality that many people make changes not only based on what they know, but on the opinions and actions of their close, trusted peers. Peer educators can communicate and understand in a way that the best-intentioned adults can't, and can serve as role models for change. (Note that peer education is not exclusively for school-based programs, but has been used in a wide range of contexts with a diversity of populations, including street youth, factory workers, sex workers, drug users, prisoners, etc.)

Rationale

Peer Educators are the locus of Young health program (YHP) of Plan India. Their training and capacity building is of utmost importance for the successful functioning and to get the desirable outcome of YHP. The study is conducted to understand how effective peer education is in health promotion among peer groups so that recourses can be invested healthily on them. A group of adolescents were selected within the community and they are trained as Peer Educators.

A network of adolescents and peers was formed with the help of these Peer Educators. Then to evaluate how effective peer education is and whether it could bring significant changes or not a pre test was conducted to check the existing knowledge of these adolescents on various health themes.

The study was conducted to record responses and quantifies knowledge attained by the adolescents with the help of Peer Educators and how significant it is statistically. Also it highlights some suggestions on the basis of result obtained and general observations attained in the study duration.

Research Questions

1. What is the present status of knowledge among Adolescents (10-19 years) visiting Health Information Center on various health themes like Communicable Diseases, Sexual Health, Menstrual and Personal Hygiene etc in urban resettlement community of Delhi?
2. What is the Impact of Training delivered by Peer Educators, on their Knowledge of Health issues?

OBJECTIVES

1. To determine the existing knowledge of adolescents (10-19 years) on various health themes like Communicable Diseases, Sexual Health, Menstrual and Personal Hygiene etc.
2. To assess the effectiveness of training delivered by Peer Educators on improving knowledge level of Adolescents (10-19 years).

Null Hypothesis

There is no significant change in the knowledge of Adolescents after Peer Education Intervention.

METHODOLOGY

- Study Type: Pre and Post test Design
- Study Location: North-West Delhi Region
- Study Area: Holambi Kalan
- Sample Size: 214 Adolescents (10-19 Years) (both Male and Female) {calculated by using the online sample size calculator (RaoSoft) in which P was taken as 50% (by Lit. Review), Population, Margin of Error as 5%, and 95% Confidence Level.}
- Study Duration: Two Months (1st March-30th April'16)
- Data Collection Tool: Self-Administered Questionnaire
- Data Analysis: SPSS and MS Excel

A Pre-Test was conducted with the help of a structured questionnaire having 52 closed ended questions.

- The questions pertained to various health themes like: Communicable Diseases (Dengue, Malaria and Tuberculosis), Water and Sanitation Hygiene (WASH), Substance Misuse (Smoking, Alcohol), Sexual and Reproductive Health, HIV/AIDS, Menstrual Hygiene, Personal Hygiene, and Importance of Peer Education were asked.
- A month's training module was delivered to the adolescents (10-19 years) by calling them on the basis of a schedule to the HIC located in the community itself. Training was delivered by Peer Educators in following ways:
 - Self Help Groups
 - Workshops
 - Street Plays
 - Health Mela
 - Rallies
 - Sanitation drives
 - Fun games
 - Competitions (painting, debate, slogan writing etc)

Thereafter a post test was conducted.

- Results of both Pre and Post Test were tabulated and analyzed using MS Excel and SPSS Software.
- The statistical test used for analysis–Mc Nemar's Test.

FINDINGS

Demographic Distribution of Respondents

Figure 1: Sex Distribution of Respondents (n=214)

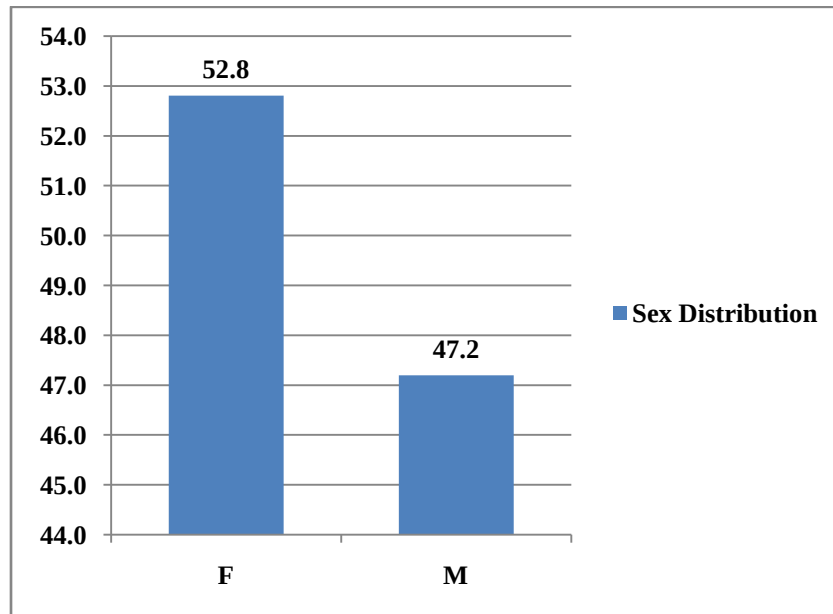


Figure 2: Age Distribution of Respondents (n=214)

