Summer Training at
Plan India, New Delhi
(23rd March to 22nd May '15)

Project Title

A Comparative Study on Knowledge and Attitude level of Peer Educators with Young People Visiting Health Information Centre (HIC) before and after training sessions

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Varidhi Sharma**, student of Post Graduate Program in Health Management, Institute of Health Management Research, Jaipur, 19th Batch, has successfully completed her summer training for the duration of **23rd March to 22nd May 2015**, under **Plan India, New-Delhi**. During this period she has completed her study on **"A Comparative Study on Knowledge and Attitude Levels of Peer Educators with Young People Visiting Health Information Centre(HIC), Before and After Training Sessions"** as part of partial fulfilment of course requirements, recommended for postgraduate program in Health Management with specialisation in Health management. Her approach towards the study has been sincere, scientific and analytical.

I wish her all the best for future endeavours.

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May 26, 2015

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Varidhi Sharma** ([redacted] of IIHMR, MBA Hospital and Health Management (2014 - 2016) has interned with us during the tenure of **23rd March 2015 to 22nd May 2015**. During this time span, she was involved with Plan India in Young Health Program.

We have found her innovative, hardworking and dedicated towards her deliverables.

I wish her success and all the very best for her future career and endeavors.

Best Regards,

Pooja Mathur
Senior Manager – Human Resources & OD

Acknowledgement

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I whole heartedly thank my mentor Dr. Susmit Jain (Assistant Professor), IIHMR University, Jaipur for his unconditional support and treasured suggestions in the completion of the project work.

Last but not the least I am forever grateful to my parents for their blessings, for having unwavering faith in me and for being an endless source of inspiration and support.

Varidhi Sharma

CONTENTS

S.No.	TOPIC	Page No.
1	List of Abbreviations	4
2	About Rashriya Kishor Swasthya Karyakram	5
	SECTION A	
3	Introduction of the Organization	8
3a	About Plan India	11
3b	About Young Health Program of AstraZeneca-Plan	15
	SECTION B	
4	Specific Project Findings	
4a	Background	15
4b	Literature Review	17
4c	Rationale for study	18
4d	Objective	18
4e	Results	19
4f	Conclusion	23
5	References	25

LIST OF FIGURES AND TABLES

S.No.	Content of the figures	Page No.
1.	World map showing countries where Plan works	8
2.	Plan's eight core areas of work	10
3.	Plan's program areas in India	9
4.	The objectives of the YHP in India	10
5.	Key programme strategies of the YHP in India	13
6.	Map showing Delhi and the areas where the YHP is being implemented	12
	Graphs	
7.	Age-Groups of Respondents	19
8.	Age-Sex distribution of respondents(cross tabs)	19
9.	Knowledge on Health & well being: TB, Malaria, Dengue	20
10.	Knowledge on Substance Misuse	20
11.	Knowledge on Harmful effects of tobacco use	21
12.	Knowledge on Hygiene Practices	21
13.	Knowledge on HIV/AIDS	22
14.	Knowledge on Sexual and Reproductive Health	22
15.	Level of Confidence on different Health Themes	23

Abbreviation

RKSK	Rashtriya Kishor Swasthya Karyakram
GoI	Government of India
YHP	Young Health Program
NGO	Non-Government Organization
HIC	Health Information Centre
PE	Peer Educator
AOC	Ambassadors of Change
FGDs	Focused Group Discussion
SRH	Sexual Reproductive Health
MDGs	Millennium Development Goals
CASP	Community Aid and Sponsorship Program
SHSTs	Slum Health and Sanitation Teams
RTI	Reproductive Tract Infection
AFHS	Adolescent Friendly Health Services
GBV	Gender Based Violence
NCD	Non-Communicable Diseases
MHS	Menstrual Hygiene Scheme
AZ	AstraZeneca
AZ-YHP	The AstraZeneca Young Health Programme
BCC	Behaviour Change Communication
AFHS	Adolescent Friendly Health Services
IEC	Information Education Communication
STIs	Sexually Transmitted Infections
TB	Tuberculosis
ToR	Terms of Reference
WES	Water Environment Sanitation
WHO	World Health Organization
WIP	Workplace Intervention Programme
YHCs	Youth Friendly Centres

Rashtriya Kishor Swasthya Karyakram

The Ministry of Health and Family Welfare has launched a new adolescent health programme – Rashtriya Kishor Swasthya Karyakram. The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation. Further, RKSK underscores the need for several constituencies to converge effectively and harness their collective strength to respond to adolescent health and development needs. The different stakeholders, working on issues related to adolescent health and development, have a lot to gain by building on each other's work both in terms of achieving programme objectives as well as in the improved indicators for adolescent health and development.

Adolescents: an opportunity and a challenge

Adolescents (10–19 years) constitute about one-fifth of India's population and young people (10–24 years) about one-third of the population. This represents a huge opportunity that can transform the social and economic fortunes of the country. The large and increasing relative share and absolute numbers of adolescent and youth population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth. The skills, knowledge, attitudes and behaviour of today's young people are essential to whether, and how well, the demographic dividend is successfully leveraged.

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 Millennium Development Goals (MDGs) at the same time, it will enhance economic productivity, effective social functioning and overall population development. However, a considerable number of adolescents face challenges to their healthy development due to a variety of factors, including:

- Structural poverty
- Social discrimination
- Negative social norms
- Inadequate education
- Early marriage and child-bearing especially in the marginalised and under-served sections of the population.

In order to respond effectively to the needs of adolescent health and development, it is imperative to situate adolescence in a life-span perspective within dynamic sociological, cultural and economic realities.

MoHFW's response: a paradigm shift

Taking cognisance of the need to respond to health and development requirements of adolescents in a holistic manner, the Ministry of Health and Family Welfare (MoHFW) has developed a comprehensive strategy, based on the principles of participation, rights, inclusion, gender equity and strategic partnerships. The strategy envisions that ***all adolescents in India are able to realise their full potential by making informed and responsible decisions related to their health and well-being.*** The implementation of this vision requires a concerted effort by all stakeholder ministries and

institutions, including health, education, women and child development, and labour as well as the adolescents' own families and communities.

