Improving adolescent girls’ health and nutrition, reducing early marriage and delaying the first pregnancy could help break the intergenerational cycle of under nutrition and improve birth outcomes. Investing in adolescent health could also help stem the rising tide of non-communicable diseases. India is home to 243 million adolescents, around 20% of the country’s population. In Jharkhand, eastern India, around one third of women aged 20-24 are married before the age of 18 and early childbearing is high. Adolescents also face a high burden of under nutrition: 44% of girls aged 15-18 have a low BMI and 67% are anaemic. India’s main adolescent health programme is the Rashtriya Kishor Swasthya Karyakram (RKSK), which sits within the Government’s Reproductive Maternal New-born Child and Adolescent (RMNCH+A) strategy. RKSK’s community interventions mainly involve peer educators conducting participatory group meetings, but there is currently no evidence-based model for carrying out such meetings and no evaluation to understand the impact.

Participatory Learning and Action (PLA) with women’s groups has the evidence to improve maternal and new-born health. PLA has also been taken up by the National Health Resource Centre for scale up within the Accredited Social Health Activists (ASHA) programme. PLA could be used with adolescent groups, but there is currently no tested model available for the same and no evaluation of its impact on adolescent health.

The “JIAH” (Jharkhand Initiative for Adolescent Health) study is a 3-year formative research project. The aim of this formative study is to develop and test a scalable peer-led integrated community intervention using principles of Participatory Learning and Action (PLA) to improve the health, nutrition and well-being of adolescents, aged 10-19 years in Khuntani block of West Singhbhum district, in Jharkhand. Along with the intervention, other activities include evidence reviews of global literature on peer-led community-based adolescent health interventions and local literature on Indian adolescent health programmes (especially in Jharkhand), qualitative research with adolescent girls and boys, their caregivers, teachers and health workers; a baseline survey of adolescent girls’ health, design and piloting of an appropriate intervention and synthesis of research findings to inform further scale up of the intervention are part of the intervention.
The study comprises five steps:

1) There are 02 evidence reviews available to understand the impact of various interventions. The first is a review of global literature concerning peer-led community-based interventions to improve adolescent health, and to understand what interventions exist in low and middle-income country settings, and to understand their impact. These include PubMed, Embase, the Cochrane Library, CINAHL, African Index Medicus, Web of Science, the Reproductive Health Library, and the Science Citation Index. The second review is identification of national and Jharkhand-specific activities to improve adolescent health to help understand how the new intervention can be embedded within RKSK and other government programs for development of youth. The source for these information is published government documents on national-level implementation of RKSK and other government programs for adolescents.

2) Needs assessment has been done to understand adolescents and their issues in our project district (West Singhbhum, Jharkhand). The qualitative data collection tools used are Focus Group Discussions (FGDs) with boys and girls aged 10-19; semi-structured interviews with married and unmarried boys and girls aged 15-24; FGDs with caregivers of adolescents; FGDs with teachers of adolescents; and semi-structured interviews with frontline health workers. The needs assessment also includes a baseline survey of around 3200 adolescent girls from 40 villages. The survey includes questions on education, financial resources, general health, nutrition, access to entitlements, sexual and reproductive health, gender norms and decision-making, violence and mental health. For measuring violence, the tools were used from sources such as - International Society for the Prevention of Child Abuse and Neglect Child Abuse Screening Tool-Child Institutional (ICAST-C, 2006) and some items from the World Health Organisation (WHO) Multi Country Study on Women’s Health and Domestic Violence against Women (Garcia-Moreno et al., 2005).

3) The third step is to use the findings from the evidence reviews and needs assessment to design a scalable, peer-led, PLA-based community intervention for adolescents through a collaborative workshop with Ekjut (our Indian partner organisation), a study technical advisory group and our funders.

4) A pilot trial of the intervention with 160 adolescent groups to determine its feasibility, acceptability, and preliminary impact on adolescent health. The 40 villages that took part in the baseline survey were randomised to an intervention arm (20 villages) or a control arm (20 villages). After 15 months of intervention, an end-line survey will be carried-out with approximately 3200 adolescent girls to examine the intervention’s impact on key adolescent health indicators. We also plan to do a process evaluation a process evaluation is also planned.

5) Finally, the lessons learned will be summarised for further implementation, evaluation and scale-up of the peer-led, PLA-based intervention to improve adolescent health.
Intervention strategy

The intervention is framed in terms of a Community Youth Team that delivers participatory adolescent groups, youth leadership activities and livelihood promotion. Each cluster (around 1000 population) has a community youth team comprising a peer facilitator (‘Yuva-Saathi’, meaning friend of youth), a youth leadership facilitator and a livelihood promoter. The intervention engages health care providers by inviting them to group meetings and providing a referral system to adolescents needing help with health, sexual and reproductive, and nutritional needs. An advisory committee, involving representatives from local governmental and non-governmental adolescent services, that advises and support the teams. PLA meetings and leadership activities with adolescent groups are done in intervention arm areas whereas the livelihood activities are common across both the arms.