



Delaying Age of Marriage and Reducing Anaemia Among Adolescent Girls in Jharkhand

October 2012

Background

Adolescents in India, and more specifically in Jharkhand, face several health risks. Although the minimum legal age at marriage for girls in India is 18 years, 63.2 percent of women aged 20-24 in Jharkhand were married by age 18, which is higher than the national average (47.5%)¹. Early marriage is associated with early pregnancy, high fertility, close spacing of births, unwanted pregnancies, and pregnancy termination (especially relative to women married at 18 years or older). Girls who become pregnant before the age of 16 face four times the risk of maternal death and the death rate for their newborns is 50 percent higher² compared to women who become pregnant in their twenties.

Adolescents in Jharkhand also face under-nutrition and anaemia, with nearly half of girls in the age group of 15-19 years mildly anaemic, 18 percent moderately anaemic and 0.8 percent severely anaemic³. Anaemia can lead to a variety of complications, including fatigue and stress on bodily organs, and anaemia during pregnancy can increase the risk of pre-term or low birth weight infants.

Given this situation, the Government of Jharkhand (GOJH) requested the USAID-funded Vistaar Project to provide technical assistance to help improve adolescent health in the state. The Project, led by IntraHealth International, worked to support GOJH in taking knowledge to practice for improved adolescent health. The Project established a collaborative working relationship with a number of GOJH departments working in adolescent health, the Department of Health and Family Welfare (DHFV), Department of Women and Child Development (DWCD) and Department of Education (DOE). Beginning in 2007, the Project and GOJH officials conducted an evidence review, an equity and gender needs assessment, a review of relevant government schemes and programmes, and a training needs assessment of frontline workers and supervisors to inform the selection of strategies. Based on these findings and recommendations, the Project's technical

assistance to GOJH focused on two key adolescent health issues: early age of marriage and adolescent anaemia.

Box 1: Key Findings of the Needs Assessments and Baseline Survey (2008-2009)

- Parents and community elders were the primary decision-makers with respect to a girl's marriage.
- There was no single national or state government policy or plan in place to specifically address the issue of delaying age of marriage.
- GOJH did not have a Behaviour Change Communication (BCC) strategy or information education communication (IEC) materials on delaying marriage.
- Frontline workers had limited knowledge and capacity, including counselling skills, related to the adolescent health issues of delaying age of marriage and anaemia.
- A key obstacle to reducing adolescent anaemia was the lack of a clear plan and programme for distribution and monitoring of iron and folic acid (IFA) supplements to adolescents, either through schools, or for out-of-school adolescents.
- There were very few adolescent-friendly health services in the state.

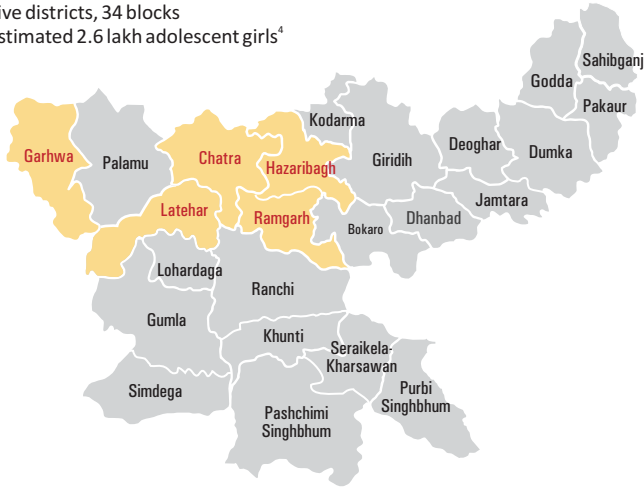
Scale of Technical Assistance

The Project supported GOJH in strengthening their adolescent health programmes at scale, and provided technical assistance across five districts in Jharkhand: Chatra, Garhwa, Hazaribagh, Latehar and Ramgarh. This area included almost six million people (Figure 1).

Figure 1: Delaying Age of Marriage Technical Assistance Districts in Jharkhand

Jharkhand

Five districts, 34 blocks
Estimated 2.6 lakh adolescent girls⁴



The Project also contracted with a local non-governmental organisation (NGO), Child in Need Institute (CINI) to support the interventions, especially at the district level. CINI identified three local Jharkhand-based NGOs to assist the intervention: *Prayas* for Hazaribagh district, *Krishi Gram Vikas Kendra* (KGVK) for Ramgarh district, and *Vikas Bharti* for Chatra, Garhwa and Latehar districts.