The strategy is a paradigm shift, and realigns the existing clinic-based curative approaches to focus on a more holistic model, which includes and focuses on community-based health promotion and preventive care along with a strengthening of preventive, diagnostic and curative services across levels of health facilities. The approach proposed in the strategy is based on a continuum of care for adolescent health and development needs, including the provision of information, commodities and services at the community level, with mapped out referral linkages through the three-tier public health system. Most importantly, it proposes a convergent model of service delivery that will engage adolescents and field service providers (for example, teachers, Accredited Social Health Activists—ASHAs, Auxiliary Nurse Midwives—ANMs, *Anganwadi* Workers—AWWs and *Nehru Yuva Kendra Sangathan* NYKS—volunteers) actively, to secure and strengthen mechanisms for access and relevance. The strategy moves away from a 'one-size-fits-all' approach to more customised programmes and service delivery specific to needs of adolescents, and aims at instituting an effective, appropriate, acceptable and accessible service package, addressing a range of adolescent health and development needs.

7Cs and six strategic priorities

To implement this paradigm shift, the strategy identifies seven critical components (7Cs) that need to be ensured across all programme areas. These components are:

- Coverage,
- Content,
- Communities,
- Clinics (health facilities),
- Counselling,
- Communication and
- Convergence.

The six strategic priorities (programme) areas that have emerged from a situational analysis of adolescent health and development needs in India are: nutrition, sexual and reproductive health (SRH), non-communicable diseases (NCDs), substance misuse, injuries and violence (including gender-based violence) and mental health.

SECTION-A

INTRODUCTION OF THE ORGANIZATION

ABOUT PLAN

Plan International is one of the oldest and largest children's development organisations in the world working in 51 developing countries across Africa, Asia and the Americas to promote child rights and lift millions of children out of poverty. Plan in India is part of Plan International which is founded over 75 years ago.

Plan was founded in 1937 by British journalist John Langdon-Davies and refugee worker Eric Muggeridge. Originally named 'Foster Parents Plan for Children in Spain', the aim was to provide food, accommodation and education to children whose lives had been disrupted by the Spanish Civil War.

Figure 1: World map showing countries where Plan Works

In 2014, Plan worked with 86,676 communities. Their work areas had a population of 164.9 million people - including 81.5 million children. Plan is independent, with no religious, political or governmental affiliations.

Plan's vision is of a world in which all children realise their full potential in societies which respect people's rights and dignity. Plan India's rights based approach helps bring lasting improvements to the lives of vulnerable children and their communities in India, including children living on the streets and those living in urban homeless families; those with disabilities or affected by HIV; those who are exploited and trafficked; the children of sex workers; and child labourers. Plan India also works to help girls overcome the disadvantages and discrimination they face in everyday life within most communities by promoting education for the girl child.

Plan's Program areas in India

1. Andhra Pradesh
2. Bihar
3. Delhi
4. Jharkhand
5. Rajasthan
6. Maharashtra
7. Orissa
8. Punjab
9. Uttrakhand
10. Uttar Pradesh
11. Karnataka
12. Tamil Nadu
13. Jammu & Kashmir

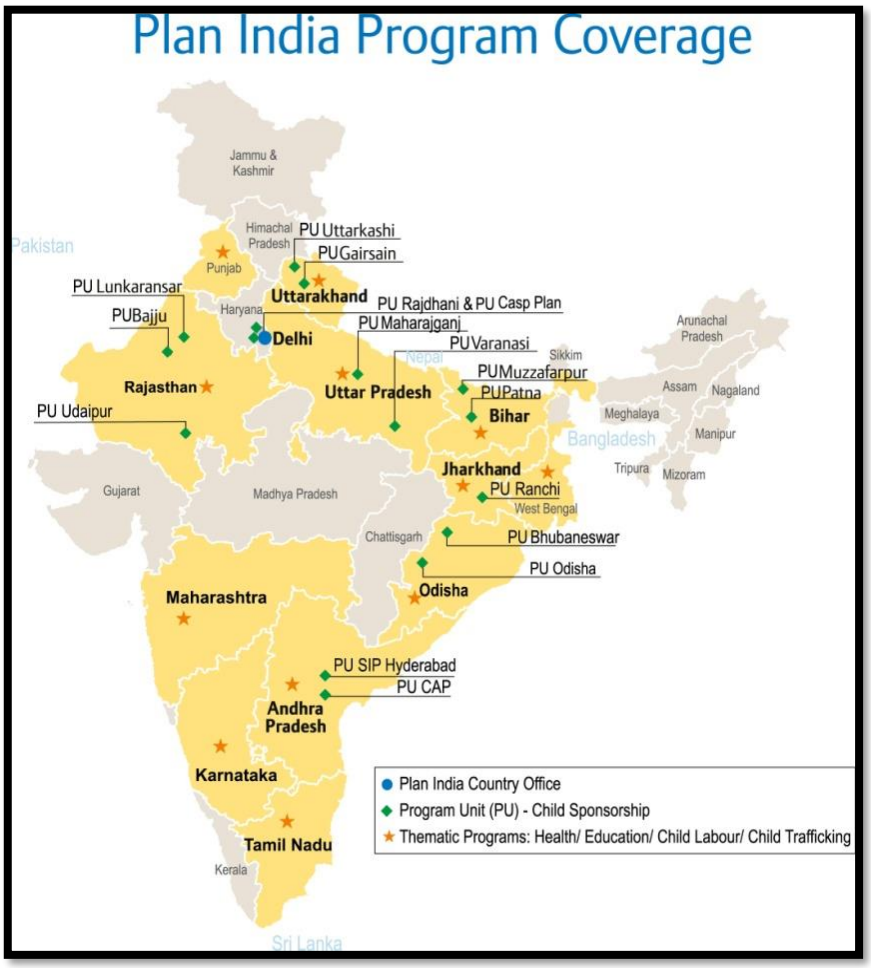

Figure 2: Plan's program areas in India

Plan has helped communities throughout India to help them, so that children have access to their rights including the right to:

- Protection
- Basic education
- Proper healthcare
- A healthy environment
- Livelihood opportunities
- Participation in decisions which affect their lives.

