Young Health Programme India:

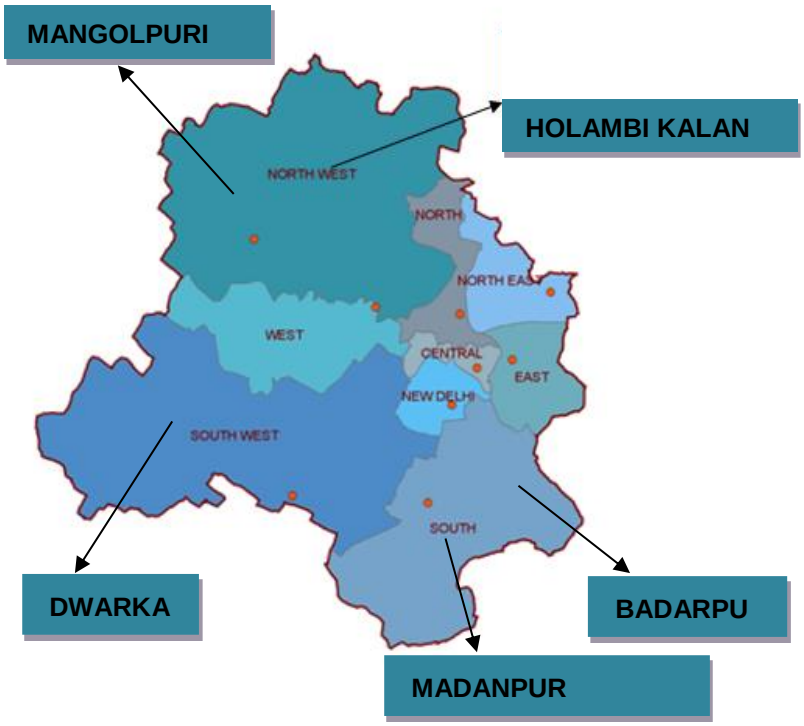
Final Evaluation Phase I&II 2010-2015

Plan

AstraZeneca
Young Health Programme

Introduction to YHP India

Between 2010 and 2015 The Young Health Programme (YHP) India was delivered in five project sites (Badarpur, Madanpur Khadar, Mangolpuri, Holambi Kalan and Dwarka), which cover three districts of Delhi. Plan India oversaw the YHP with the support of four community based NGOs: CASP, ALAMB, Dr. A.V. Baliga Memorial Trust and Navshristi. Phase 1 began in November 2010 and was extended to Phase 2 in November 2013. Phase 2 programme activity completed in October 2015.



Map showing Delhi and the areas where the YHP has been implemented

Overall Goal: To make a meaningful difference to the health and well-being of marginalised and disadvantaged adolescent boys and girls by helping them to make informed choices to protect their health, now and in the future.

- **Objective 1:** Capacity building and support for adolescents by providing relevant information, knowledge and skills on lifestyles and better choices, that will help enhance responsive health-seeking behaviour.
- **Objective 2:** Building community understanding and engagement in key adolescent health and protection issues.
- **Objective 3:** Improving awareness of and access to youth-friendly healthcare systems and services.
- **Objective 4:** Addressing the immediate needs of the community in issues relating to health care, hygiene and sanitation.

Monitoring & Evaluation

The **Final Evaluation** forms a critical part of the **Monitoring and Evaluation (M&E)** mechanisms for the YHP India. Plan India, their partners and Plan UK, developed a detailed monitoring, evaluation and learning framework to set out when and how the output and outcome indicators were monitored from the outset. This was developed further in 2013 when the YHP was extended from 3 years (Phase 1) by another 2 years (Phase 2). The M&E cycle included a **Base-line Evaluation** completed in February 2011 to ascertain the situation for adolescents with regards to their health in the project communities. This was followed in 2014 by a **Mid-line Evaluation** to gauge the change in health status of young people that could be attributed to the YHP India.

The Final Evaluation has been carried out to measure the change that can be credited to the YHP India across the 5 years, employing both qualitative and quantitative methods and incorporating the previous Base-line and Mid-line evaluations with an **End-line evaluation**. A multi-stage sampling method was used to select interviewees from young people, Peer Educators, parents, teachers, health service providers and other key stakeholders to assess their knowledge and behaviour related to the YHP thematic areas. In addition **all relevant programme documents** such as reports, curriculum materials and register of referrals were reviewed and in-depth interviews were conducted with YHP programme staff both at Plan India and the partner organisations.

The Base-line, Mid-line and Final Evaluations have all been conducted **by external, independent consultants.**

Key Findings: Programme Reach

Between November 2010 and October 2015 YHP India reached

- a total of **199,387** young people
- including **2,200** young people trained as Peer Educators
- **119,770** members of the wider community, including
- **623** healthcare workers
- **13,685** parents
- **362** teachers
- **67** community leaders

In total **319, 223 people have been reached** in 5 project communities in Delhi.

