EXECUTIVE SUMMARY

mHealth for adolescents in India, South Africa, and the Philippines



TASKS

1. Carry out research on how adolescents use mobile phones in South Africa, India and The Philippines.

2. Carry out research on 2-3 existing mobile health programs for adolescents which have been successful in South Africa, India and The Philippines.

This report details important findings about the potential of a mobile health programme tackling sexual/menstrual health among adolescents in India, South Africa and The Philippines. The Philippines was our country of choice in part due to the expertise and contacts of one of our group members, but also because of the potential it presents, since the lifting of the ban on contraceptives in 2017. Research was conducted using three methods: secondary literature review, interviews and a survey.

KEY FINDINGS

Adolescents (10 - 19 years) have sexual, menstrual and reproductive issues in all countries.

There are information gaps in all three countries, and an expressed need from adolescents. For example, in a survey done in South Africa, 84% of adolescents expressed willingness to receive health messages on mobile phones.

There is good mobile phone penetration in all countries. For example, 78% of the adolescents in The Philippines own a cellular phone and 58.9% have access to the internet. Most adolescents use smartphones in all countries.

However, ownership and access among target group differs from country to country. In-country access also differs along gender lines area of residence (rural or urban). For example, in India, Uttar Pradesh State (where every 16th adolescent in the world lives -

Population Council, 2017), 57% of the boys aged 15 -19 years own phones, compared to 9% of the same age group, yet 75% of the girls could access the phone from a family member. The adolescents in urban areas have slightly more access to phones and internet.

There is increasing use of social media sites such as Facebook and WhatsApp.

While it was difficult to get concrete information on how adolescents pay for their mobile phone credit, some studies and results from the survey indicate that a majority ask for money from their parents while others used savings. Prepaid is the preferred plan.

Successful mobile health programmes: m-ASSIST, Cell Life, Star for Life, Kilkari, RKSK and Ligtas Buntis Safe Motherhood System are some of the programmes that were identified for using mobile phones to deliver health messages. None of them is exploring all the issues among the particular age group that Content Consultants wants to reach. Many of these programmes have scanty information on monitoring and evaluation, such as number of people reached, and lessons learnt. Impact evaluation has not yet been done, or the data is not publicly available.

MAIN BARRIERS

1. Cultural myths and taboos surrounding menstruation

2. Access to phones and internet - most adolescents do not own phones but access them from family members (gatekeepers) who might be hesitant to mhealth

3. Gender dynamics

4. Infrastructure

RECOMMENDATIONS

1. Involve Gatekeepers: This includes parents, teachers and the community at large. This is to enable young people have a network supporting their sexual/menstrual awareness, and to tackle stigma that may cause a barrier to accessing resources otherwise.

2. Partnerships: Link up to other organisations and government agencies on the ground. This will be an entry point to access; young people, distribution networks, and easier means of conducting monitoring and evaluation. Several interviewees we spoke to were very interested in an mHealth project being implemented and want to be kept up to date with our research as many considered it to have great potential in these contexts.

3. Interactive/Two-Way Messaging: Although this invokes a cost, our research showed that the delicacy and personal nature of these health issues demanded a more personal and interactive form of communication. Participants and practitioners alike reported a need for young people to be able to ask questions, be directed to services and be targeted with certain issues.

4. Consider the Rural/Urban Divide: Our research found that in most rural settlements, there was technological capacity to support an mHealth programme. Though you indicated that you would want to focus more on urban and suburban areas, the lack of access we have identified to health information in rural areas is a pertinent issue that cannot be overlooked especially since there is increasing mobile phones access.

CONCLUSION

With the above recommendations in mind, we suggest that you conduct a pilot programme in each of the countries to better assess the barriers and opportunities of providing such a service in the different contexts. Due to unavailability of data from currently operating organisations and the limited time and budget we had on this project, we recommend that more research within these countries be done. Otherwise, there is potential in using mobile phones to address information gaps in the areas of sexual and menstrual health among adolescents in South Africa, India and The Philippines.