

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)?



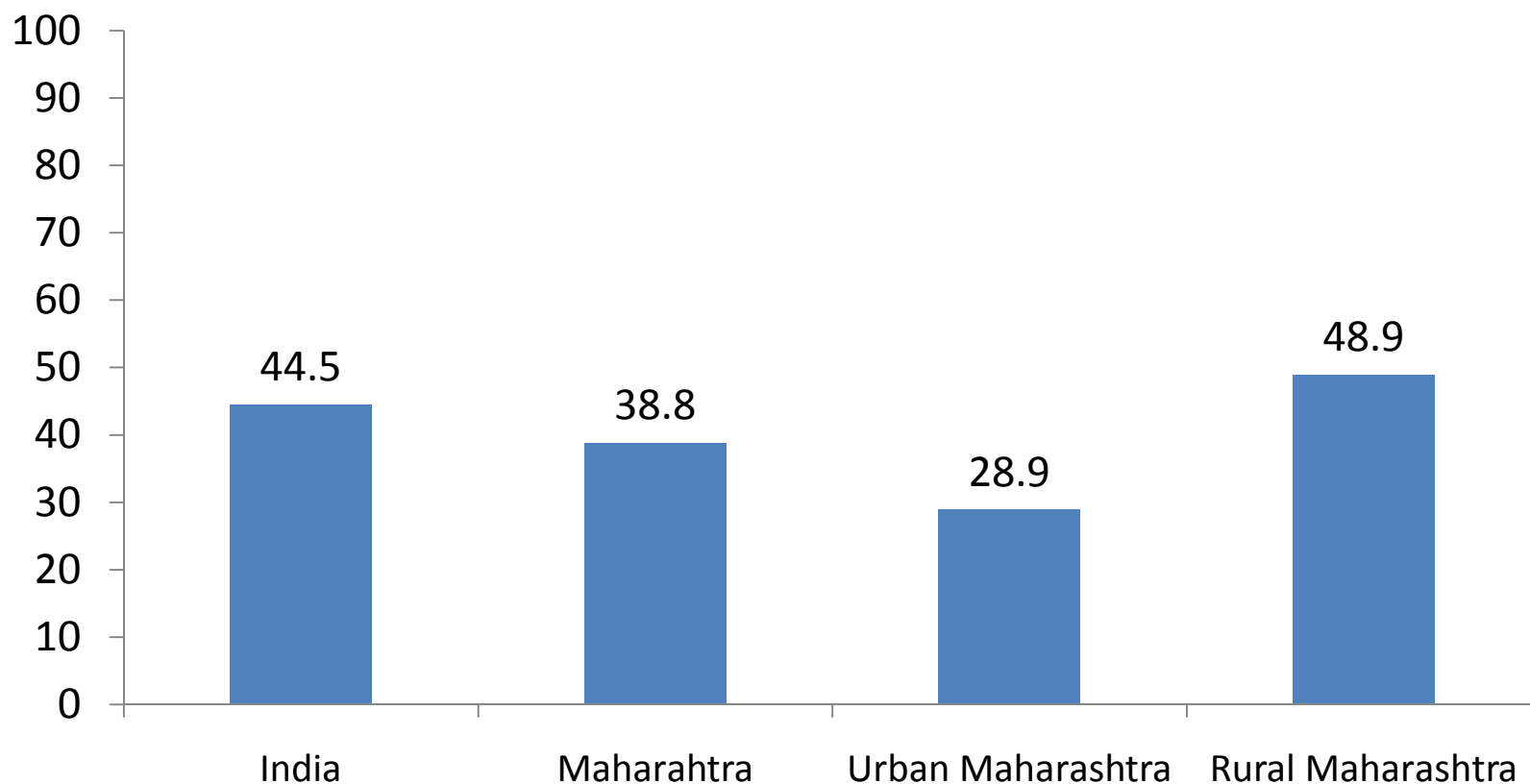
Meera - married at age 13

Had one miscarriage & one fetal