Targets for programme reach were either met or exceeded

* The most effective communication medium as reported in the focus group discussions and quantitative survey has been directly from the **Peer Educators** (97%) followed by **Information, Education and Communication (IEC) materials** (87.8%). With increased focus on IEC activity in Phase 2 the reach through this medium increased significantly in the last 2 years by 9.5%

* Of the young people surveyed, **awareness of the HICs was high at 90%** but the actual **use of the HICs was measured at 39%**. Even though demand for the HICs was high there were **some limitations such as lack of space, distance from home and timings the HICs were open**. The number of HICs in the programme could not accommodate the population of all the young people in the communities. This also shows the value and importance of outreach activities such as health fairs and street plays outside the HIC buildings.

* K**nowledge of the HICs continues to be high amongst parents** (96.1%) which illustrates the impact of activities designed specifically to reach this group.

Key Findings: Impact of Peer Education Approach

* The Peer Education model has been the most effective communication medium for generating awareness about YHP.

* **As a tool for raising general awareness it has been strong but more technical, in depth knowledge is also needed for full understanding of the YHP thematic areas** to be achieved.

* 94.3% of youth reported that the attitude of Peer Educators **was supportive towards them**. Many related personal examples of this.

* **96.3% of the Peer Educators felt their knowledge on YHP thematic areas had increased** after Peer Education training. **All Peer Educators** who reported this increase in knowledge **are using this knowledge in their daily life**, and are confident in discussing these topics with others in the community.

* Peer Educators in the **10-14 years age bracket participated in the most number of YHP activities**. During discussion it was felt this was because their school commitments were lesser and they had more time available in school holidays.

* During focus group discussions many parents reported how their children's involvement in the YHP had helped their children **deal better with peer pressure.**

* **The percentage of Peer Educators pursuing higher education (secondary and above) is significantly higher** than among other young people surveyed – 72% compared with 19%. It could be theorised that this trend can be in part attributed to the skills, training and development of the Peer Educators.

"Some of our school students are Peer Educators. Training imparted to them has made leaders."

– Teacher from Mangolpuri

Key Findings: Impact of Health Information Centres

* Community members surveyed perceive the HIC as **an important community based-resource centre** for engaging youth and imparting knowledge to them.

* Young people using the services from the HICs received IEC materials (87.4%) and counselling (78%). **73% young people reported that they were always satisfied with the services** received from HICs.

* **Girls were more likely to use the HIC services** than boys (42% as compared with 36%)

* HICs have played a crucial role in increasing the number of referrals related to various health issues such as concerns about menstrual problems, malaria and reproductive tract infections to the health centre. **1,551 Young people were referred to health facility**. **7.4% of the youth surveyed have reported using referral services** from the HICs.

* One of the **best practices highlighted in the HICs was the use of drop boxes**. These are anonymous post boxes in a private area of the HIC where young people can deposit their questions and these are discussed weekly in a group setting. A similar method has also been adopted by some schools in the YHP communities, implemented by the partner organisations.

"Drop boxes are available at every HIC to allow us to ask questions anonymously. These have sometimes proved dramatically helpful. The most common questions are to do with involuntary ejaculation and hair-growth from boys and about menstruation from girls"
– female HIC member, Dwarka

Key Findings: Awareness of Programmatic Health Issues

* Most of the respondents amongst both youth and Peer Educators gave **spontaneous responses (76.6%) on their awareness about Malaria and Dengue**, which is a significant increase from Base-line to End-line.

* The **enhanced knowledge on TB** is also translated in the behaviour of the community and the youth in particular regarding the curability of the disease. 84% of the youth were of the opinion that TB is curable.

* During focus group discussions with young people many reported that they are **more confident to discuss issues around reproductive tract infections and sexually transmitted infections (RTIs/STIs)** with other young people and health care providers. Interviews with **parents revealed there were still a lot of misconceptions** around these health issues within this group. **Healthcare providers shared their changes in attitude for the better** around RTIs and STIs

because of training from a number of quarters including the YHP and government run programmes.

* The **reporting of sexual violence has increased by 3%** among youth and Peer Educators from Mid-line to End-line survey. 6% of youth respondents and 6.6% of Peer Educators have reported facing incidences of sexual violence. The episodes of sexual violence remained high among youth in the bracket 15-19 (51.6%) with a **10% increase** of what was reported during Mid-line study. This could also be attributed to increase in awareness and openness among girls as the YHP carried out many activities around Gender Based Violence (GBV), such as meetings with Delhi Police and street plays on GBV.

* In the Mid-line 70.9% of the youth respondents have reported **awareness of HIV/AIDS and in the End-line it has increased to 85%**. This shows that there has been significant increase in awareness on HIV / AIDS. This has also been attributed to government programmes which have had a particular focus on this area.