Plan currently works in 13 states in India and has impacted the lives of more than a million children.

Vision

Plan's vision is of a world in which all children realise their full potential in societies that respect people's rights and dignity.

Mission

Plan aims to achieve lasting improvements in the quality of life of deprived children in developing countries, through a process that unites people across cultures and adds meaning and value to their lives, by:

- Enabling deprived children, their families and their communities to meet their basic needs and to increase their ability to participate in and benefit from their societies
- Building relationships to increase understanding and unity among peoples of different cultures and countries
- Promoting the rights and interests of the world's children.

Core areas of Work

Plan works to promote child rights and lift millions of children out of poverty, based around 8 core areas:

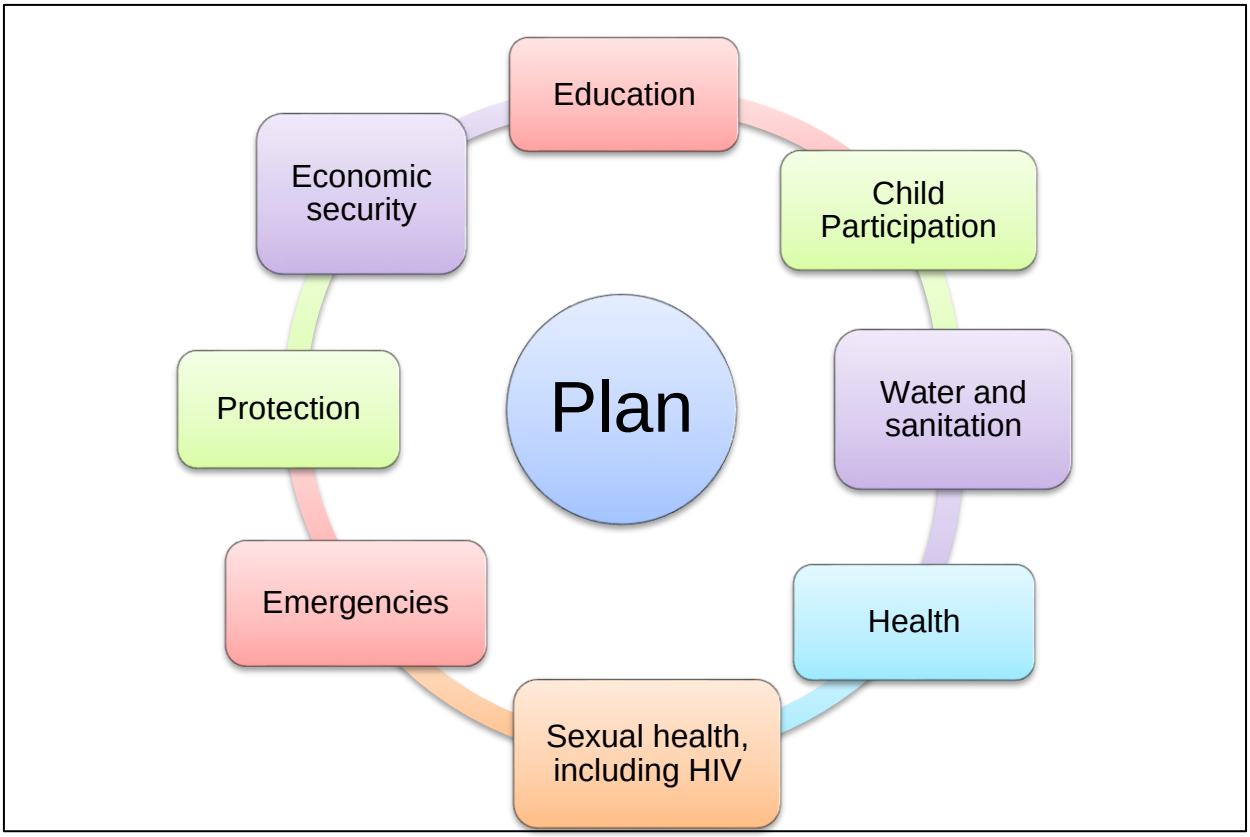

Figure 3: Plan's eight core areas of work

Plan India-Astra Zeneca Young Health Program

Young Health Program Initiative started by Astra Zeneca, Plan UK and Plan India, to bring meaningful difference to health and well being of marginalized and disadvantaged adolescents and young people(10-24years) by helping them to make informed choices to protect their health, now and in future. Plan India has been steering this Project with support of four partner organizations

- Navshriti
- CASP
- Alamb
- Dr. A V Baliga Trust

At five project locations: Holambi Kalan, Manadpur Khadar, Badarpur, Dwarka and Mangolpuri of Delhi.

Key Issues of the program:

Following the baseline survey and an understanding of the overreaching health related issues of adolescents in the community chosen for intervention under the program, the key issue identified included:

- Hygiene and Sanitation, including personal Hygiene.
- Sexual Hygiene and safe practices (leading to overall reproductive health), including menstrual hygiene and sexually transmitted infections.
- Communication diseases such as TB and Malaria as well as general ailments like diarrhea.
- Non-Communicable diseases and ailments, related to diet, substance abuse, etc. and
- Life skills, a focus that cuts across all other core themes.

Aim

- To make a meaningful difference to health and well being of marginalised and disadvantaged adolescents by helping them to make informed choices to protect their health, now and in the future

Objectives of Astra Zeneca Young Health Program are:

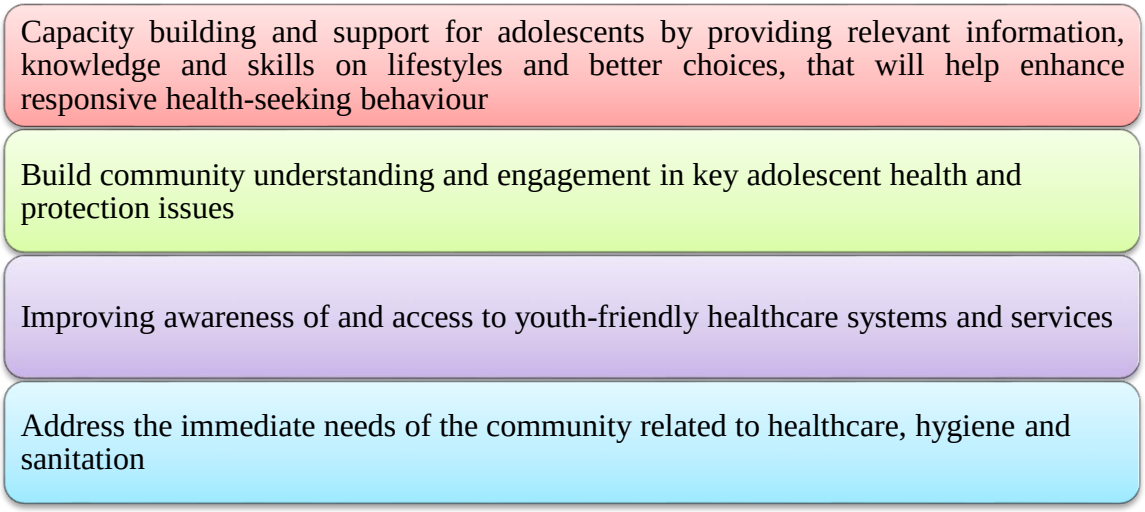

Figure 4: The objectives of the YHP in India Key Programme Strategies

Project Location Map of YHP Delhi

The Young Health Programme (YHP) is being rolled out in five project sites (Badarpur, Madanpur Khadar, Mangolpuri, Holambi Kalan and Dwarka), which covers three districts of Delhi. Plan India is overseeing the roll out of YHP with the support of four grass roots NGOs, detailed below:

District	Area	Implementing agency name
South	Badarpur & Madanpur Khadar	CASP
West	Dwarka	ALAMB
North – West	Mangolpuri	Dr. A.V. Baliga Memorial Trust
North – West	Holambi Kalan	Navshristi

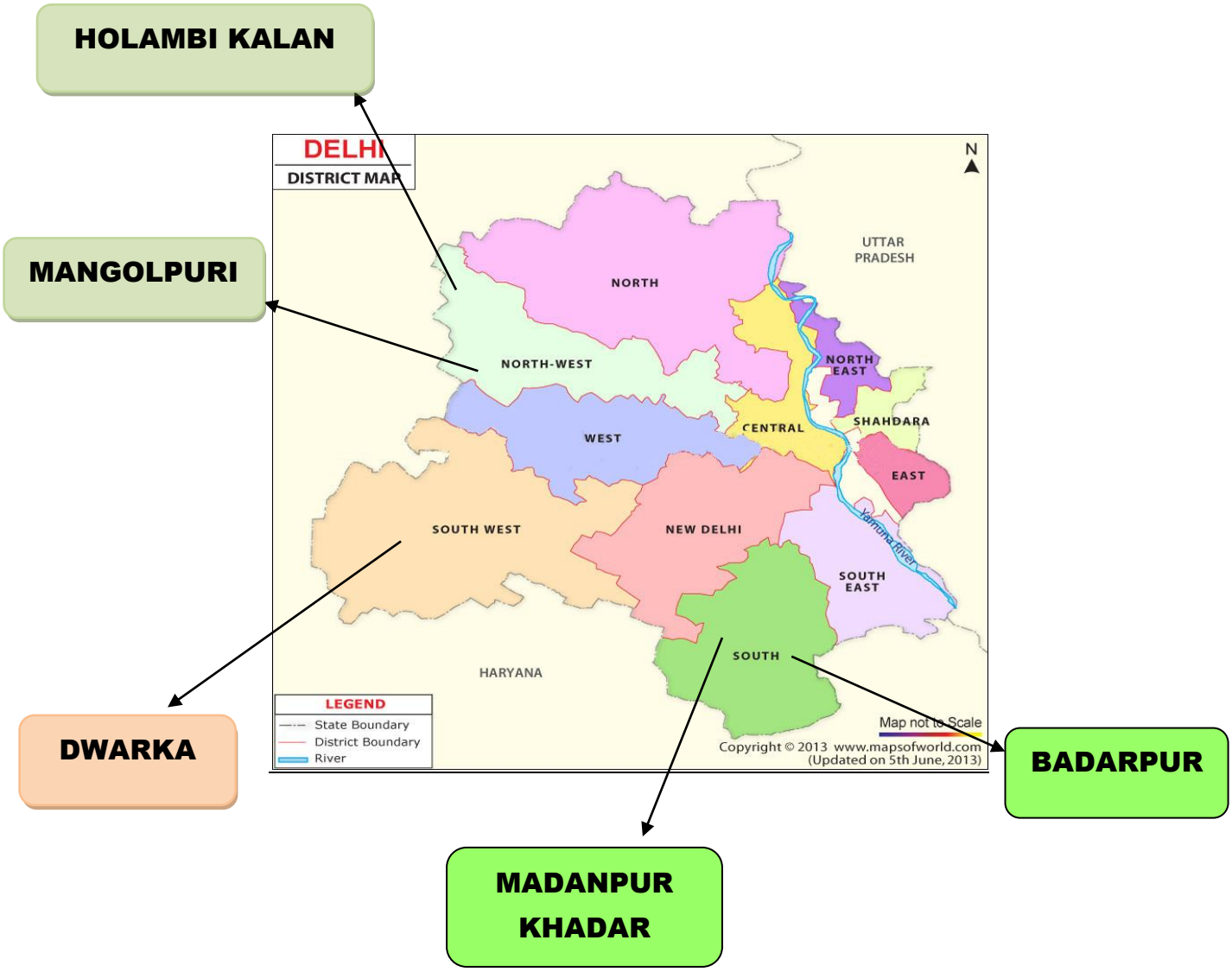

Figure 5: Map showing Delhi and the areas where the YHP is being implemented

Key Programme Strategies

PEER EDUCATION: Training young people as peer educators to take the knowledge forward. These peer educators are trained on Life Style Diseases, Community Diseases, Water & Environmental Sanitation, Sexual Reproductive Health and Gender Based Violence

HEALTH INFORMATION CENTRE (HIC): A community based knowledge hub wherein young people can access a range of services including internet, health educative session, training, indoor games and psychosocial counselling

BEHAVIOUR CHANGE COMMUNICATION (BCC): Using locally acceptable and appreciated means to change the behaviour pattern of community in general and young people in particular

STRENGTHENING HEALTH AND ALLIED SYSTEMS: Capacitating front line workers [Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs) and Accredited Social Health Activists (ASHAs)] to work towards the betterment of young people's health

Figure 6: Key program strategies of the YHP in India

SECTION-B

SPECIFIC PROJECT FINDINGS

Background:

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. (Pande, Kurz, Walia, MacQuarrie, & Jain, 2006)

Despite the fact that adolescents represent almost one quarter of the Indian population, their Health needs are poorly understood and ill served. (Jejeebhoy, 1998)

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. (UNICEF, 2011).