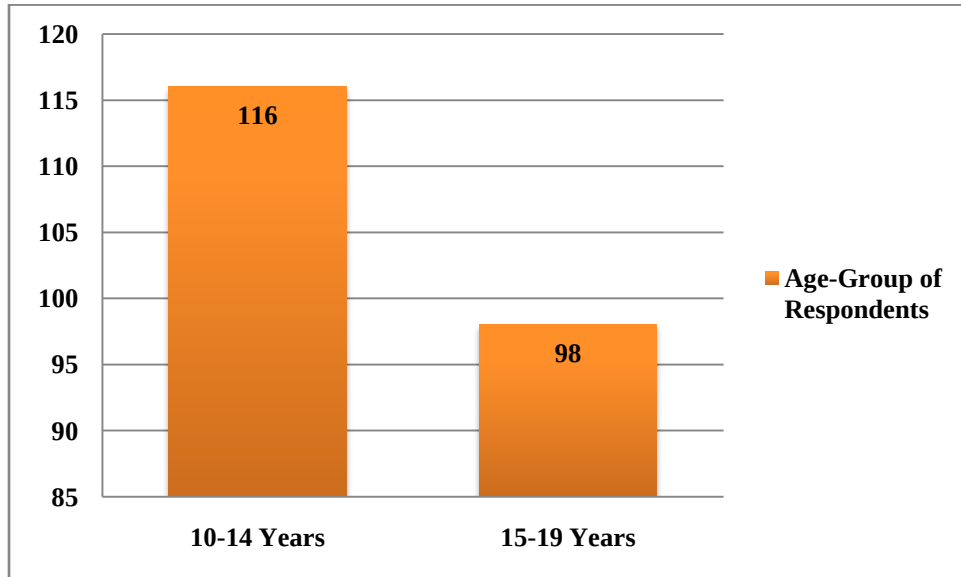
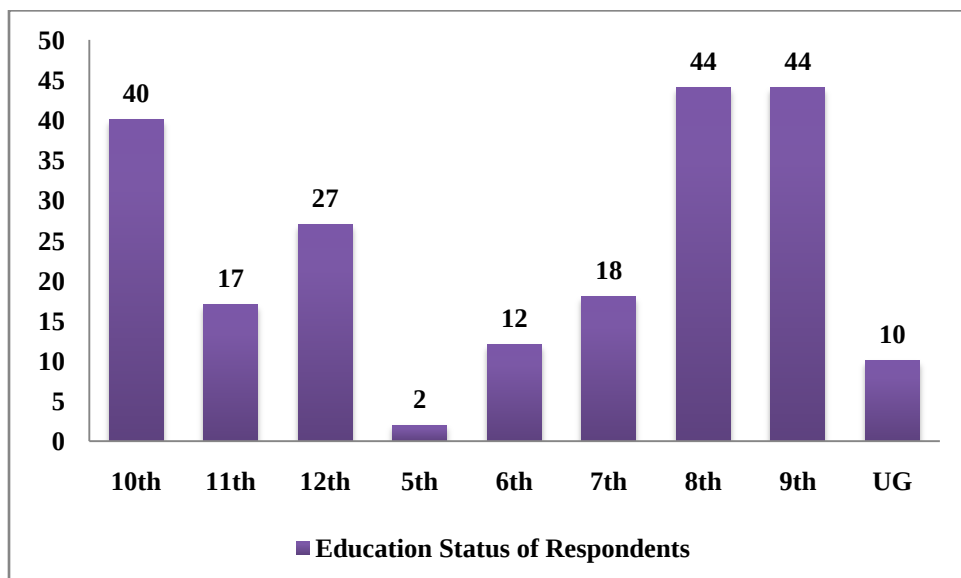


Figure 3: Education Status of Respondents (n=214)



Responses on Different Health Themes

On the account of first objective of this study, various responses were recorded to find out the existing knowledge of the adolescents before and after Peer Education.

Figure 4: Responses of adolescents on communicable diseases (n=214)

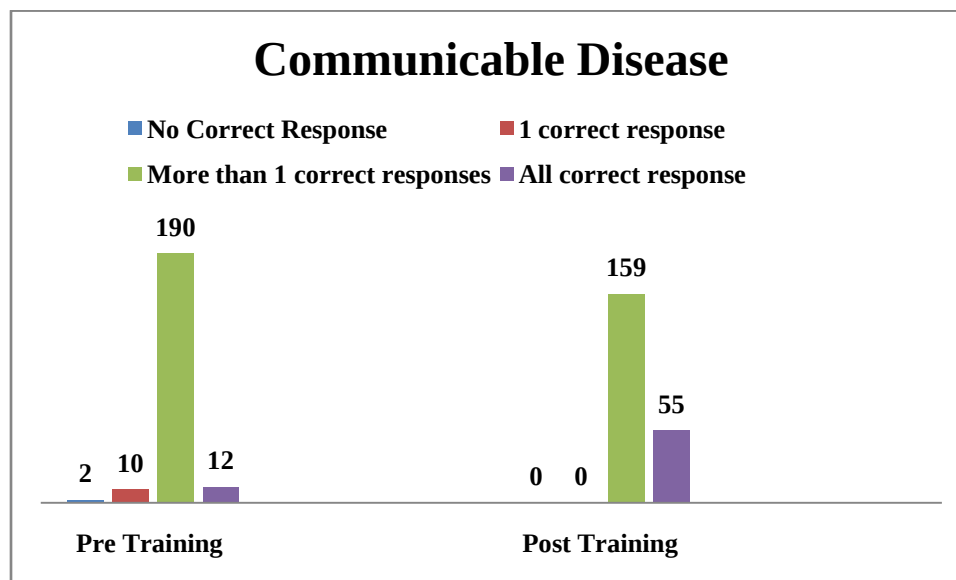


Figure 4 depicts responses of adolescents on Communicable Disease. About 1% of respondents had no correct responses (n=2) in pre-training phase. Which decreased to nil that is zero in post training phase. Also in pre training phase approximately five percent of the respondents (n=12) had all correct responses which increased to approximately twenty-five percent (n=55) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>Communicable Disease</u>	Pre Training (n=214)	2 (.9%)	10 (4.7%)	190 (88.8%)	12 (5.6%)
	Post Training (n=214)	-	-	159 (74.3%)	55 (25.7%)

Table 1: Pre-test and Post-test response on Communicable Disease (n=214)

Figure 5: Responses of adolescents on Water and Sanitation Hygiene (n=214)