death before she reached 17 years

There are millions of girls like Meera in India

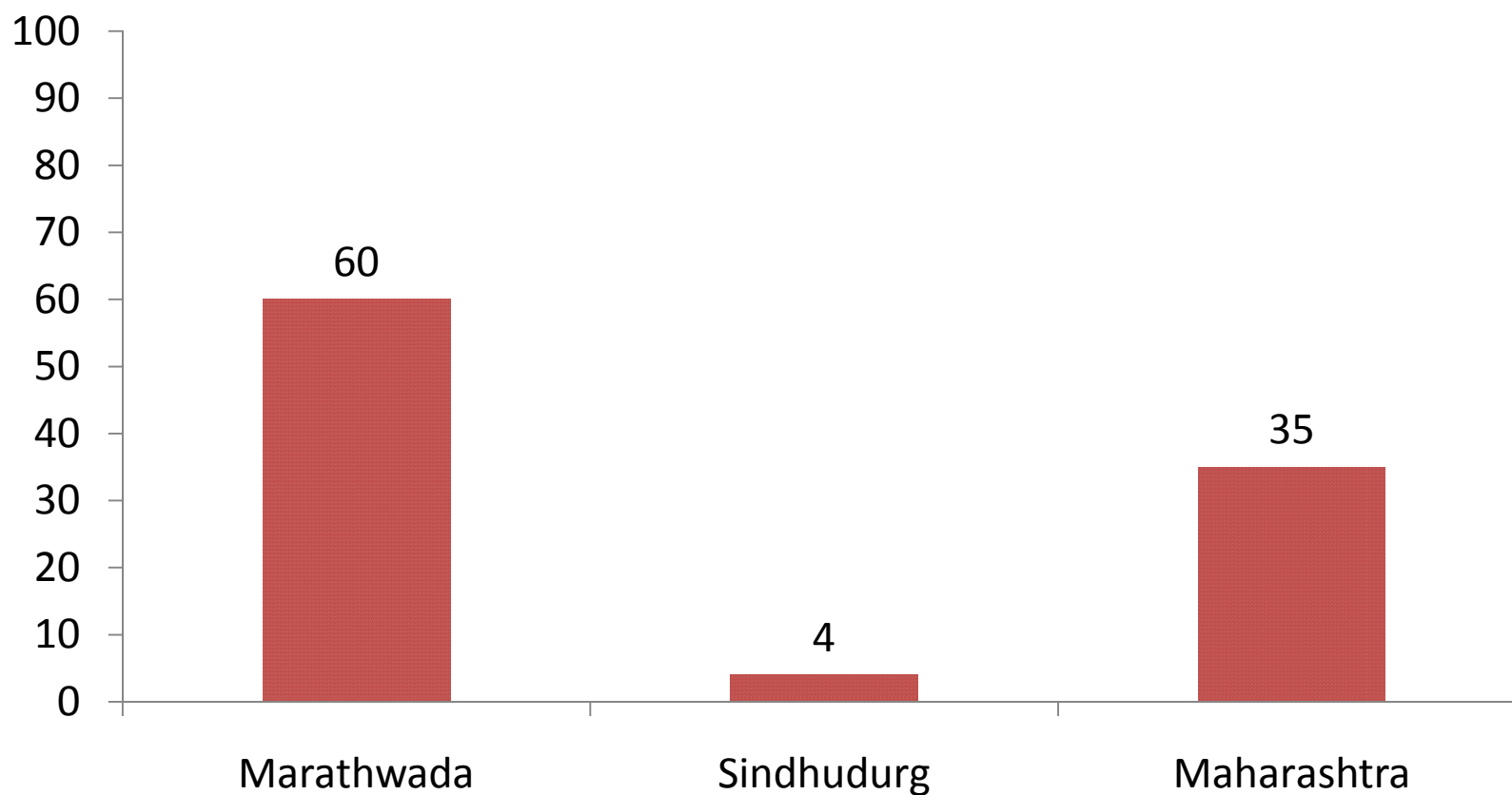
Why married adolescent girls (MAGs)?