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. Adolescences 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 (UNICEF, State of world-Children - Key facts, 2011).

Physical well-being
Adolescents across the world are generally healthier today than in previous generations. Yet in 2004, nearly 400,000 adolescents died of unintentional injuries such those caused by road accidents.

More than 70 million girls and women aged 15–49 have undergone female genital mutilation/cutting (FGM/C), usually by the onset of puberty.

The available evidence from 14 developing countries suggests that adolescent females run a greater risk of nutritional difficulties than adolescent males, notably anaemia. For both sexes, obesity is a serious and growing concern in both industrialized countries and the developing world.

Worldwide, one third of all new HIV cases involve young people aged 15–24.The risk of HIV infection is considerably higher among adolescent females and young women than adolescent males and young men. Among adolescents aged 15-19 in the developing countries, only 30 per cent of males and just 19 per cent of females have correct, comprehensive knowledge of HIV.

Adolescents with disabilities are likely to suffer forms of discrimination, exclusion and stigmatization. Access to transportation, educational facilities and other resources is crucial to ensure that adolescents with disabilities can enjoy the same opportunities as their peers.
It is estimated that around 20 per cent of the world's adolescents have a mental health or behavioural problem, with depression being the most frequently experienced disease.
Evidence shows that some adolescents engage sexual relations in early adolescence (10-14 years). To stay healthy and safe adolescents need access to high-quality sexual and reproductive health services and information from an early age.

As adolescents flourish, so do their communities, and all of us have a collective responsibility in ensuring that adolescence does in fact become an age of opportunity (UNICEF, State of world- Children - Key facts, 2011).

Defining Peer Education

Peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. The English term 'peer' refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status". The term 'education' (v. educate) refers to the "development", "training", or "persuasion" of a given person or thing, or the "knowledge" resulting from the educational process (Merriam Webster's Dictionary, 1985). In practice, peer education has taken on a range of definitions and interpretations concerning who is a peer and what is education (e.g. advocacy, counselling, facilitating discussions, drama, lecturing, distributing materials, making referrals to services, providing support, etc.) (Shoemaker et al., 1998; Flanagan et al., 1996). 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.

Behavioural theory and peer education

Peer education as a behavioural change strategy draws on several well known behavioural theories. For example, Social Learning Theory asserts that people serve as models of human behaviour and that some people (significant others) are capable of eliciting behavioural change in certain individuals, based on the individual's value and interpretation system (Bandura, 1986). The Theory of Reasoned Action states that one of the influential elements for behavioural change is an individual's perception of social norms or beliefs about what people who are important to the individual do or think about a particular behaviour (Fishbein & Ajzen, 1975). The Diffusion of Innovation Theory posits that certain individuals (opinion leaders) from a given population act as agents of behavioural change by disseminating information and influencing group norms in their community (Rogers, 1983). Peer education draws from elements of each of these behavioural theories as it implicitly asserts that certain members of a given peer group (peer educators) can be influential in eliciting behavioural change among their peers.
The Theory of Participatory Education has also been important in the development of peer education (Freire, 1970). "Participatory or empowerment models of education posit that

powerlessness at the community or group level, and the economic and social conditions inherent to the lack of power are major risk factors for poor health" (Amaro, 1995). Empowerment in the Freirian sense results through the full participation of the people affected by a given problem or health condition; through such dialogue the affected community collectively plans and implements a response to the problem or health condition in question. Many advocates of peer education claim that this horizontal process of peers (equals) talking among themselves and determining a course of action is key to peer education's influence on behavioural change.

LITERATURE REVIEW

Peer education draws on the credibility that young people have with their peers, leverages the power of role modelling, 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 (working for youth, 2013).

Peer Education is 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 behaviour 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. (Boyle, 2011). A team of peer educators can extend health promotion outreach and be more accessible then paid health professionals. 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 (Wiskochil, 2007).

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 behaviour, helping to create and reinforce social norms that support safer behaviours, 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 (Main, 2002).

Apart from training and capacity building of peer educators , To help tackle key issues affecting young people, Plan has created Health Information Centres (HICs); a safe space specifically for adolescents and their families to access health information, discuss medical concerns, and where necessary, be referred on for treatment. Issues such as HIV, sexual health, hygiene and drugs are covered. People are encouraged to talk about their worries, and overturn common misconceptions about health. They are always invited to come to community meetings at the Health Information Centres at a later date if they want to know more.

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

programmes, 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.)

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 behaviour. Some of the ways they are doing this in schools around the world include:

- Leading informal discussions
- Video and drama presentations
- One-on-one time talking with fellow students
- Handing out , leaflets and brochures
- Offering counselling, support and referral to services

RATIONALE

This study would enable the organisation to quantify the knowledge attained in the training sessions amongst a group of peer educators.

Also it would help us to compare the knowledge, skills and abilities of the peer educators and the students visiting HIC before and after the training sessions.

Hence it would enable us to analyze the appropriateness of the learning objectives as well as to target any instructional needs to improve the training programs.