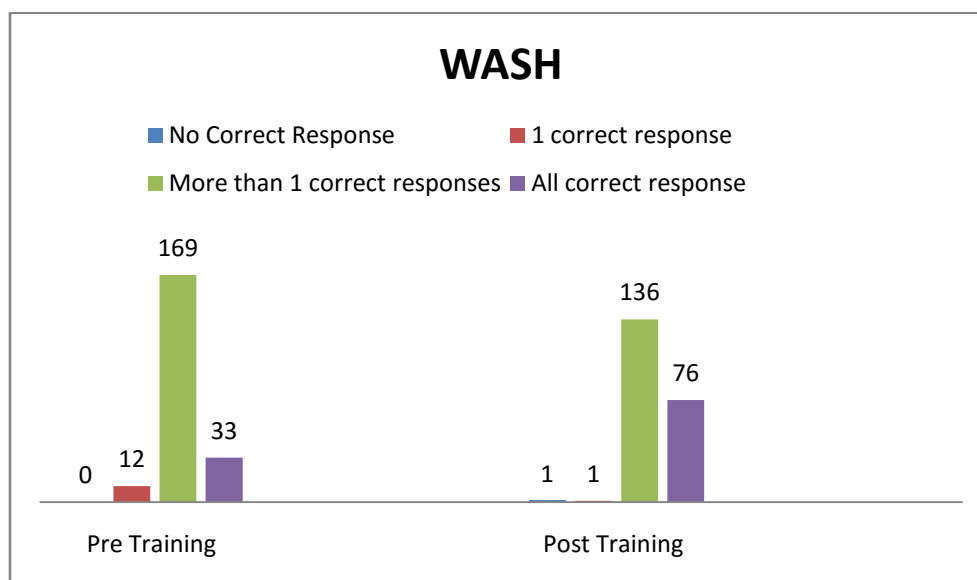


Figure 5 depicts responses of adolescents on Water and Sanitation Hygiene. In pre training phase approximately fifteen percent of the respondents (n=33) had all correct responses which has increased to almost half that is 35% (n=76) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
WASH	Pre Training (n=214)	-	12 (5.6%)	169 (79.0%)	33 (15.4%)
	Post Training (n=214)	1 (.5%)	1 (.5%)	136 (63.6%)	76 (35.5%)

Table 2:Pre-test and Post-test response on WASH (n=214)

Figure 6: Responses of adolescents on Substance Use (n=214)

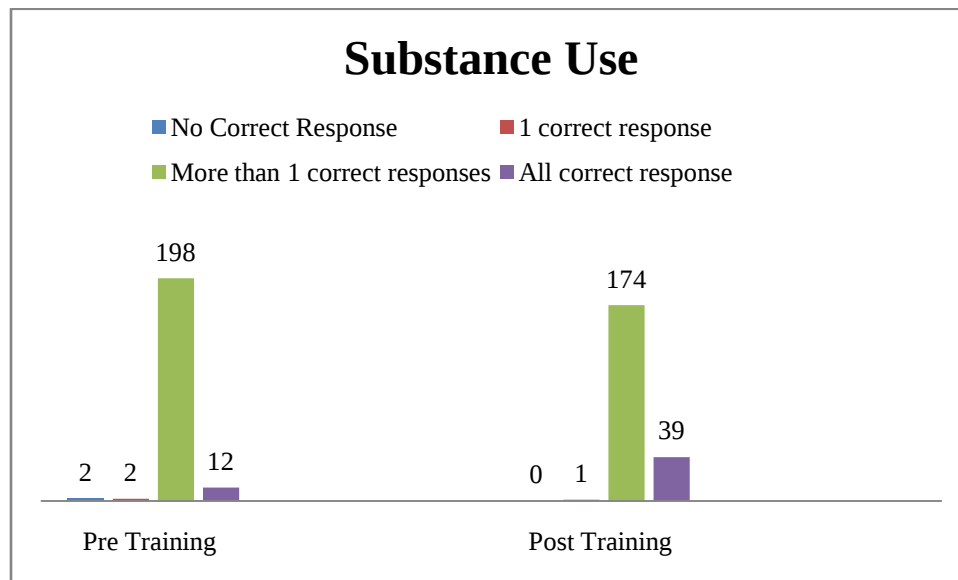


Figure 6 depicts responses of adolescents on Substance Use. About 1% of respondents had no correct responses (n=2) in pre-training phase. Which decreased to nil that is zero in post training phase. Also in pre training phase approximately five percent of the respondents (n=12) had all correct responses which increased to approximately eighteen percent (n=39) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>Substance Use</u>	Pre Training (n=214)	2 (.9%)	2 (.9%)	198 (92.5%)	12 (5.6%)
	Post Training (n=214)	-	1 (.5%)	174 (81.3%)	39 (18.2%)

Table 3: Pre-test and Post-test response on Substance Use (n=214)

Figure 7: Responses of adolescents on Sexual and Reproductive Health (n=214)