Technical Assistance Approaches

The Project collaborated with state and district officials to identify specific interventions, including a number of innovative approaches and tools for improving adolescent health in selected districts.

Raising awareness and building the capacity of district and block functionaries

The Project team started by reviewing and raising awareness of DHFW, DWCD and DOE district-level officials about the seriousness of anaemia and early marriage in Jharkhand, and reviewing the proven approaches to address them. The team worked closely with these officials to improve the response to these adolescent health problems. The Project and GOJH officials focused on improving planning and collaboration between departments at the district and block level. The efforts also included building the capacity of teachers and gender coordinators in two major government programmes, *Kasturba Gandhi Balika Vidyalyaya* (KGBV)⁵ and the National Programme for Education of Girls at Elementary Level (NPEGEL)⁶ as well as building the capacity of *Anganwadi* workers (AWWs), the

frontline workers within DWCD’s Integrated Child Development Services (ICDS) programme. The capacity-building efforts are described in the following sub-sections.

Developing Life Skills Education curriculum: In order to reach in-school adolescents, the Project team developed a Life Skills Education (LSE) curriculum (building on existing materials to the extent possible) to provide adolescent girls with information to help them make healthy life choices. The curriculum is designed for teachers to lead one session each month at school. The curriculum provides information to adolescent girls on a number of topics, including the legal age of marriage, the health consequences of early marriages and pregnancy, contraception, adolescent anaemia and related gender issues. It also provides adolescents with the opportunity to discuss these issues and seek needed support or information. The Project supported the training of 207 teachers (in five districts) from KGBV and NPEGEL.

Interpersonal communication and counseling skills: In order to reach out-of-school adolescents, as well as parents of adolescents, the team built the capacity of AWWs and their supervisors in interpersonal communication (IPC). This training included information about the needs and concerns of adolescents and their health problems, the negative effects of early marriage, the benefits of delayed marriage for the mother and child, iron deficiency, anaemia and its prevention, dietary practices, iron folic acid (IFA) supplementation, and contraception. Using a cascade approach, the Project team and government officials trained 39 ICDS Lady Supervisors as Master Trainers, and they, in turn, trained 976 AWWs during regular monthly meetings.

The frontline workers used home visits, group meetings during Village Health and Nutrition Days (VHNDs), and adolescent health weeks (*Kishori Swasthya Saptah* [KSS]) to counsel mothers and adolescent girls.

Addressing gender and equity issues: The Project included a focus on addressing gender and equity issues in both the LSE and IPC training programmes, since this is essential to improving girls’ and women’s health. Both the LSE training for teachers and the IPC training for the ICDS Lady Supervisors and AWWs addressed gender and equity issues underlying age at marriage and anaemia in adolescent girls. The curricula addressed gender-based roles that translate into inequities in intra-household food distribution, access to education and opportunities, the right to self-determination and the resulting impact on quality of life and health. These issues were integrated into the communications messages developed with the Project’s support for KSS.

Involving community leaders to delay age of marriage

The Project team worked with the District Collector and Registrars in Chatra, Garhwa and Ramgarh districts on an innovative pilot to motivate and mobilise religious leaders to prevent early marriages. The team held orientation workshops with 96 Hindu and Muslim religious leaders about the minimum legal age of marriage, the negative effects of early marriage, the benefits of delayed marriage, legal aspects of the Child Marriage Prohibition Act, and the systems and procedures for legal registration of marriages. District officials including those from DHFW, DWCD, Department of Social Welfare and Department of Police, and other health and development partners participated in these meetings.

Designing a health communication strategy and materials

The Project and GOJH officials prepared a health communication strategy for adolescent health for the state, which was submitted for approval to DHFW in September 2009. However, the strategy was not approved, partly due to investigations into financial misappropriations in the state government at that time, and a resulting reluctance to obligate funds for any new activities. Nonetheless, the Project assisted GOJH in other efforts by developing messages and communications material for short-term media campaigns during the adolescent health weeks (KSS), which included messages on adolescent anaemia, and the importance of IFA supplementation, delaying marriage and delaying first childbirth.