* **51.5 % of the youth responded that they can never say no to peer pressure if asked to consume alcohol. But for smoking the influence of peer pressure was reduced with only 35.6 % stating they will never say no to peer pressure.** It can be concluded that alcohol consumption has greater impact of peer pressure and more focus is needed to work at the family as well as individual level to address this.

* On the knowledge of the **harmful effect of substance use 83.3% of the respondents have reported that substance use leads to addiction**, and addiction finally leads to anti-social behaviour.

* End-line survey presented the similar trend as the Mid-line survey where a **majority (91.2%) of youth respondents comfortably shared their issues with their friends followed by siblings and parents.**

"Earlier I was too hesitant to tell someone that I was suffering from a STI problem, and did not know what to do. Now YHP has empowered me with the information on what should be done and where one should go for such treatment."

- HIC member, Dwarka

Key Findings: Adolescent Friendly Health Services

* **Medical officers at the health centres attribute the increased uptake** of Adolescent Friendly Health Services **(AFHS)** to the YHP. Among young people there was a **16% increase in awareness of Adolescent Friendly Health Services** and **20% increase amongst Peer Educators.**

* Interviews with key stakeholder working in health facilities revealed that the training of health care workers delivered by the YHP has helped them address the needs of young people in a better way.

"Earlier we didn't have adequate infrastructure to deliver AFHS in the area, but YHP has really helped in making the health facility adolescent friendly. We now hold a dedicated clinic on Tuesdays and Saturdays between 12-2pm for adolescents"

- Medical Officer Holambi Kalan

Recommendations

1. The knowledge of Peer Educators has tangibly increased and they are using this knowledge to reach out to more and more young people in schools and communities. However, post YHP phase out from 5 communities, the team should make concerted efforts to link all the Peer Educators with government programme (RKSK).

2. The HICs should be handed over to the partner NGOs, community stakeholders group and young people so that they can be sustainably run.

3. Efforts should also be made to lobby for opening more HICs so that more adolescents can access preventive and promotive health services.

4. Peer leaders and their group members should be linked to Nehru Yuva Kendra Sangathan (NYKS), Ministry of Youth Affairs & Sports to mobilize support to run adolescent friendly health spaces like (HICs) in the communities.

5. The partner NGOs should advocate more strongly with stakeholders on the issue of provisioning Adolescent Friendly Health services, ensuring water and sanitation facilities in all communities etc.

6. The focus needs to be given on the issue of RTIs and STIs and sexuality education as this is still a taboo area in schools and within many families.

7. Policy analysis of the law related to substances alcohol, tobacco and drugs and their link with Non Communicable Diseases (NCDs) should be conducted in YHP phase 3.

8. There should be more school based interventions for sustainability and to generate more evidence of impact of programme interventions.

9. The police with support from community stakeholders group, Peer Educators and NGOs can work closely to address the problem of Gender Based Violence. Besides, NGOs, schools and other stakeholders should work together to address the structural causes of GBV

10. Engagement and support from parents is critical to the success of the YHP both in their support of their children becoming Peer Educators and also to facilitate openness and discussion with young people. Parents also need accurate information on health issues and services for their children.

Legacy & Sustainability

For more detail of plans for Phase 3 refer to YHP India Phase 3 proposal written by Plan UK and Plan India.

Through the programme delivery between 2010 and 2015, the YHP India has generated significant learning about effectively addressing health issues affecting young people, and this learning has been integrated into the programme design for the next phase of implementation 2015-2020 (Phase 3). Some of the key learnings and the influence on the design of activities are outlined below.

Youth engagement:

A key strategy in the success of the 2010-2015 programme (phase 1 and 2) has been utilising young people themselves as active agents of change in their own communities. Young people are not passive recipients benefiting from the project, but the programme itself depends on them to deliver outreach activities. This helps ensure the project remains relevant to the needs and interests of young people, is able to make use of the insider knowledge and creativity of the adolescents, and helps build the status of young people as positive contributing members of their communities. The project will continue to use proven successful methodologies of peer education and HICs.

In phase 1 and 2, peer education was adapted for two different age ranges. In the new programme peer education training will be developed for 3 specific age ranges to more closely meet the needs of the different groups. The content will also be adapted both in terms of thematic focus (to focus on the 5 targeted risk behaviours) but also to incorporate specific sessions on facilitation skills and child protection awareness that were identified as gaps in previous training.

Recognising that working with young people on risk behaviours such as poor eating habits may identify cases where individuals may require support beyond what the YHP is able to directly provide, the programme will map out external partners with expertise in these areas who young people can be referred to for additional support. In this phase the YHP will also equip the HICs with health libraries and sports equipment to encourage young people to voluntarily further their learning and put it into practice beyond the guided HIC sessions. Building on the success of the previous participatory research into substance use, additional research will be carried out using this methodology to explore issues of poor eating habits, inactive lifestyles and risky sexual behaviours in the targeted communities.