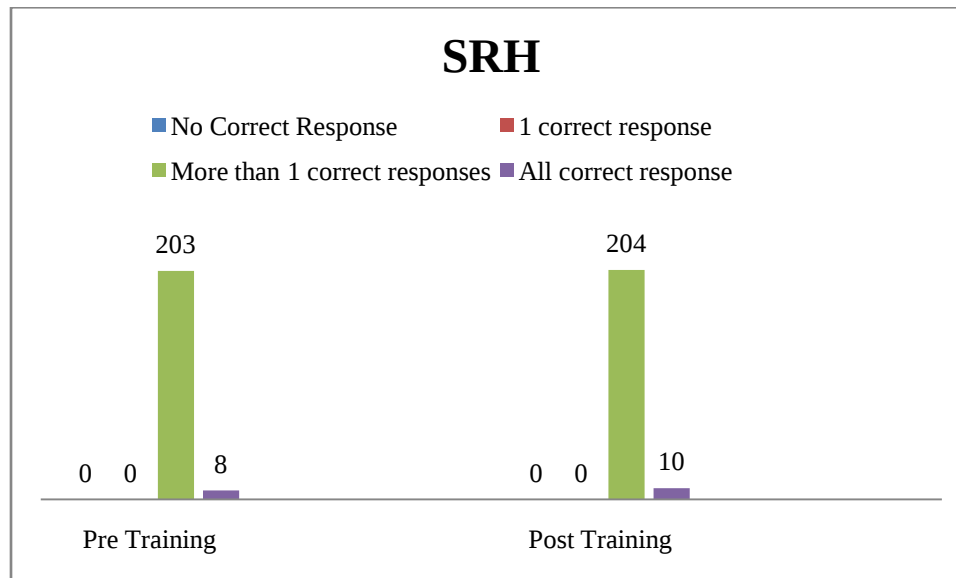


Figure 7 depicts responses of adolescents on Sexual and Reproductive Health. About Ninety four percent of respondents had more than one responses (n=203) in pre-training phase. Which increased to Ninety Five Percent (n=204) in post training phase. Also in pre training phase approximately four percent of the respondents (n=8) had all correct responses which increased to approximately five percent (n=10) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>Sexual and Reproductive Health</u>	Pre Training (n=214)	-	-	203 (94.9%)	8 (3.7%)
	Post Training (n=214)	-	-	204 (95.3%)	10 (4.7%)

Table 4: Pre-test and Post-test response on Sexual and Reproductive Health (n=214)

Figure 8: Responses of adolescents on Sexual and Reproductive Health (n=214)

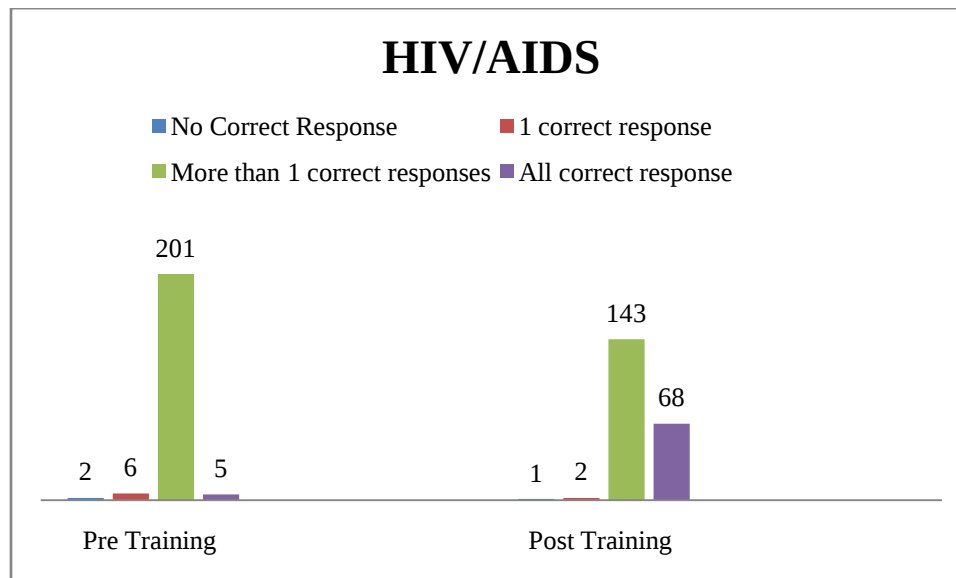


Figure 8 depicts responses of adolescents on HIV/AIDS. In pre training phase approximately two percent of the respondents (n=5) had all correct responses which increased to around one-third (n=68) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>HIV/AIDS</u>	Pre Training (n=214)	2 (.9%)	6 (2.8%)	201 (93.9%)	5 (2.3%)
	Post Training (n=214)	1 (.5%)	2 (.9%)	143 (66.8%)	68 (31.8%)

Table 5: Pre-test and Post-test response on HIV/AIDS (n=214)

Figure 9: Responses of adolescents on Menstrual Hygiene (n=214)

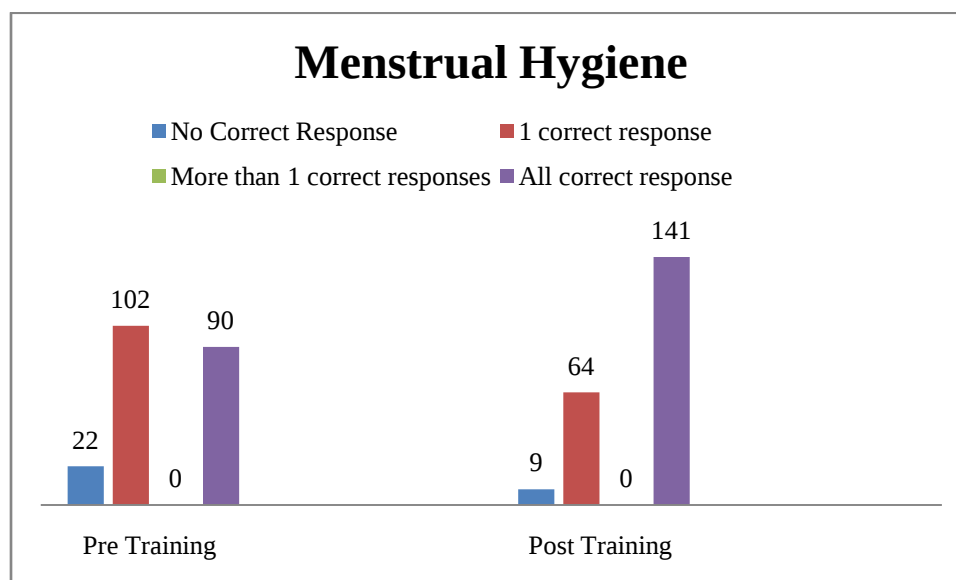


Figure 9 depicts responses of adolescents on Menstrual Hygiene. About ten percent of respondents had no correct response (n=22) in pre-training phase. This decreased to half that is around four percent in post training phase. Also in pre training phase two-fifth of the respondents (n=90) had all correct responses which increased two-third (n=141) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>Menstrual Hygiene</u>	Pre Training (n=214)	22 (10.3%)	102 (47.7%)	-	90 (42.1%)
	Post Training (n=214)	9 (4.2%)	64 (29.9%)	-	141 (65.9%)

Table 6: Pre-test and Post-test response on Menstrual Hygiene (n=214)