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

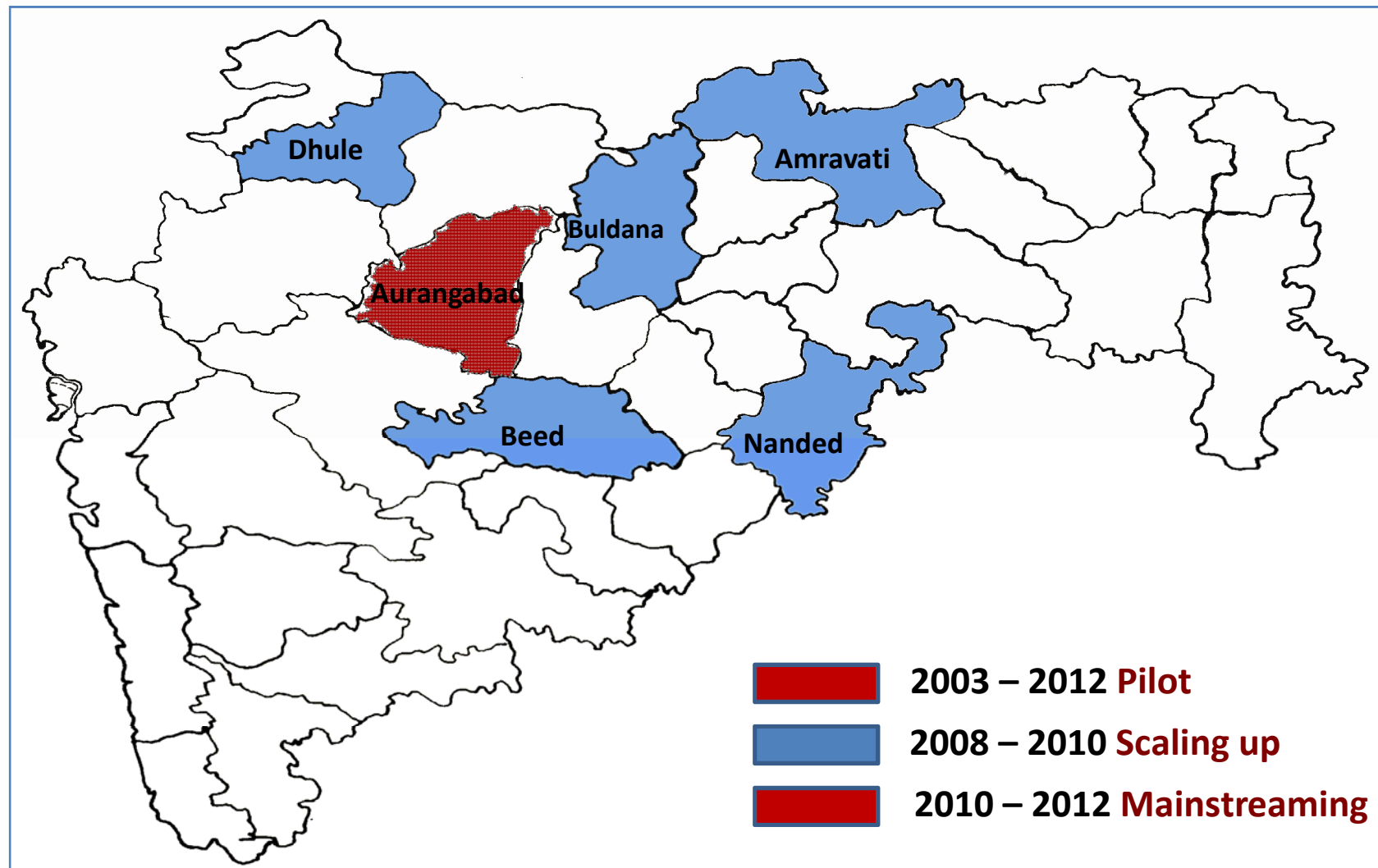


Prevalence of Early Marriage in Maharashtra