Expanding adolescent-friendly health services

In the districts of Hazaribagh and Ramgarh, the Project staff worked with Civil Surgeons from DHFW to organise capacity-building sessions with Medical Officers (MOs) to increase their knowledge and awareness of the needs and concerns of adolescents, the health benefits of delaying marriage, the prevalence of adolescent anaemia and ways to treat and prevent it, and how to provide adolescent-friendly counselling and services, as outlined in the Government of India's adolescent-friendly health services (AFHS) and adolescent reproductive and sexual health (ARSH) guidelines. The major intervention efforts are described in the following sub-sections.

Establishing adolescent-friendly clinics: The Project and district officials established adolescent-friendly health clinics and health weeks. As a pilot effort, seven⁷ community health centres (CHCs) started adolescent-friendly clinics in Hazaribagh and Ramgarh. They hold weekly clinics for adolescents for two

hours, where service providers trained in IPC and counselling skills are present, along with an MO and Auxiliary Nurse Midwife (ANM). The Project team also assisted DHFW to develop medical protocols for ANMs and MOs for the treatment of mild, moderate, and severe anaemia, and oriented them on the relevant Government of India adolescent health guidelines.

IFA supplementation in schools: The Project team provided information to raise awareness of anaemia and the importance of IFA supplementation with district education officials including Block Education Officers, Child Development Project Officers, school principals and teachers. The Project team and DOE officials worked to improve IFA supplementation for Classes 6 to 10 in KGBV schools, building their capacity to lead an IFA supplementation programme and secure the needed supplies, following a streamlined process between DHFW and DOE. The school-based LSE trainings through both KGBV and NPEGEL complemented this effort, by providing nutrition counselling and promoting IFA supplementation. By June 2010, almost all KGBV schools in the five districts were implementing an IFA supplementation programme. However, this programme suffered from severe disruptions in IFA supplies from late 2010 through 2011.

Facilitating adolescent health weeks (Kishori Swasthya Saptah): Based in part on the Project's advocacy, DHFW initiated a week-long campaign to raise awareness about anaemia, early age of marriage and other adolescent health issues. The Project and other development partners supported GOJH in the implementation of KSS, which was first held statewide in August 2010 and was attended by over a million adolescent girls, across the state. The slogan for the week was



Swasth Kishori, Khushhaal Parivaar (Healthy Adolescent Girl, Happy Family).

The KSS activities included haemoglobin testing for anaemia, analysis of body mass index, IFA distribution, de-worming, anti-malarial medicine distribution, health counselling and referrals. GOJH also sponsored various communication efforts on adolescent health and nutrition, which addressed the harmful effects of early marriage and early pregnancy. The Project supported the development of billboards, banners and posters for KSS. Following the positive response to the first KSS, the GOJH organised it again in 2011 and planned to hold it every year.

Strengthening Village Health and Nutrition Days to reach out-of-school adolescent girls: VHND is an important NRHM intervention offering basic maternal and child health information, counselling and services, at a fixed time, place and day each month. Nutrition counselling and IFA supplementation are also priorities at VHNDs, which also provide IFA supplementation and take home rations for out-of-school adolescent girls.

The Project team worked to build the capacity of AWWs to increase the distribution and consumption of IFA in the community, following the protocol of once-a-week IFA supplementation for 52 weeks per year, as well as twice a year de-worming for adolescent girls. The team developed a report card for AWWs to record the actual distribution and consumption of IFA and de-worming tablets by adolescent girls. In addition, through IPC and other training, as well as through monthly meetings, the Project and district teams encouraged frontline workers involved in VHNDs to use this platform to provide counselling services on the issues of delaying age at marriage and reducing nutritional anaemia, targeting, primarily, out-of-school adolescent girls and their mothers.

Evaluation

To evaluate the efforts, the Project team contracted external agencies to conduct a baseline survey in November-December 2008 and an endline survey in March-April 2012. The agencies conducted the baseline survey in five districts, Chatra, Garhwa, Hazaribagh, Latehar and Ramgarh. Due to various factors, such as political unrest in Naxalite areas, disruption in IFA supplies and frequent transfers of officials, the level of technical assistance was higher in Hazaribagh and Ramgarh, and the Project conducted the endline survey only in Hazaribagh and Ramgarh. These surveys targeted adolescent girls aged 15-19 years, their mothers, and community leaders such as village leaders (*pradhans*), local government (*panchayat*) or ward members, teachers, AWWs or *Sahiyyas*.