Figure 10: Responses of adolescents on Personal Hygiene (n=214)

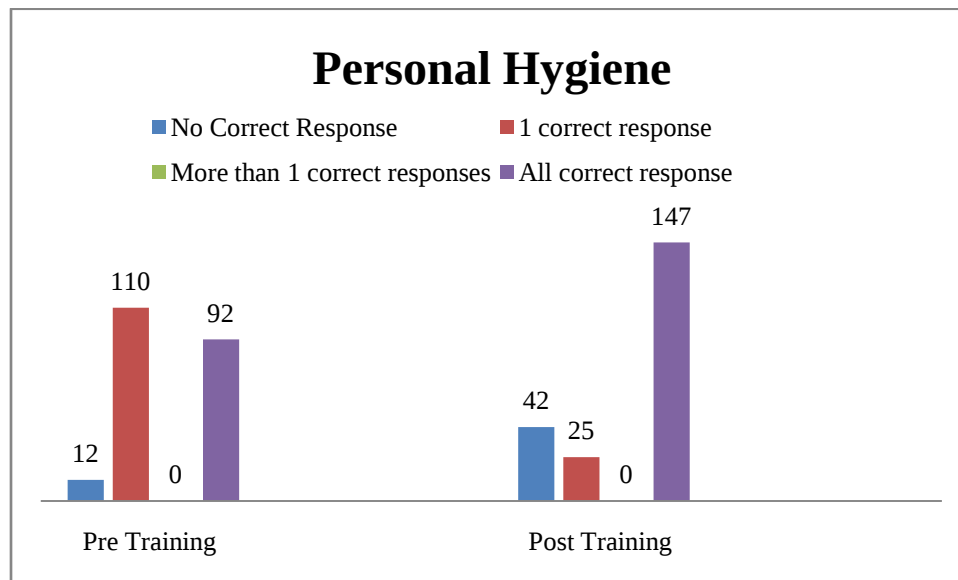


Figure 10 depicts responses of adolescents on Personal Hygiene. About fifty percent of respondents had one correct response (n=110) in pre-training phase. This decreased to one tenth that is around eleven percent in post training phase. Also in pre training phase two-fifth of the respondents (n=92) had all correct responses which increased to around two-third (n=147) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
<u>Personal Hygiene</u>	Pre Training (n=214)	12 (5.6%)	110 (51.4%)	-	92 (43%)
	Post Training (n=214)	42 (19.6%)	25 (11.7%)	-	147 (68.7%)

Table 7: Pre-test and Post-test response on Personal Hygiene (n=214)

Figure 11: Responses of adolescents on Importance of Peer Education (n=214)

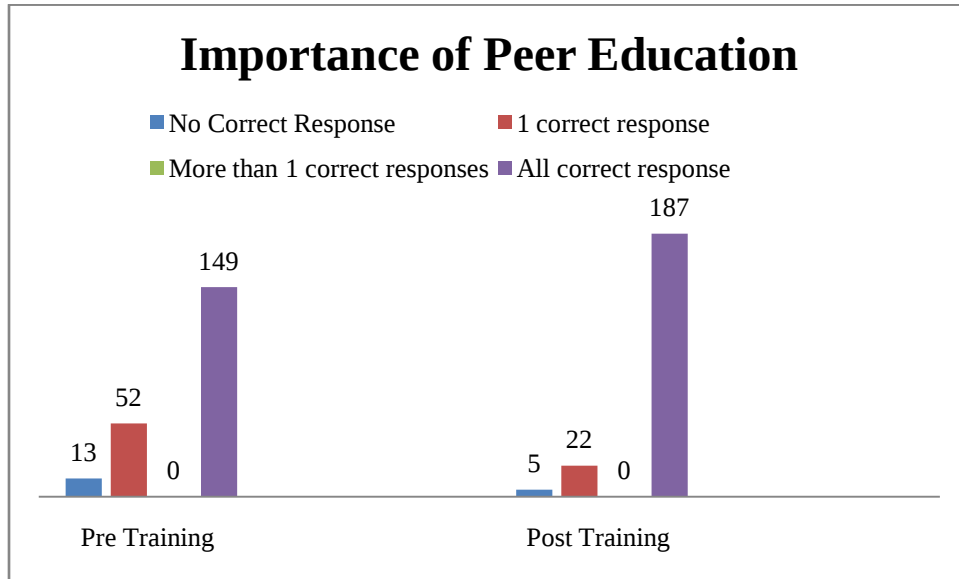


Figure 11 depicts responses of adolescents on Importance of Peer Education. About Six percent of respondents had no correct response (n=13) in pre-training phase. This decreased to one tenth that is around two percent in post training phase (n=5). Also in pre training phase around seventy percent of the respondents (n=149) had all correct responses which increased to around ninety eight percent (n=187) in post-training phase.

Area		No Correct Response Number (Percent)	1 correct response Number (Percent)	More than 1 correct responses Number (Percent)	All correct response Number (Percent)
Peer Education	Pre Training (n=214)	13 (6.1%)	52 (24.3%)	-	149 (69.6%)
	Post Training (n=214)	5 (2.3%)	22 (10.3%)	-	187 (97.4%)

Table 8: Pre-test and Post-test response on Importance of Peer Education (n=214)

Note: Thus it's clearly reflecting from the above graphs that there is a significant improvement in the number of respondents giving all correct answers after the Peer Education intervention.

And thus to further prove it statistically the findings are as mentioned below.