Proportion of Girls Getting Married Before
Age 18 Years in Maharashtra



Intervention sites – Maharashtra



Consequences of early marriage & conception

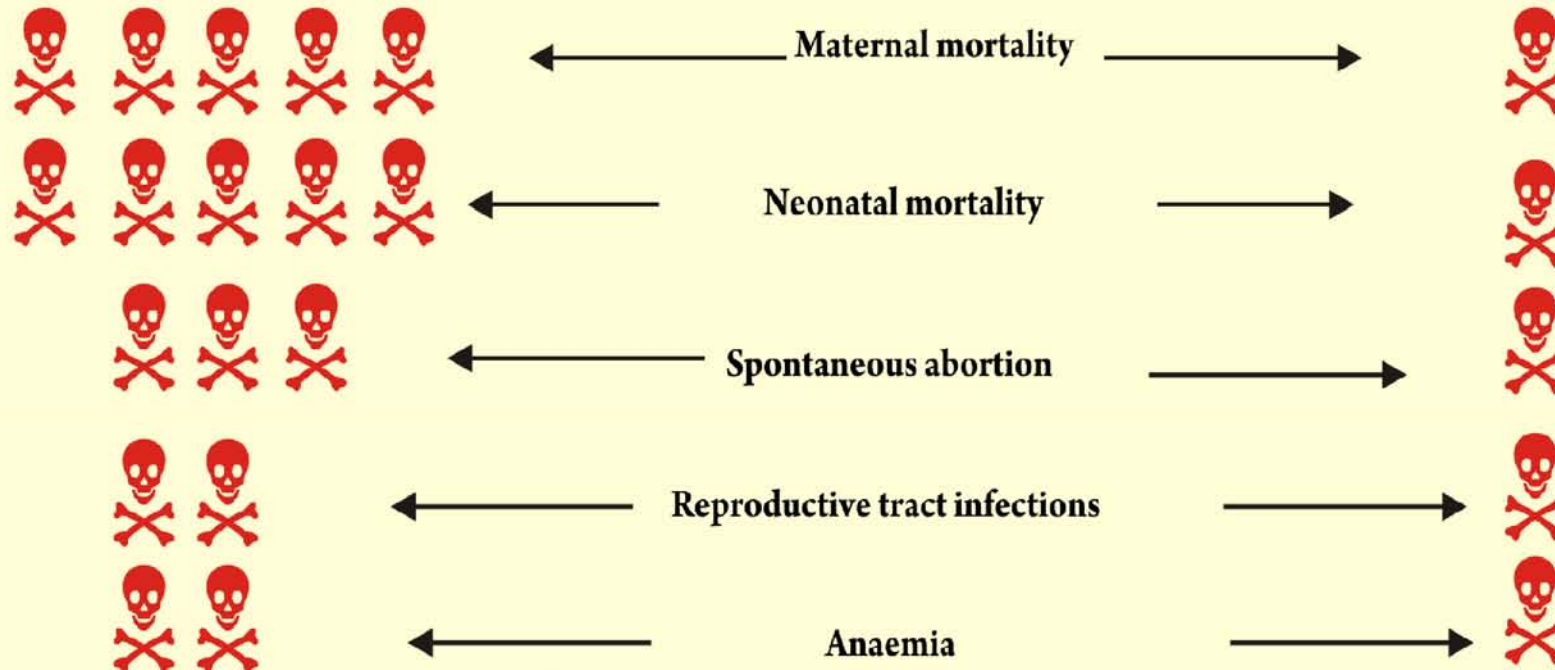