Key Findings

Overall, the survey data indicate that the interventions have contributed to increased knowledge and changed perceptions of adolescent girls, their mothers and community leaders regarding the correct age at marriage for girls, early pregnancy, and contraception. In addition, there have been changes in knowledge and attitudes of adolescent girls, their mothers and community leaders about nutritional anaemia and changes in the consumption of iron-rich food and iron supplements by adolescent girls. Other highlights from the endline survey are presented below. In this document, asterisks (*) are used to highlight the statistically significant difference at 5 percent level of significance, between baseline and endline data.

Lower incidence of early marriage in endline sample

At baseline, 17 percent of adolescent girl respondents were married, but at endline, the proportion of adolescent girl respondents who were married was only six percent. The mean age of adolescent girls interviewed was 16.6 years, both at baseline and endline. Given that the same randomised sampling techniques were employed in baseline and endline surveys, this suggests that changes are taking place in terms of age of marriage in the target population. At endline, 78 percent of the girls interviewed were currently attending school compared to 71 percent at baseline and eight percent of girls were engaged in earning compared to 12 percent at baseline (Table 1).

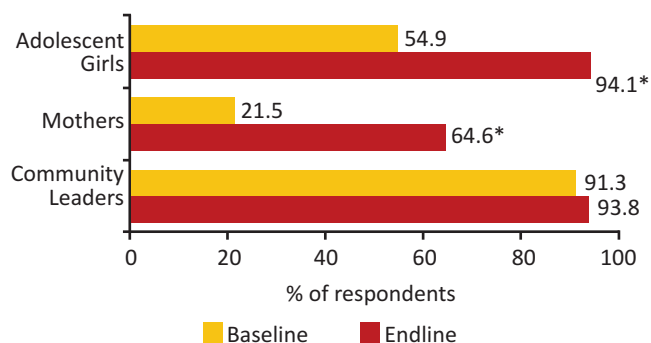
Table 1: Profile of adolescent girls

Background characteristics	% Adolescent girls	
	Baseline	Endline
Marital status		
Never married	83.2	93.6
Ever married	17.2	6.4
Educational status		
Never attended school	9.2	2.9
Currently in school	70.5	77.8
Out of school	20.3	19.3
Occupational status		
Engaged in earning	12.1	7.5
Not engaged in earning	87.9	92.5
Number of adolescent girls	1,899	1,000

Improved knowledge and attitude about age of marriage

At endline, adolescent girls, their mothers and community leaders were much more knowledgeable about the legal age of marriage for girls (Figure 2). Respondents across all the categories reported increased awareness of the negative aspects of early marriage such as negative psychological effects (challenges in terms of dealing with family matters and child care, and mental stress), increased incidence of domestic violence and denial of education. Moreover, various benefits of delaying girls' age at marriage were well-known across respondent categories and were higher at endline than at baseline. Significantly, a higher proportion of girls cited that one benefit of delayed marriage was the opportunity to complete their education (20% at baseline to 72% at endline).

Figure 2: Correct knowledge of legal age of marriage



The three most common reasons for marrying girls before the legal age of marriage, as stated by adolescent girls, their mothers, and community leaders were:

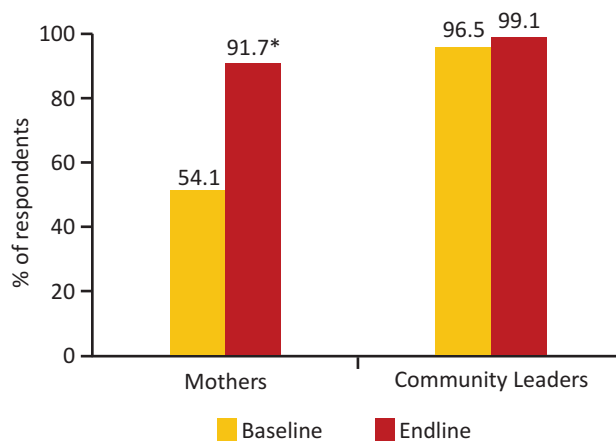
- concern for the girl's protection, as she becomes an adolescent
- the belief that finding a suitable groom is easier if the bride is younger
- less dowry is required for younger brides

Other reasons cited were custom or tradition, a cultural preference for younger brides, and less opportunities for marriage as the girls grow older. The reasons cited were the same at both baseline and endline, although a significantly higher percentage of adolescent girls, mothers, and community leaders mentioned these at endline, perhaps indicating increased attention to this issue, and increased awareness about the causes of early marriage. The most frequently cited actions which can delay marriage were keeping girls in school and helping them find meaningful work.