Impact of Training: Thematic –Area wise composite Analysis

Table 9: Composite Analysis of Communicable Disease (n=214)

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
Communicable Disease	<i>Incorrect</i>	50	132
	<i>Correct</i>	26	6

Chi Square Statistic (Mc Nemar): 109.522, Critical Value: 3.841, *p<0.001, **Decision about Ho=Reject**

Table 9 shows that out of 214 respondents, 50 are such respondents who gave incorrect answers in both pre-training and post-training phase but the majority of respondent's i. e. 132 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 26 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values <0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 10: Composite Analysis of Water and Sanitation Hygiene

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
WASH	<i>Incorrect</i>	47	119
	<i>Correct</i>	30	18

Chi Square Statistic (McNemar): 51.9731, Critical Value: 3.841, * $p < 0.001$, **Decision about Ho=Reject**

Table 10 shows that out of 214 respondents, 47 are such respondents who gave incorrect answers in both pre-training and post-training but the majority of respondent's i. e. 119 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 30 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values < 0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 11: Composite Analysis of Substance Use

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
Substance Use	<i>Incorrect</i>	34	143
	<i>Correct</i>	27	10

Chi Square Statistic (Mc Nemar): 77.794, Critical Value: 3.841, * $p < 0.001$, Decision about H_0 =Reject

Table 11 shows that out of 214 respondents, 34 are such respondents who gave incorrect answers in both pre-training and post-training but the majority of respondent's i. e. 143 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 27 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values < 0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 12: Composite Analysis of Sexual and Reproductive Health

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
SRH	<i>Incorrect</i>	27	142
	<i>Correct</i>	45	0

Chi Square Statistic (Mc Nemar): 49.283, Critical Value: 3.841, * $p < 0.001$, Decision about H_0 =Reject

Table 12 shows that out of 214 respondents, 27 are such respondents who gave incorrect answers in both pre-training and post-training but the majority of respondent's i. e. 142 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 45 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values < 0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 13: Composite Analysis of HIV/AIDS

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
HIV/AIDS	<i>Incorrect</i>	42	147
	<i>Correct</i>	22	3

Chi Square Statistic (McNemar): 90.982, Critical Value: 3.841, * $p < 0.001$, **Decision about Ho=Reject**

Table 13 shows that out of 214 respondents, 42 are such respondents who gave incorrect answers in both pre- training and post-training but the majority of respondent's i. e. 147 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 22 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values < 0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 14: Composite Analysis of Menstrual Hygiene

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
Menstrual Hygiene	<i>Incorrect</i>	41	80
	<i>Correct</i>	27	66

Chi Square Statistic (McNemar): 25.2710, Critical Value: 3.841, *p<0.001, **Decision about Ho=Reject**

Table 14 shows that out of 214 respondents, 41 are such respondents who gave incorrect answers in both pre-training and post-training but the majority of respondent's i. e.80 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 27 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values <0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 15: Composite Analysis of Personal Hygiene

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
Personal Hygiene	<i>Incorrect</i>	14	75
	<i>Correct</i>	51	74

Chi Square Statistic (McNemar): 4.198, Critical Value: 3.841, *p=0.040, **Decision about Ho=Reject**

Table 15 shows that out of 214 respondents, 14 are such respondents who gave incorrect answers in both pre-training and post-training but the majority of respondent's i. e. 75 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 51 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values = 0.040 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Table 16: Composite Analysis of Importance of Peer Education

Thematic Area	↓ Pre Training	Post Training	
		<i>Incorrect</i>	<i>Correct</i>
Importance of Peer Education	<i>Incorrect</i>	10	54
	<i>Correct</i>	17	133

Chi Square Statistic (McNemar): 18.2535, Critical Value: 3.841, *p<0.001, **Decision about Ho=Reject**

Table 16 shows that out of 214 respondents, 10 are such respondents who gave incorrect answers in both pre-training and post-training and 54 out of total 214 respondents are the ones who gave incorrect answers during pre training but their answers are converted/ improved to correct answers after Peer Education Intervention.

The matter of concern in the observation is the incorrect responses by 17 respondents in post training phase. The possible reason for the same could be their disinterest in the study and responses could be by chance.

*P values <0.001 shows Pre vs. Post test results are statistically significant and there is a definite improvement in knowledge in the health issues under study, thus we reject the null hypothesis.

Recommendations

Best Peer Education does not happen because organization are funded to do it or government want it done, it happens in response to an identified need within users network and among individuals.

Some of the recommendations are as follows:

- Other activities where learning and empowerment are more clearly articulated as immediate goals should be rigorously undertaken, such as: Outreach interventions, Workshops and community forums, short term education projects, one on one support, resource development (Magazines and Newsletters etc.) Where principles of peer education can be applied with most effect.
- Resources are definitely finite, so we should shape our choice of subjects and mode of delivering peer education by understanding the need within the community and means available to fulfill that.
- Within a small area, widely publicized workshops may create a negative impression (on certain sensitive issues like HIV/AIDS, Substance Use etc.) as it can raise issues related to privacy and confidentiality, thus discreet outreach with individuals and networks will be more effective.
- Presence of set criteria that should be followed while selecting peer educators in order to maximize the effectiveness of Peer Education Program.
- Organizations funding peer education program should invest healthily in Peer Educators orientation, Education and Training, resource rising by involving Peer Educators, Establishing a code of conduct (guiding personal and professional actions of Peer Educators), supportive and responsive system of supervision.
- Peer Educators engaged in outreach should be required to follow regular consultations with services and authorities operating in their area to make their work more effective.
- Work of Peer Educators should be directed efficiently, avoiding unnecessary burden on them.
- System should be generated in which Peer Educators can observe their own track record that gives them a sense of satisfaction and avoiding undue burden on them.

- One on one counseling education sessions should be conducted by and at times for Peer Educators to resolve issues faced by them if any.
- Peer Educators should develop their own methods to impart information and the method implied should be verified according to individual needs, as they are not necessarily able to replicate across populations, areas, cultures or issues.

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Annexure

QUESTIONNAIRE FOR ADOLESCENTS

Questionnaire No.