Girl less than 20 years

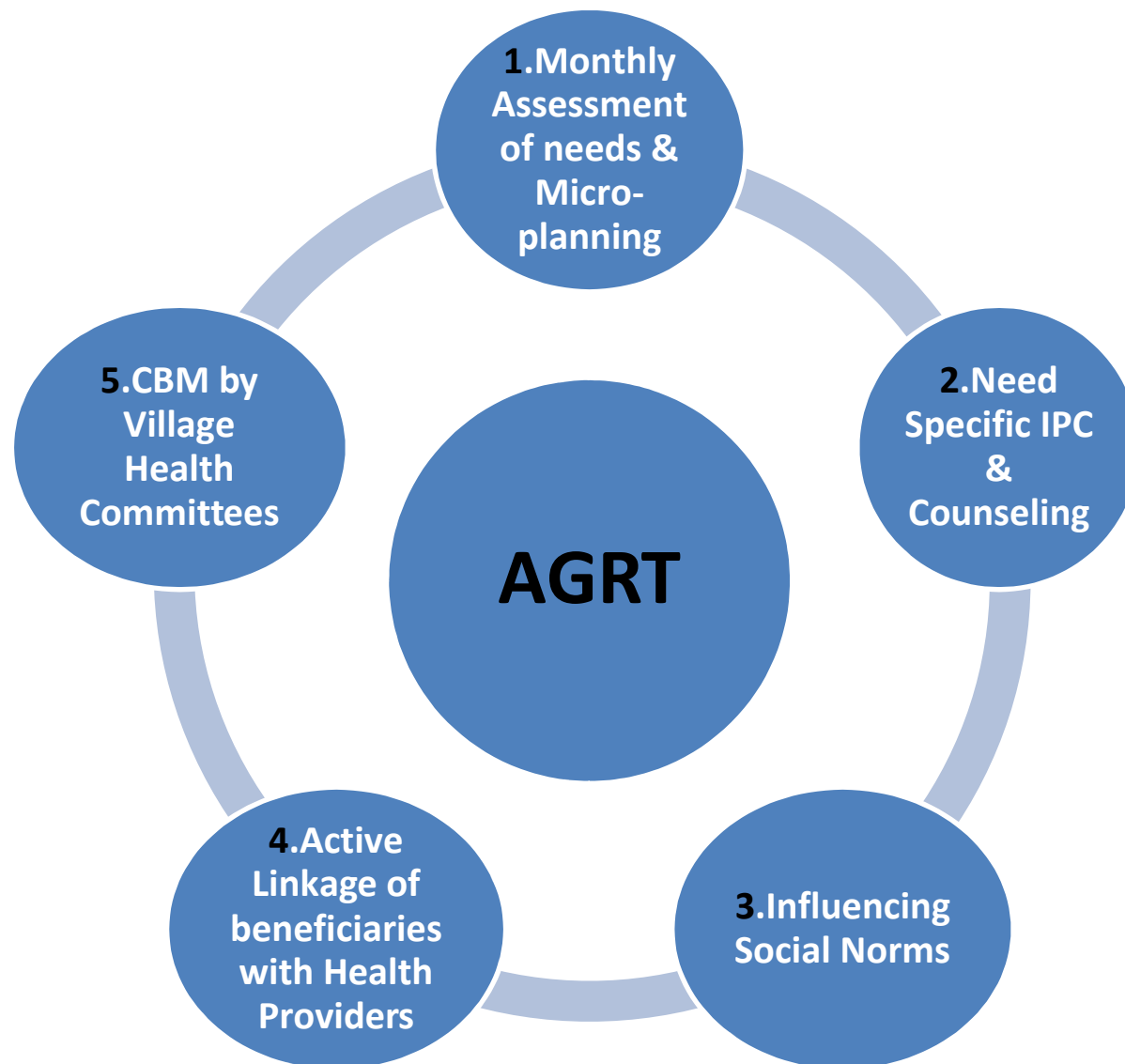


Woman more than 20 years

Relative Risk



Model - 5 Discrete Interventions