Objective

- To compare the knowledge level among peer educators and young people visiting HIC on various health themes covered under YHP.
- To check the effectiveness of training given to them for a period of 2 months

METHODOLOGY

- Type of Study: Cross Sectional Descriptive study
- Location of Study: The study was conducted in the 24 Blocks of Mangolpuri resettlement colony, Delhi.
- Duration Of Study: Two Months(March-May’15)
- Sample Size: 100
- Data Collection Tool: Self-Administered Questionnaire
- Data Analysis: SPSS and MS Excel

Results

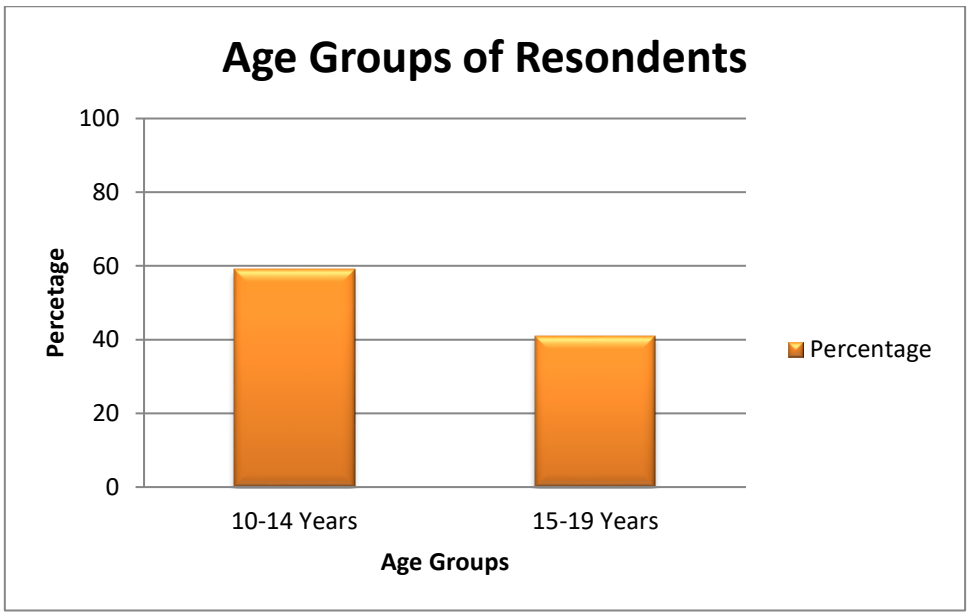

Figure: 7- Age groups of respondents (HIC Youth and Peer Educators)

The age groups of Peer Educators and young people visiting HIC is distributed as shown in figure 7.

It depicts that out of 100 respondents around 59 percent were in age group 10-14 years, the knowledge level of health themes like, Dengue, Malaria, Hygiene Practices, Diet and Nutrition, Harmful use of tobacco etc. were prime focus for this group., likewise for the age group of 15-19 years, sexual and reproductive health, Substance misuse, HIV/AIDS, etc. are the area of focus.

Distribution of Age groups with Sex

Age * Sex Cross tabulation

		Sex		Total
		Male	Female	
Age	10-14 years	34	25	59
	15-19 years	16	25	41
Total		50	50	100

Knowledge on different Health Themes under YHP:

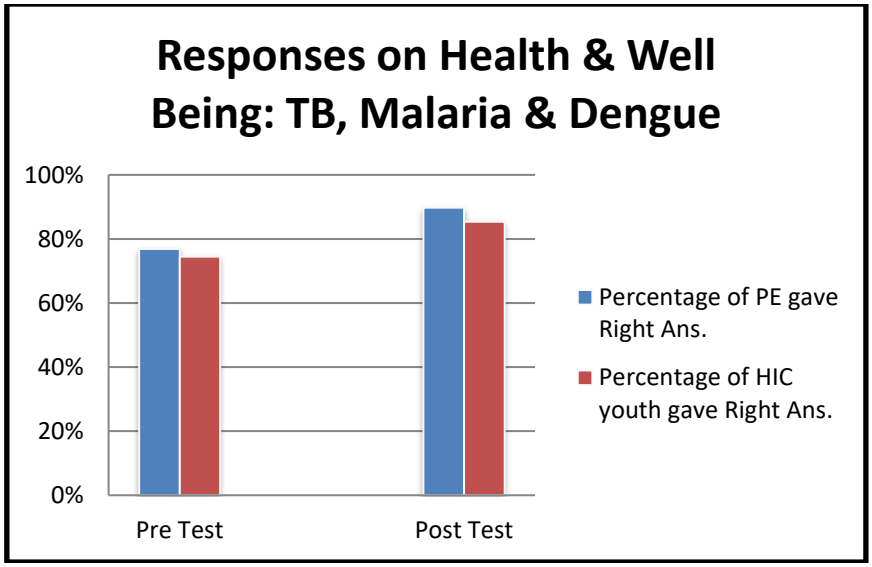

Figure:8- Knowledge on Tb, Malaria, Dengue of PEs with young people visiting HIC, Pre and Post Test

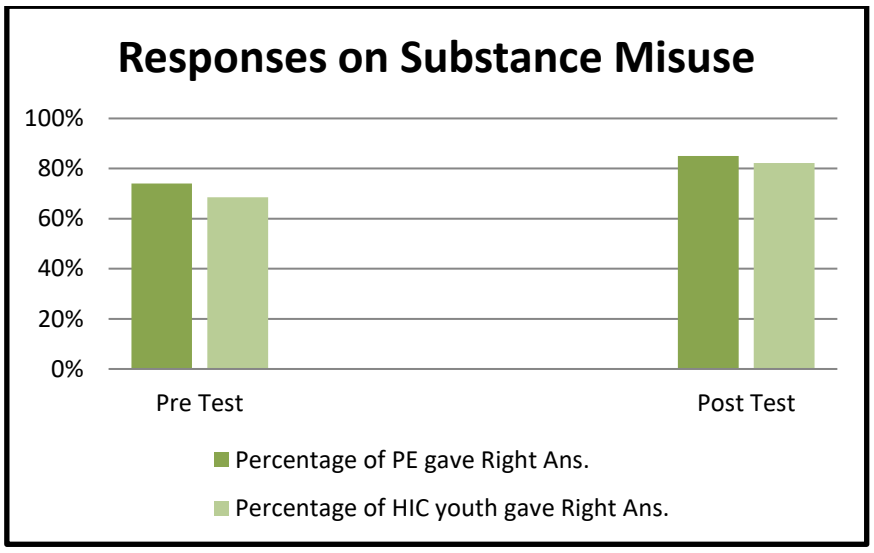

Figure:9- Knowledge on Substance Misuse of PEs with young people visiting HIC, Pre and Post Test