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A	Location	Holambi Kalan	1
B	Date of Interview	DD	MM YY
C	Start Time of Interview (Hrs & Min)-	End Time of Interview(Hrs & Min)-	
D	Name and Address of the respondent		
E	Contact number of the respondent		
F	Name of the Interviewer		
H	Result	Completed	1
		Partly Completed	2
		Refused	3
		Other, specify _____	4

Signature of the Researcher _____

Introduction & Consent

Namaskar!!! My name is Varidhi Sharma and I am an MBA Student from IIHMR, Jaipur. Under my research, I am doing a survey on Knowledge level of Adolescents (aged 10-19) on Various Health Themes, I am interviewing in Holambi Kalan District of N-W Delhi to understand the present health scenario among them. This information would be helpful in comparing their knowledge level after delivering training to them by peer educators. I would appreciate your participation in the survey. The survey will take about 20 minutes. The information you will provide will be kept confidential and will not be shown to other persons. At this time do you want to ask anything about the survey? I would like to speak to you in this regard. May I begin the interview now?

Yes.....1 No.....2

A) Demographic Profile	
------------------------	--

1)	Age of the respondent			
2)	Sex of the Respondent	Male	1	
		Female	2	
3)	What is your level of education?	1. Illiterate	1	
		2. Zero to three years	2	
		3. Primary	3	
		4. Higher secondary	4	
		5. Senior secondary	5	
		6. Graduation	6	
		7. Post graduation	7	
4)	What is/was your occupation, that is, what kind of work you mainly do?	1. No occupation	1	
		2. Home maker	2	
		3. Student	3	
		4. Service	4	
		5. Business	5	

B) Awareness on health issues	
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A) Communicable Diseases (Tuberculosis/Malaria/Dengue)

1)	What is the best way to stop Tuberculosis?	a) Test for TB if coughing persists for more than two weeks. b) Finishing the full course of treatment. c) By maintaining personal hygiene, following a healthy and nutritious diet and abstinence from tobacco. d) All of above e) Don't Know	
2)	Do you think that habit of smoking could lead to Tuberculosis?	a) Yes b) No	1.....Yes 0.....No
3)	If coughing Persists for more than 2 weeks, should one go for Tuberculosis Testing?	a) Yes b) No	1.....Yes 0.....No
4)	Can Tuberculosis be completely cured with the help of DOTS?	a) Yes b) No	1.....Yes 0.....No
5)	Immediately going for full treatment, prevention from mosquito bites, prevent mosquitoes from breeding, etc., spreading information on all the above mentioned, could be helpful in prevention and control of Malaria and Dengue?	a) Yes b) No	1.....Yes 0.....No

6)	How Dengue is Transmitted?	a) Transmitted by the bite of infected anopheles. b) By the bite of infected Aedes Aegypti. c) Both a and b. d) Don't Know	
7)	Sudden fever of 103 to 105 degrees, which lasts 5 to 7 days, is a sign of Dengue?	a) Yes b) No	1.....Yes 0.....No
8)	Dengue fever can't be treated?	a) Yes b) No	1.....Yes 0.....No
B) Water and Sanitation Hygiene (WASH)			
9)	How clean and safe drinking water can be made?	a) By chlorination b) By boiling c) Both a and b d) Don't know	
10)	Clean-looking water could also have microorganism that can cause disease?	a) Yes b) No	1.....Yes 0.....No
11)	Job of keeping water clean and safe for drinking should be done by Female/ Girls only?	a) Yes b) No	1.....Yes 0.....No

12)	Not washing hands after defecation and before eating food, could it lead to disease?	a)Yes b) No	1.....Yes 0.....No
13)	Smell of chlorine from the water can be removed?	a)Yes b) No	1.....Yes 0.....No
C) Substance Misuse (Smoking/ Alcohol/ Tobacco)			
14)	Why Children are at risk of drug abuse in Adolescence?	a) Use as a trend. b) More affective behavior then adults. c) Peers and friend's pressure and not enough courage to say no to them. d) All of above e) Don't Know	
15)	Do you think that smoking and alcohol is good for health?	a)Yes b) No	1.....Yes 0.....No
16)	Do you know how to help others to quit addiction?	a)Yes b) No	1.....Yes 0.....No
17)	Do chewing tobacco, increases the chance of cancer of the mouth?	a)Yes b) No	1.....Yes 0.....No

18)	Does cigarette smoke causes the same damage as of smoking?	a)Yes b) No	1.....Yes 0.....No
19)	Beer helps in overall physical development?	a)Yes b) No	1.....Yes 0.....No
20)	Chewing tobacco kills teeth worms?	a)Yes b) No	1.....Yes 0.....No
21)	Smoking and drinking alcohol is sign of a real boy/man?	a)Yes b) No	1.....Yes 0.....No
22)	Drinking alcohol is a sign of being rich and successful?	a)Yes b) No	1.....Yes 0.....No
23)	Drinking alcohol increases the likelihood of accidents and crimes?	a)Yes	1.....Yes 0.....No

		b) No	
24)	Drug Reduces Physical Potential?	a)Yes b) No	1.....Yes 0.....No
D) Sexual And Reproductive Health			
25)	Beginning of menstruation is a sign of?	a) A girl could become pregnant. b) Sign of becoming sexually active and capable of being pregnant. c) Impure d) Don't Know	
26)	Is Night Fall is common?	a)Yes b) No	1.....Yes 0.....No
27)	Is it normal if one masturbates?	a)Yes b) No	1.....Yes 0.....No
28)	Changes in the onset of adolescence in the body mean that if he/she is ready to be sexually active and pregnant?	a)Yes b) No	1.....Yes 0.....No
29)	A girl can become pregnant from having sex only once?	a)Yes	1.....Yes

		b) No	0.....No
30)	During adolescence teenager should eat green vegetables and fruits so that they could meet the special nutritional needs?	a)Yes b) No	1.....Yes 0.....No
31)	Girls become unclean and impure during menstruation?	a)Yes b) No	1.....Yes 0.....No
32)	It's alright having sexual relations during menstruation?	a)Yes b) No	1.....Yes 0.....No
33)	Menstruation is not the subject of discussion.	a)Yes b) No	1.....Yes 0.....No
34)	During menstruation, the girl must be excluded from the family.	a)Yes b) No	1.....Yes 0.....No
35)	Women are responsible for the spread of sexually transmitted disease?	a)Yes	1.....Yes 0.....No

		b) No	
36)	If condom is not used correctly during sex the girl may become pregnant?	a) Yes b) No	1.....Yes 0.....No
37)	Sexual relations should be made during teenage?	a) Yes b) No	1.....Yes 0.....No
38)	Early pregnancy could lead to mother and child mortality or increase their chances of getting sick.	a) Yes b) No	1.....Yes 0.....No
39)	It is important to make sexual relations for overall physical development during adolescence?	a) Yes b) No	1.....Yes 0.....No
E) HIV/AIDS			
40)	Which of the following bodily fluids could spread AIDS Virus?	a) Blood b) Breast Milk c) Semen d) All of Above	
41)	Having sex with someone (infected with HIV) only once can transmit HIV.	a) Yes b) No	1.....Yes 0.....No