Improved attitude towards girls' involvement in marriage decisions

Almost all mothers and community leaders interviewed at endline considered it important to ask for the girl's consent about the age at which she would like to get married and the timing of her marriage. This represents a significant change in mothers' attitudes compared to baseline (Figure 3).

Figure 3: Intent to take the consent of the girl for marriage



Improved knowledge about and attitude toward family planning

Knowledge and attitude toward family planning showed significant improvements. More adolescent girls believed that married couples should use contraception to delay pregnancy, 85 percent at endline compared to 65 percent at baseline. Forty-one percent of adolescent girls felt that the ideal gap between a couple getting married and having their first child should be more than two years at endline compared to only 17 percent who held that view at baseline (Table 2). This shows the potential for healthier timing and spacing of births.

Table 2: Perception of adolescent girls on healthy timing and spacing of births

Perceptions	% Adolescent girls	
	Baseline	Endline
Young couple should use any contraceptive method to delay pregnancy after marriage	64.5	84.7*
Ideal gap between marriage and first child's birth:		
0-1 years	17.4	15.6
1-2 years	55.2	40.5*
2+ years	16.9	40.8*
Number of adolescent girls	1,899	1,000

Endline findings indicate that adolescent girls' knowledge of contraceptive methods like oral contraceptive pills, condoms, Copper T and injectables had significantly increased at endline (Table 3). Almost all (98%) adolescent girls interviewed at endline expressed interest in receiving more information on contraception, a significant increase from baseline (84%).

Table 3: Awareness of adolescent girls about family planning methods

Family planning methods	% Adolescent girls	
	Baseline	Endline
Oral contraceptive pills	94.7	98.4*
Copper T	11.7	33.3*
Condom	44.0	68.0*
Injectable contraceptives	8.9	21.9*
Implant/Foam tablets	0.3	0.7
Periodic abstinence/ safe period	2.6	1.4
Number of adolescent girls aware of family planning methods	918	859

Improved nutrition knowledge and practices

Adolescent girls, their mothers, and community leaders were more aware of the causes, signs and symptoms of nutritional anaemia, than at baseline. At endline, a significantly higher percentage of adolescents and mothers mentioned weakness, dizziness, fatigue, pallor, swelling of the hands, feet and face, visual disturbances, and pregnancy complications as important signs of anaemia. When adolescent girls and mothers were asked about what causes nutritional anaemia in adolescents, more than 90 percent mentioned low intake of food and lack of green leafy vegetables in the diet as reasons.

At baseline, only 10-12 percent of the adolescents or their mothers could identify girls at risk of anaemia. However, during endline, close to 90 percent of them were aware that girls who have low intake of food and who lack nutritious food in their diet were prone to suffering from anaemia. A significantly higher proportion of adolescent girls and mothers were also aware that girls with menstrual problems, those that married early, and those who had early and frequent pregnancies were more likely to be anaemic than at baseline.

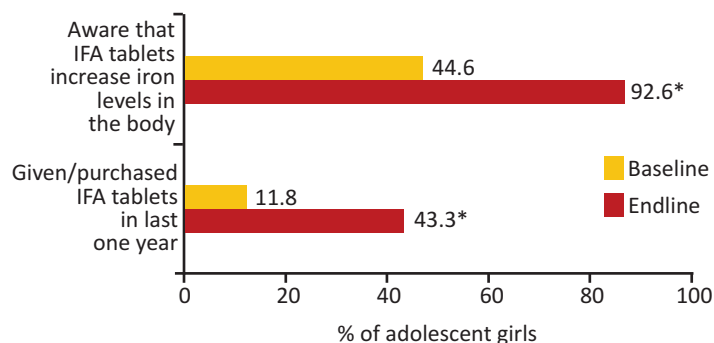
When adolescent girls and mothers were asked about the measures that can be taken to prevent anaemia, more than 95 percent were aware that eating green leafy vegetables would help. In addition, around half of adolescents and one-third of mothers interviewed knew that IFA supplementation could prevent or reduce anaemia, an increase from baseline (Table 4).