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



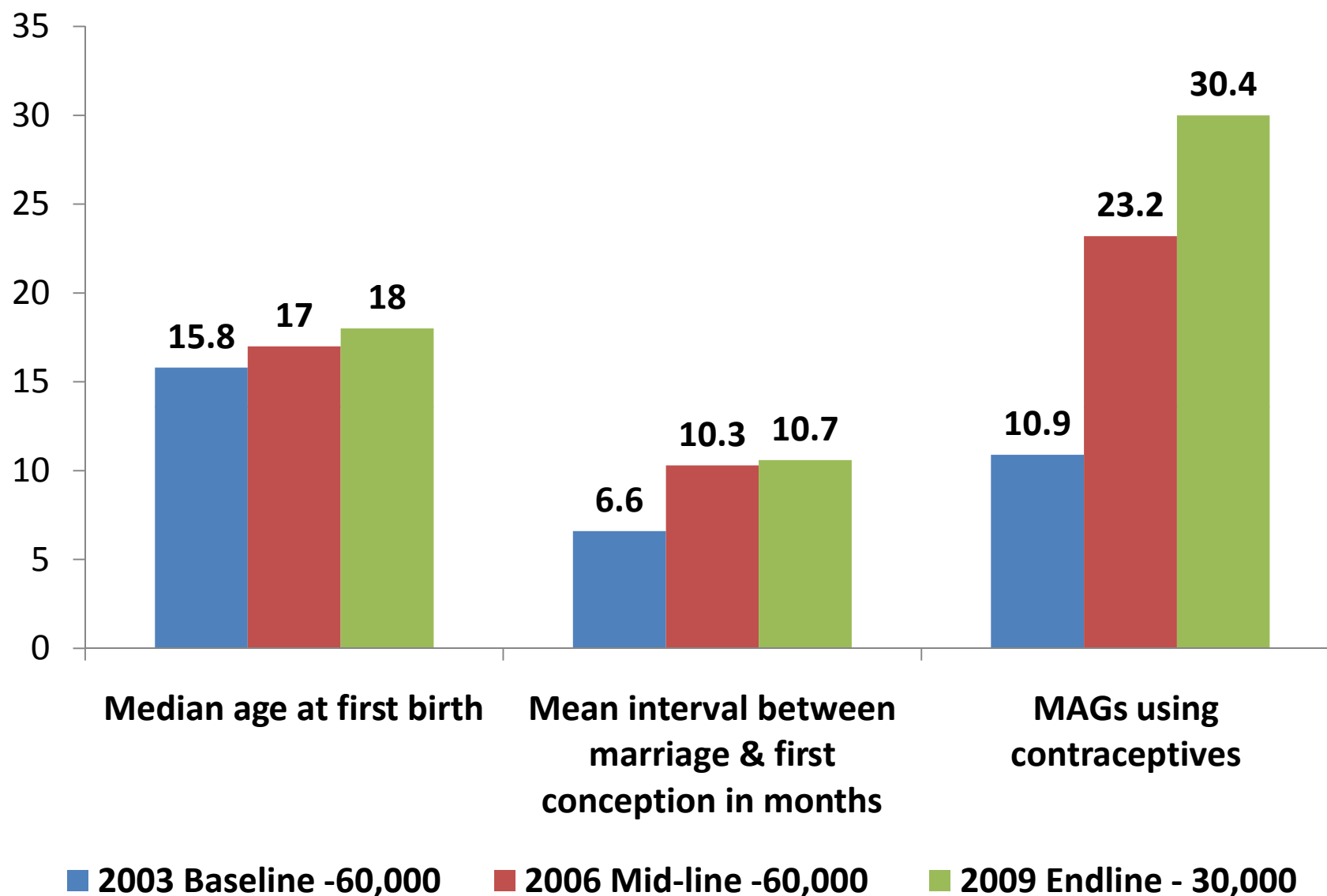
VHSC Reviews Needs Assessed by ASHA and Service Delivery by ANM