Community engagement:

Securing the wider support of the communities has been a critical success factor in addressing some of the wider influencing factors that affect adolescent health. The YHP will again establish Community Stakeholder Groups (CSGs) to act as a focal point for identifying and addressing community concerns and advocating with local government. However based on learning from the previous phase, the YHP will establish a smaller number of CSGs (2-3 per areas instead of 10+ per area) and focus on building their capacity so that they are stronger and more sustainable entities by the end of the programme. The YHP will also support the CSGs on specific identified new actions including targeting the vendors of

unhealthy products (food, tobacco and alcohol) near schools. The YHP will continue to run campaign days linked to wider national and international celebration days, but in the new programme these will be more closely aligned to the 5 risk behaviours.

In previous years the YHP has run anaemia prevention camps. To reinforce messages around healthy eating and ensure parents also recognise the importance of diet, the YHP will instead begin to run nutrition camps which will include visits from a professional nutritionist who will hold sessions for parents on how to plan and prepare attractive, nutritious and good value meals for their families. To address issues of gender-based violence, instead of just holding many small meetings with communities, the YHP will organise bi-annual large scale meetings on the topic of community safety which will include the participation of key duty bearers including senior police and government representatives.

Service provision:

In addition to creating the demand from young people and communities, the YHP will also continue to focus on improving the supply of Youth Friendly Health Services. Score-carding was a new approach piloted in the last year of the YHP and has proven an effective way of bringing service providers and service users together to jointly identify and address gaps in service provision, and so this methodology will be replicated in clinics in the new areas.

Exchange visits to model health clinics from health care providers will be expanded to also include teachers and adolescents to improve wider understanding of youth friendly services in practice. Previously the YHP had tried to support local clinics to improve their Management Information Systems but this proved very hard to achieve and so this activity will be dropped from the new phase. The YHP will continue to provide sensitisations to health workers and teachers on the YHP thematic areas, but in the new programme this will be preceded by a mapping of existing knowledge and skills among the participants to ensure the trainings are adapted to their specific needs and gaps.

Wider policy environment:

During phase 1 and 2 of the programme the YHP started to carry out advocacy work and this led to some positive achievements such as the establishment of specific adolescent clinic times at local health facilities within the targeted areas. During the next phase, the YHP will build upon this to seek opportunities to influence policies and advocate for policy implementation both within the targeted areas and beyond. To achieve this, the YHP will conduct an external mapping of the relevant policy and legal environment and key stakeholders to identify where to focus advocacy efforts and where there is potential for collaboration with other organisations working on risk behaviours.

Other new activities include developing a set of policy briefs and training a cohort of young people to become youth advocates that can represent the YHP advocacy goals at relevant forums; this methodology is based upon learning from the Brazil YHP. As in previous years the YHP India will continue to use launch and celebration events as a way to increase the profile and wider awareness of the programme.

Conclusions

The five years of the YHP India has ensured high quality implementation, importantly by ensuring youth engagement in activities at all stages during the programme cycle. It is evident that the core strategies of Peer Education, establishing and running Health Information Centres, using young people to develop IEC materials and mass awareness campaigns has meant the YHP has been embedded into the project communities.

Each strategy has worked well in increasing the programme reach and bringing about change in knowledge, attitude and practice indicators. The successful initiative to advocate for Adolescent Friendly Health Services (AFHS) at the primary health centres has helped in increasing the uptake of health services by young people.

The HICs have developed as a relevant community based resource centre and referral point for young people.

The YHP India has also been a catalyst to improve the government's flagship programme on adolescent health (RKSK) by leveraging support from the YHP Peer Educators. This will also strengthen the sustainability and legacy of the YHP India.

The overall goal of the YHP India 2010-2015 was to make a meaningful difference to the health and well-being of marginalised and disadvantaged adolescent boys and girls by helping them to make informed choices to protect their health, now and in the future. Under this the 2 specific goals in the programme design were to

1. **Increase in number of adolescent boys and girls accessing health centre services**
2. **Increase in number of Peer Educators who report increased self-efficacy as a result of participation in the YHP**

The analysis conducted during the Final Evaluation evidences increases in both these areas and the legacy and programme design of a third phase will ensure this is continued and expanded in the future, continuing to contribute to the improved health and well-being of girls and boys between 10-24 years in Delhi by ensuring that young people in the North West District of Delhi are practising fewer risk behaviours due to an increased capacity to make informed choices about their health, in the context of improved health services, an enabling support system and policy environment.

"The HIC is the best thing to happen in our block as we can access various services in a secure atmosphere without any cost."

-Chandan, from Madanpur