Intervention to delay age at first conception and avert the adverse consequences of early motherhood among Married Adolescent Girls

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Why married adolescent girls (MAGs)?

Meera - married at age 13
Had one miscarriage & one fetal death before she reached 17 years
There are millions of girls like Meera in India
Why married adolescent girls (MAGs)?

Prevalence of Early Marriage (< 18 years) among Women 20-24 yrs (NFHS 2006)

- India: 44.5%
- Maharashtra: 38.8%
- Urban Maharashtra: 28.9%
- Rural Maharashtra: 48.9%
Prevalence of Early Marriage in Maharashtra

Proportion of Girls Getting Married Before Age 18 Years in Maharashtra

- Marathwada: 60
- Sindhudurg: 4
- Maharashtra: 35
Consequences of early marriage & conception

Relative Risk

- Maternal mortality
- Neonatal mortality
- Spontaneous abortion
- Reproductive tract infections
- Anaemia

Girl less than 20 years

Woman more than 20 years
Model - 5 Discrete Interventions

1. Monthly Assessment of needs & Micro-planning
2. Need Specific IPC & Counseling
3. Influencing Social Norms
4. Active Linkage of beneficiaries with Health Providers
5. CBM by Village Health Committees

AGRT
1. Monthly assessment by ASHAs of:

- Health service needs
- Information needs
- Morbidity
2. Need Specific IPC & Counseling

ASHAs provide information & counseling specific to the needs of MAGs & their families.
3. Create Space for Young Married Couples

Influencing Social Norms
4. ASHA actively links adolescent girls to ANMs & PHCs
5. VHSCs – Community based monitoring

VHSC Reviews Needs Assessed by ASHA and Service Delivery by ANM
Capacity building of ASHAs & ANMs for skills related to 5 interventions

Over-arching Input
Impact indicators – Age at first birth, contraceptive use

- Median age at first birth: 15.8, 17, 18
- Mean interval between marriage & first conception in months: 6.6, 10.3, 10.7
- MAGs using contraceptives: 10.9, 23.2, 30.4

2003 Baseline - 60,000  |  2006 Mid-line - 60,000  |  2009 Endline - 30,000
Impact indicators – Maternal & Neonatal health

- MAGs utilized standard antenatal care
  - 2003 Baseline: 32.4%
  - 2006 Mid-line: 70.3%
  - 2009 Endline: 80.4%

- Postnatal morbidity
  - 2003 Baseline: 23.3%
  - 2006 Mid-line: 9.2%
  - 2009 Endline: 8.5%

- Low birth weight babies
  - 2003 Baseline: 35.8%
  - 2006 Mid-line: 25.3%
  - 2009 Endline: 21%
Impact indicators – Reproductive Health

Prevalence of RTIs/STIs

- 2003 Baseline: 60,000
- 2006 Mid-line: 60,000
- 2009 Endline: 30,000

MAGs with RTIs/STIs sought treatment

- 2003 Baseline: 25
- 2006 Mid-line: 25
- 2009 Endline: 82
### Impact indicators – Intervention Vs Control sites – Evaluation - 2006

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Intervention area - 2006</th>
<th>Control area 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at first birth</td>
<td>17.0</td>
<td>15.9</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>23.2%</td>
<td>07.0%</td>
</tr>
<tr>
<td>Minimum standard antenatal care</td>
<td>70.3%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Low birth weight babies</td>
<td>25.3%</td>
<td>40.0%</td>
</tr>
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</tbody>
</table>
USP – readiness for scalability

Pre tested Systems & Protocols for:
- Surveillance of Health Needs
- Monthly Micro-planning
- IPC and counseling material
- Community based monitoring
- Culturally appropriate scale to measure empowerment
  - Rural Adolescent Girls (Principal Component Analysis)

Demonstrated capacity for
- Managing partnerships
- Training & capacity building
- Management information systems
- Monitoring & evaluation
Scalability

• Model scaled up in 5 districts through NGOs – External evaluation – Outcomes same as pilot

• Mainstreamed with RCH in public sector in one block – 196 villages 250,000 population – Significant change in SRH Status of MAGs

Inputs at scaling up

1. Skills development
2. Systems design
3. Protocols, tools and materials
4. Monitoring and Evaluation
Future Plans

Integrated Adolescent SRH Programme:

In addition to SRH of married adolescent girls we have included:

1: Empowerment of unmarried adolescent girls through LSE
2: Gender sensitization of young men to reduce domestic violence and gender inequitable behaviors
Future Plans

• Implement the integrated programme in 30,000 rural population

• Adapt the integrated programme for adolescents in 30,000 urban slum population

• Scale up Integrated model to cover 10,000 adolescent girls and young men
Organization structure / Organogram

Board of Trustees – AGRT

Director- IHMP

Additional Director Rural / Additional Director Urban / Administrator Finance Manager / Coordinator Training

Staff Intervention & Research SRH Rural / Staff Intervention & Research SRH Urban / Staff BCC design & development / Administrative and Finance staff / Training Staff

Supervisors

Front Line Health Providers (ANMs & MPWs)

Community based workers / volunteers (ASHAs)
Leadership

• Dr. A. Dyalchand  M.B.B.S, CMC, Vellore, MPH, JHU, Baltimore *(Health Management & Epidemiology)*

• Ms. Manisha Khale - M.Sc. Nutrition;  M.Sc. Community Health, LSHTM London *(Sexual and Reproductive Health)*

• Mr. Gopal Kulkarni - M.Sc, Statistics, Training in Epidemiology, JHU Baltimore *(MIS, M&E & Research)*

• Dr. Nandita kapadia Kundu - MPH, PhD,  JHU Baltimore *(Behavioural Sciences)*

• Mr Koshy Abraham - Diploma in Hospital Administration (D.H.A), CMC, Vellore;  Post Graduate Diploma in Business Management - *(Financial Management)*
Thank You

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