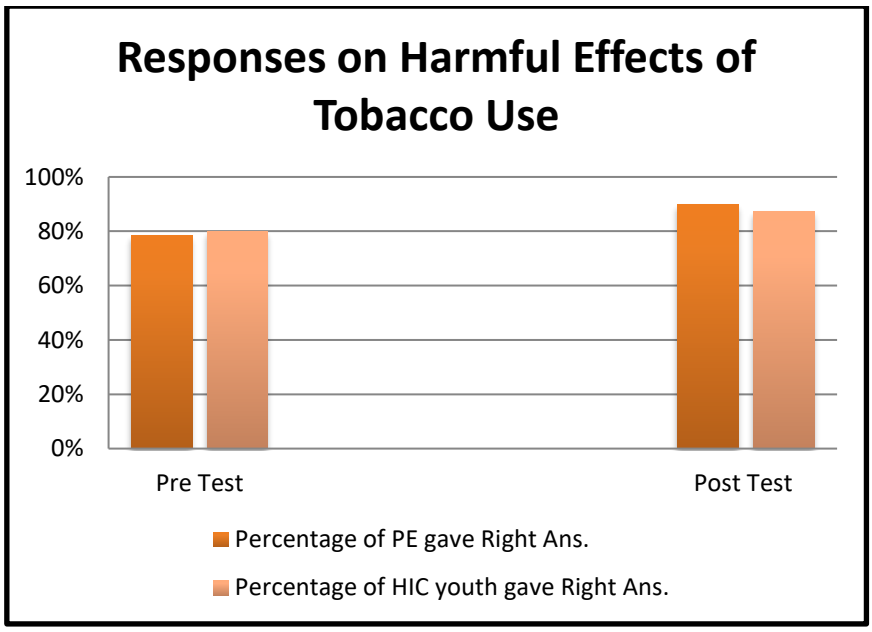

Figure:10- Knowledge on Harmful effects of Tobacco Use of PEs with young people visiting HIC, Pre and Post Test

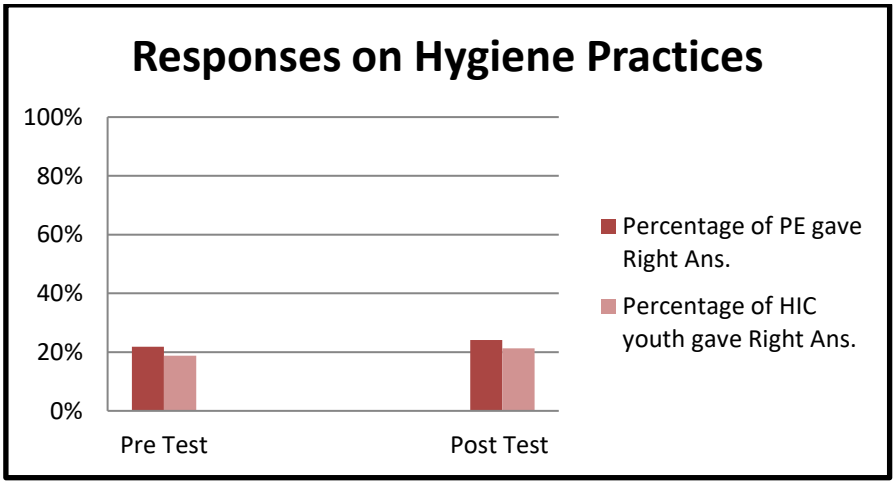

Figure:11- Knowledge on hygiene, of PEs with young people visiting HIC, Pre and Post Test

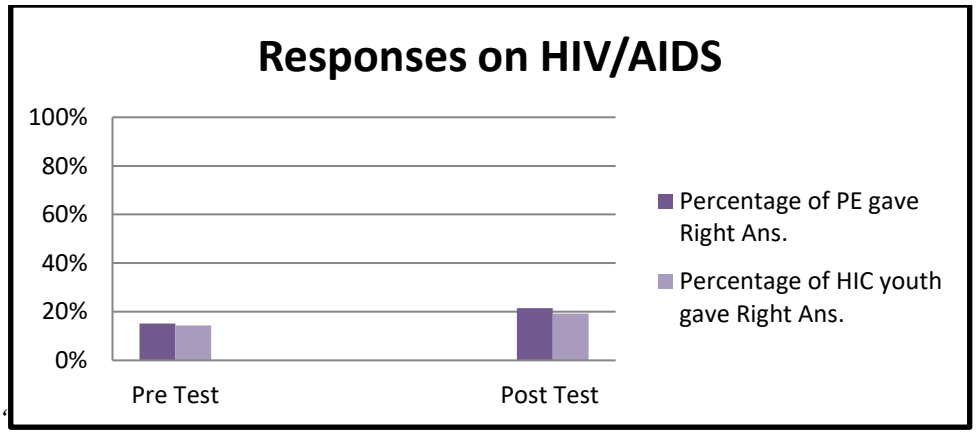

Figure:12- Knowledge on HIV/AIDS, of PEs with young people visiting HIC, Pre and Post Test