Table 4: Awareness of preventive measures against anaemia

Preventive measures against anaemia	% Adolescent girls		% Mothers	
	Baseline	Endline	Baseline	Endline
Eating green leafy vegetables	23.2	96.8*	17.4	94.8*
Eating more fruits	19.9	93.6*	14.5	88.9*
Taking IFA tablets	2.8	52.5*	0.7	33.2*
Cooking in iron pots	0.7	4.5*	0.7	1.4
De-worming	0	0.4*	0.1	0.9*
Number of respondents	1,899	1,000	904	1,000

More respondents knew the important nutritional sources of vitamin C (which aids in iron absorption), such as tomatoes and other citrus fruits, *amla* (gooseberry), radish, coriander and fenugreek leaves, as compared to those surveyed at baseline, when very few could identify vitamin C-rich foods. They also knew that IFA supplementation could prevent or reduce anaemia. Access to IFA increased at endline, despite a long period of supply shortages (Figure 4).

Figure 4: Awareness and access to IFA tablets by adolescent girls



Adolescent girls received, on average, 47.3 tablets, and reported that they consumed most of the tablets (46.3 tablets). As per public health protocol, the recommendation is that adolescent girls consume one IFA tablet weekly (52 tablets in a year) (Table 5).

Table 5: Consumption of IFA tablets by adolescent girls over the last one year

Status of IFA receipt and consumption	Baseline	Endline
Average number of IFA tablets given/purchased	10.8	47.3
Average number of IFA tablets consumed	6.1	46.3
Number of adolescent girls	112	433

There was an improvement in the practice of de-worming among adolescent girls. Twenty-two percent of the adolescent respondents reported taking tablets to treat intestinal worms at endline, compared to three percent at baseline. On an average, these adolescent girls had taken anthelmintics twice within the one year prior to the endline survey. As per public health protocol, it is recommended that de-worming should be carried out once every six months.

The correlation of increased IFA consumption and de-worming with improved awareness of symptoms and causes of anaemia and knowledge of how to prevent it demonstrates the success of nutrition education and counselling efforts.

Increased awareness and utilisation of Village Health and Nutrition Days

VHNDs were taking place on a regular basis, with communities finding them beneficial. During the baseline survey, less than a tenth of mothers and about half the community leaders interviewed were aware of VHNDs. At endline, however, a significantly higher percentage of mothers (98%) and community leaders (94%) were aware of VHNDs. Over 90 percent also reported that VHNDs were held regularly in their area and that they found them to be beneficial. During endline, nearly all the adolescent girls surveyed were aware of VHNDs, although only about half of them could correctly state their date or frequency. About two-thirds of the girls stated that they themselves, or a family member, had received services from a VHND. The services received most frequently by adolescent girls were supplementary nutrition, IFA supplementation and counselling.

Improved knowledge and practices of religious leaders

Religious leaders who participated in the orientation workshops agreed that they had a responsibility not to conduct underage marriages. For example, priests of the Rajrappa Temple in Ramgarh district published an advertisement in the local newspapers and placed a billboard at the entrance to the temple, stating that the temple would not conduct underage marriages. The priests at this temple began asking for proof of age and residence when families approached them to conduct marriages, which seems to have served as a deterrent to those violating the legal age of marriage. At the Tootijharna Temple in Ramgarh district, the priests started verifying the age of the bride and bridegroom as well as asking for passport-size photographs of the couple for their records, before solemnising marriages in the temple. When the priests refused to perform underage marriages, word spread in the community which helped discourage parents from planning to marry their adolescent children. At the Banjari Temple in Ramgarh district,

sensitisation efforts led to a significant reduction in underage marriages as reported by the priests. Muslim religious leaders (*Maulvis*) in this district also started speaking out against early marriages during the Friday prayers in mosques.

Lessons Learned and Recommendations

As a result of the collaborative interventions, more adolescent health activities are taking place, adolescent health is a significant part of ongoing GOJH plans (e.g., adolescent health weeks, LSE), inter-departmental collaboration has increased, as have the skills of frontline workers, teachers and other government officials. In addition, the data shows that mothers and community leaders have increased knowledge in the key areas of early marriage and anaemia, and healthy practices are more prevalent. Awareness of the benefits of delaying marriage, anaemia prevention measures and family planning methods has significantly increased among adolescents. Most importantly, practices such as the consumption of IFA and de-worming tablets have significantly increased.