Capacity building of ASHAs & ANMs for skills related to 5 interventions

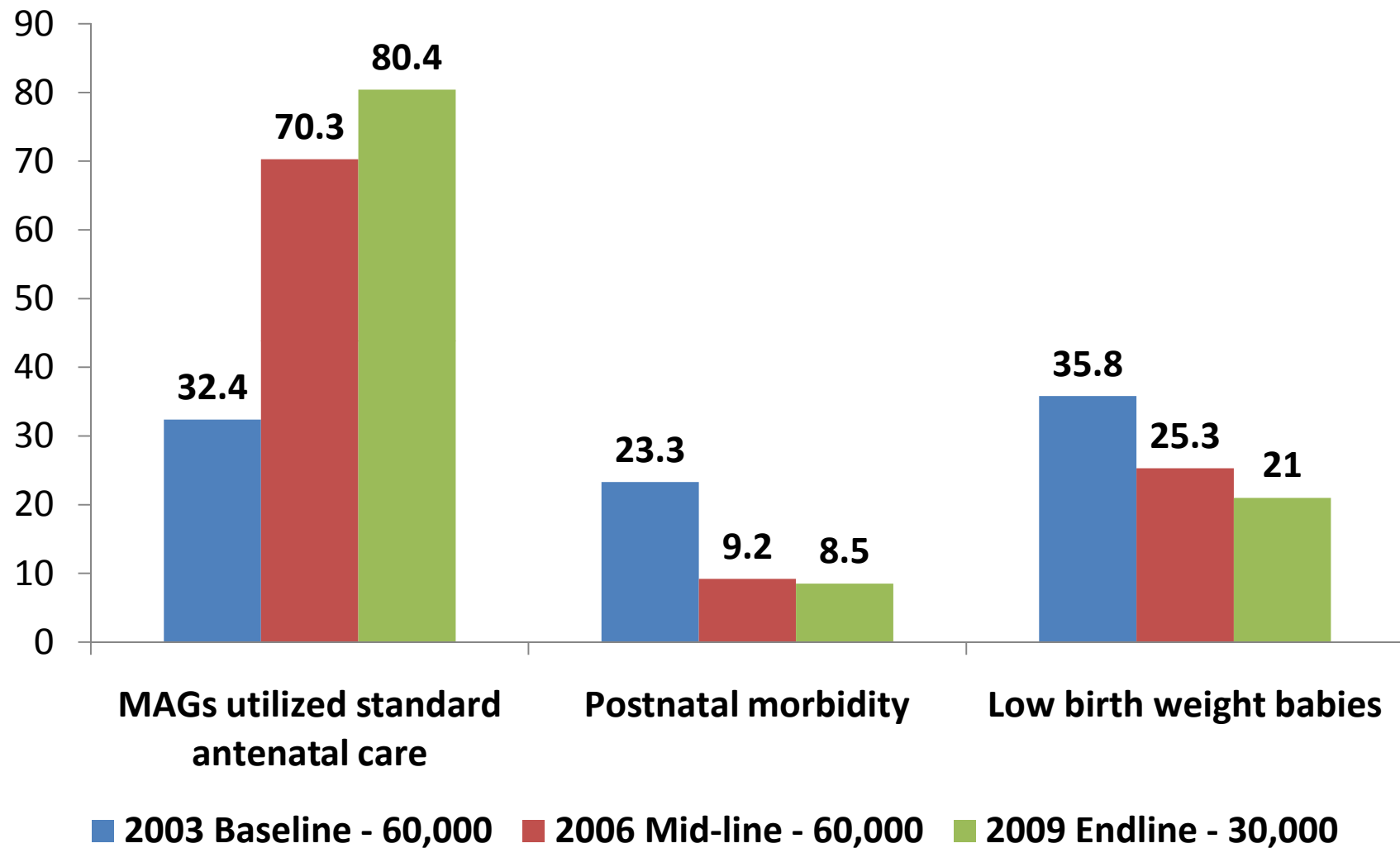


Over-arching Input

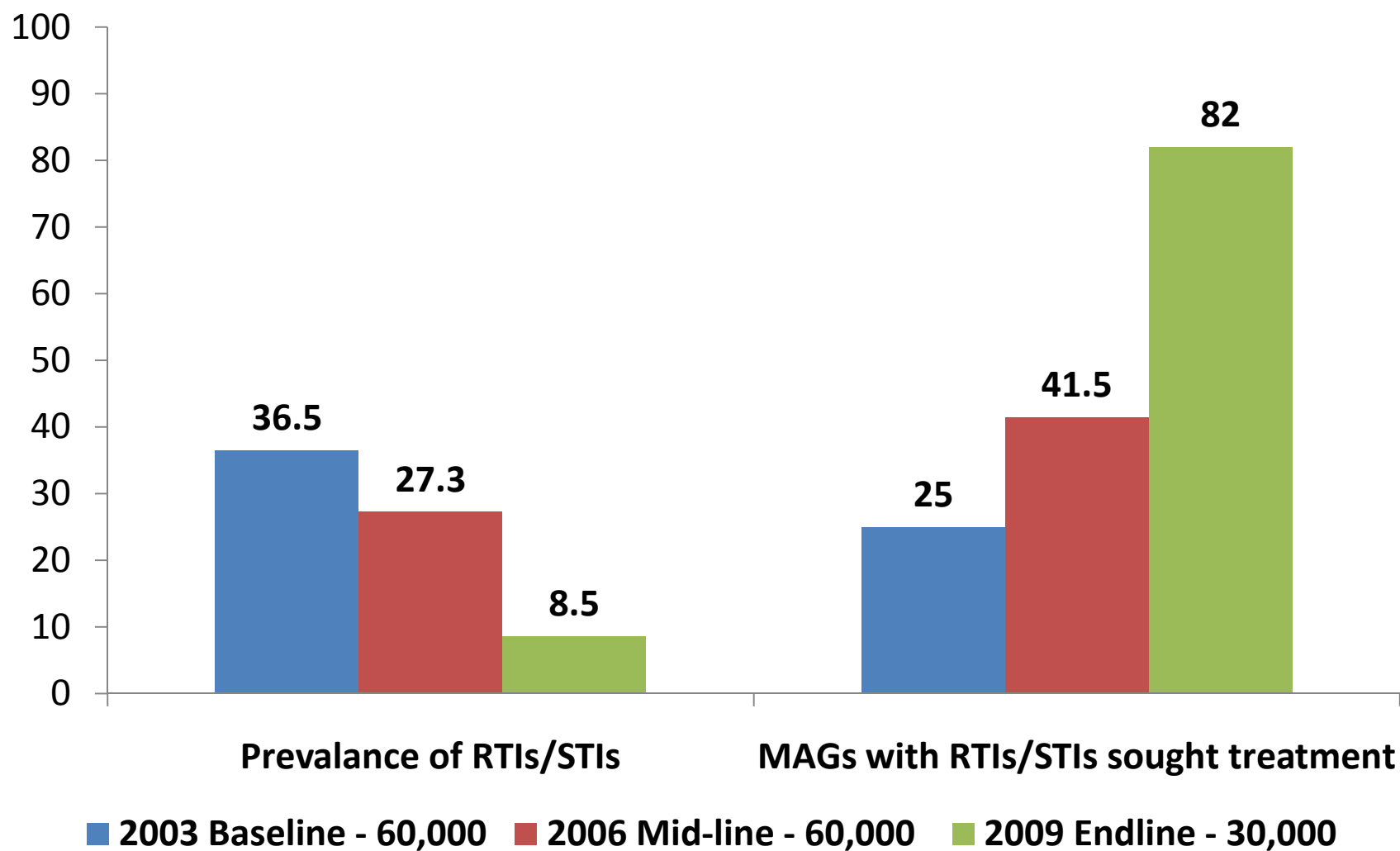
Impact indicators – Age at first birth, contraceptive use



Impact indicators – Maternal & Neonatal health



Impact indicators – Reproductive Health



Impact indicators – Intervention Vs Control sites – Evaluation - 2006

Indicator	Intervention area - 2006	Control area 2006
Age at first birth	17.0	15.9
Contraceptive use	23.2%	07.0%
Minimum standard antenatal care	70.3%	58.0%
Low birth weight babies	25.3%	40.0%
Prevalence of RTI/STIs	27.3%	36.0%

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



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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