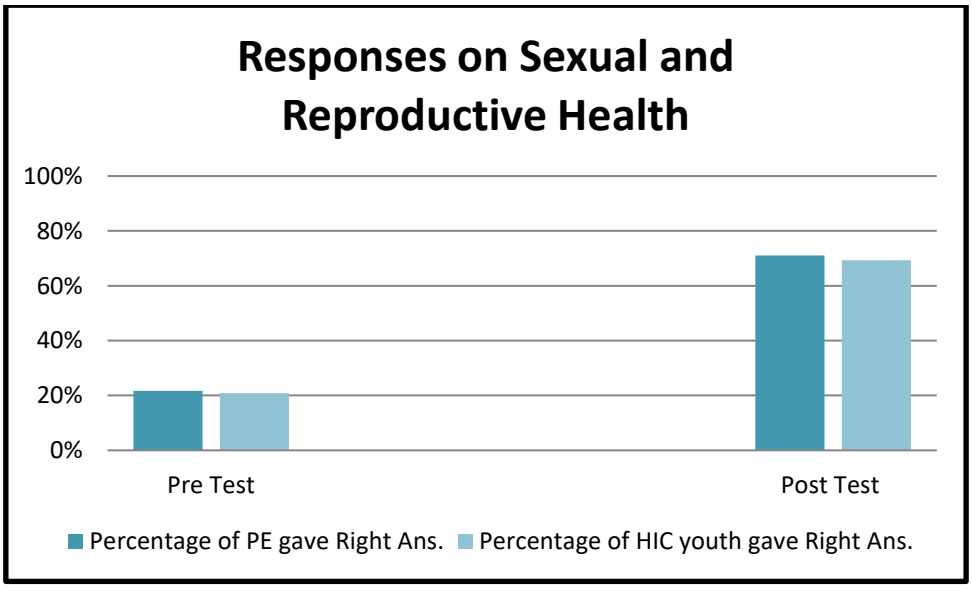

Figure:13- Knowledge on sexual & reproductive health of PEs with young people visiting HIC, Pre and Post Test

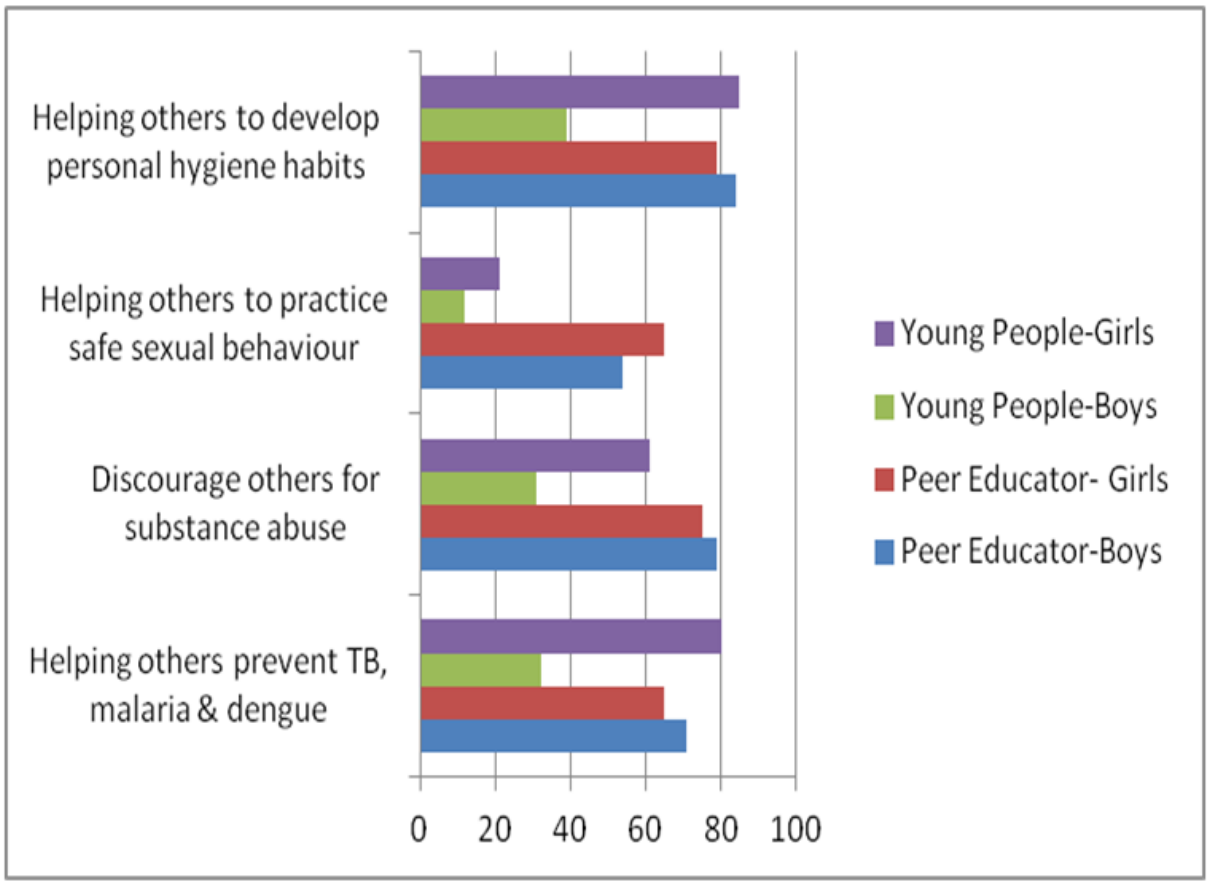

Figure:14- Level of attitude among PEs and young people visiting HIC on various health themes

Conclusion

- As the level of confidence in helping others in case of substance abuse and to practice safe sexual behaviour is very low for young boys and girls (fig 14) , Peer Educators can be trained on these themes and for rest of the issues , capacity building and strengthening of the health information centres should be undertaken.

- Health care delivery should be made more personal and engaging for adolescents directly by involving them in the planning and delivery of health services in order to make it more beneficial to the people visiting HIC. This would help in saving resources which are being used for the training of the peer educators. Actively engaging adolescents in the creation of programs and services can be seen as essential in ensuring a system of care that is responsive to their needs.

- Developing flexible service provision strategies for individual provider sites is also recommended. Strategies implementing the least restrictive requirements for mental

health and substance abuse treatment services, and developing active and flexible STD treatment and follow-up.

- Integrate outreach and follow-up services to enhance service delivery. Recommended methods for follow-up included the establishment of follow-up services through case management and verification of appropriate follow-up care. This would help young People Visiting HIC to retain the knowledge imparted to them at the centres and also at the same time would reduce the requirement of peer educators and hence resources required for their training.

- Improve Training in Adolescent Health. Of particular concern is the need to improve the education of parents, teachers, youth group leaders, state adolescent health coordinators, social workers, and foster care providers.

- Increase the number of racially and ethnically diverse professionals working with adolescents.

- Develop family-centred services to keep families intact.

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