The major lessons and recommendations from the collaborative efforts of the Project and GOJH to strengthen adolescent health are:

- The evidence review process helped in building consensus among experts, GOJH and other stakeholders, as well as in selecting the interventions.
- It is important to include evidence-based interventions, with a matching budget, in the state and district annual plans (e.g., DHFW Programme Implementation Plans) to ensure that adolescent health activities are integrated, implemented at scale, and sustainable.
- Focusing on health related issues is a good entry point for efforts to delay age of marriage, since many stakeholders, such as parents and religious leaders, are concerned about adolescent health and well-being, and seem to be receptive to these messages. Health services and programmes such as VHNDs also offer an appropriate platform for providing information and counselling about early marriage.
- Multiple outreach mechanisms can be utilised to reach more adolescents. Events such as adolescent health weeks and counselling from AWWs can reach out-of-school adolescent girls and their parents, and contribute to improved knowledge and attitudes.
- Religious leaders can play a significant role in reducing early marriage. The positive response of religious leaders

Vision

IntraHealth International believes in a world where all people have the best possible opportunity for health and well-being. We aspire to achieve this vision by being a global champion for health workers.

Mission

IntraHealth empowers health workers to better serve communities in need around the world. We foster local solutions to health care challenges by improving health worker performance, strengthening health systems, harnessing technology, and leveraging partnerships.

For more information, visit www.intrahealth.org

The Purpose of the Vistaar Project

To assist the Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status

to the effort to delay early marriages was very encouraging and holds great promise to positively influence social norms related to age at marriage.

- The DOE's LSE programme can lead to important improvements in adolescent health and empowerment. Training teachers is a critical component, since the LSE curriculum is more effective when shared in a participatory manner that presents, discusses and analyses real life problems and situations (rather than just presented through lectures). High quality training is also critical because many of the trainee teachers were uninformed or uncomfortable with subjects like contraception and gender-based inequities.
- Age of marriage is a complex and cross-sectoral issue. However, there is limited experience and few mechanisms for coordination between the relevant government departments such as DHFW, DWCD and DOE.
- Although enthusiasm for the IFA supplementation programme through schools and VHNDs was high, ensuring regular and adequate IFA supplies in the state was a major challenge.
- A capacity-building package linked with supportive supervision for AWWs can lead to improved counselling and increased knowledge in the target groups.
- There are many process innovations that can help the state system address adolescent health issues at large scale, such as improving existing departmental and inter-departmental meetings, integrating adolescent health training into existing training or monthly health worker meetings, and improving the quality of training so that it is more participatory and skill-based. These are low cost and efficient approaches, which build on existing platforms.

In conclusion, the Project and GOJH's collaboration demonstrated several approaches that can positively influence adolescent health. These interventions, such as coordination among the departments of Health, Education and ICDS, building the capacity of teachers and frontline workers, and involving religious leaders to reach adolescent girls and parents, are relatively simple and cost-efficient, and should be scaled up in the state.

IntraHealth International, Inc. is the lead agency for the Vistaar Project. For more information on the Vistaar Project, see: www.intrahealth.org/vistaar

Technical assistance partners:



¹International Institute for Population Sciences (IIPS) and Macro International, 2007. National Family Health Survey (NFHS-3), 2005-06: India: Volume I. Mumbai: IIPS

²National Family Health Survey (NFHS-3), 2005-06

³Adolescent Pregnancy: A Culturally Complex Issue, Volume 87, Number 6, June 2009, 405-484.

⁴As per C14 Table of Census of India, 2001, 4.5 percent of total population was adolescent girls aged 15-19. Also, the total population of five Vistaar TA districts was 57,73,528. Therefore, it was estimated that these five districts have 2.6 lakh adolescent girls.

⁵The Government of India introduced the KGBV scheme in August 2004 to provide educational opportunities to girls belonging to scheduled castes, scheduled tribes, other backward classes, minority communities and families below the poverty line in blocks with low educational levels. The scheme supports one residential school per block with boarding facilities.

⁶NPEGEL is the Government of India's programme designed to provide education for the 'hardest to reach' girls, especially those not in school. The programme has outreach initiatives and supports specialised teachers and gender coordinators who provide basic education as well as vocational training.

⁷The CHCs are in Bishnugarh, Barhi, Chouparan, Churchu, Gola, Ichak, and Patratu

Disclaimer: This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of IntraHealth International and do not necessarily reflect the views of USAID or the United States Government.