42)	Is it possible to treat HIV/AIDS?	a)Yes b) No	1.....Yes 0.....No
43)	Young men/women are at great risk of being infected with HIV/AIDS.	a)Yes b) No	1.....Yes 0.....No
44)	HIV/AIDS could spread from shaking hands and kissing.	a)Yes b) No	1.....Yes 0.....No
45)	Avoiding physical relationship is the best way to avoid HIV and pregnancy.	a)Yes b) No	1.....Yes 0.....No
46)	Habit of taking drugs through Injection could lead to HIV	a)Yes	1.....Yes 0.....No

		b) No	
F) Menstrual Hygiene			
47)	Why menstrual hygiene is important?	a) Stay away from infections b) General comfort and easy mobility. c) Both a and b d) None of these	
48)	Is it safe to take a bath during menstruation?	a) Yes b) No	1.....Yes 0.....No
G)			
49)	What all are included in personal hygiene.	a) Understanding the body b) Showering (face, hands, feet, underarms, groin and bottom) c) Washing hair d) Changing clothes. e) Maintaining good oral health f) All of above g) None of These	
50)	Lack in Personal cleanliness can lead to infection and diseases.	a) Yes b) No	1.....Yes 0.....No
H) Importance of Peer education			
51)	Young can better help in changing society's view in Maintenance of water and sanitation, habits of	a) Yes	1.....Yes 0.....No
53			

	personal cleanliness and adapting healthy habits.	b) No	
52)	It is necessary for a peer educator to understand and responsibly carrying his duties to create awareness so that they could protect the rights of others.	a)Yes b) No	1.....Yes 0.....No

QUESTIONNAIRE for Community Members

Questionnaire No.

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A	Location	Holambi Kalan		1
B	Date of Interview	DD	MM	YY
C	Start Time of Interview (Hrs & Min)-	End Time of Interview(Hrs & Min)-		
D	Name and Address of the respondent			
E	Contact number of the respondent			
F	Name of the Interviewer			
H	Result	Completed	1	
		Partly Completed	2	
		Refused	3	
		Other, specify_____	4	

Signature of the Researcher _____

Introduction & Consent

Namaskar!!! My name is Varidhi Sharma and I am an MBA Student from IIHMR, Jaipur. Under my research, I am doing a survey on Knowledge of community members on Various Health Themes I am interviewing people here in Holambi Kalan District of N-W Delhi to understand the present health scenario among them. I would appreciate your participation in the survey. The survey will take about 20 minutes. The information you will provide will be kept confidential and will not be shown to other persons. At this time do you want to ask anything about the survey? I would like to speak to you in this regard. May I begin the interview now?

Yes.....1 No.....2

A) Demographic Profile			
1)	Age of the respondent		
1)	Age of the respondent		
2)	Sex of the Respondent	Male	1
		Female	2
3)	What is your level of education?	8. Illiterate	1
		9. Zero to three years	2
		10. Primary	3
		11. Higher secondary	4
		12. Senior secondary	5
		13. Graduation	6
		14. Post graduation	7
4)	What is/was your occupation, that is, what kind of work you mainly do?	6. No occupation	1
		7. Home maker	2
		8. Student	3
		9. Service	4
		10. Business	

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B) Awareness on health issues

1)	What is the best way to stop Tuberculosis?	f) Test for TB if coughing persists for more than two weeks. g) Finishing the full course of DOTS treatment. h) By maintaining personal hygiene, following a healthy and nutritious diet and abstinence from tobacco. i) All of above j) Don't Know	
2)	Sudden fever of 103 to 105 degrees, which lasts 5 to 7 days, is a sign of Dengue?	a) Yes b) No	1.....Yes 0.....No
3)	How clean and safe drinking water can be made?	e) By chlorination f) By boiling g) Both a and b h) Don't know	
4)	Not washing hands after defecation and before eating food, could it lead to disease?	a) Yes b) No	1.....Yes 0.....No
5)	Why Children are at risk of drug abuse in Adolescence?	f) Use as a trend. g) More affective behavior then adults. h) Peers and friend's pressure and not enough courage to say no to them. i) All of above j) Don't Know	

6)	Drinking alcohol increases the likelihood of accidents and crimes?	a)Yes b) No	1.....Yes 0.....No
7)	Beginning of menstruation is a sign of?	e) A girl could become pregnant. f) Sign of becoming sexually active and capable of being pregnant. g) Impure h) Don't Know	
8)	During adolescence teenager should eat green vegetables and fruits so that they could meet the special nutritional needs?	a)Yes b) No	1.....Yes 0.....No
9)	Women are responsible for the spread of sexually transmitted disease?	a)Yes b) No	1.....Yes 0.....No
10)	Which of the following bodily fluids could spread AIDS Virus?	e) Blood f) Breast Milk g) Semen h) All of Above	
11)	Why menstrual hygiene is important?	e) Stay away from infections f) General comfort and easy mobility. g) Both a and b h) None of these	
12)	What all are included in personal hygiene.	h) Understanding the body i) Showering (face, hands, feet, underarms, groin and bottom) j) Washing hair k) Changing clothes. l) Maintaining good oral health m) All of above n) None of These	

13)	What is your Source of Information on Adolescents Health Issues.	a) Television b) Print Media c) Radio d) Relatives/Friends e) Peer Educators	
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