Smt Sonia Gandhi Hon'ble UPA Chairperson | Dr. Manmohan Singh Hon'ble Prime Minister

Ministry of Women and Child Development pays tribute to **Shri Rajiv Gandhi** on the occasion of his birth anniversary by announcing

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls– 'SABLA'

The scheme will empower adolescent girls of 11-18 years by :

- Improving their nutritional and health status;
- Upgrading their home skills, life skills and vocational skills;
- Equipping them on health and hygiene, family welfare
- Main streaming out-of-school girls into formal / non-formal education

- To be implemented in 200 selected districts using the ICDS platform.
- To benefit nearly 100 lakh adolescent girls every year in all States/UTs.
- Allocation Rs 1,000 crore per year.

EMPOWERED GIRL EMPOWERS INDIA

Ministry of Women and Child Development, Government of India

SABLA

Findings of Baseline Study in Six Districts of West Bengal

(Cooch Behar, Jalpaiguri, Kolkata, Maldah, Nadia and Purulia)

Report Submitted to: CINI-YUVA

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CONTENTS

A: EXECUTIVE SUMMARY 5
B: DETAILED REPORT 13
C: Overall Findings 21
1 DEMOGRAPHIC PROFILE OF MALDA 21
1.1. Urban 21
1.2. Rural 21
2. STUDY FINDINGS 22
2.1. Respondents' Profile 22
2.2. General Health & Healthy Practices 24
2.3. Knowledge of Anaemia & Nutrition 26
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets 27
2.5. Menstrual Health 30
2.6. HIV/ AIDS 33
2.7. Gender Status - Rights, Beliefs & Practices 34
3. Discussion: 36
4. Recommendation: 37
1. DEMOGRAPHIC PROFILE OF NADIA 39
1.1. Urban 39
1.2. Rural 39
2. STUDY FINDINGS 40
2.1. Respondents' Profile 40
2.2. General Health & Healthy Practices 42
2.3. Knowledge of Anaemia & Nutrition 44
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets 46
2.5. Menstrual Health 50
2.6. HIV/ AIDS 52
2.7. Gender Status – Rights, Beliefs & Practices 54
3. Discussion: 56
4. Recommendation: 57
1. DEMOGRAPHIC PROFILE OF PURULIA 58
1.1. Urban 58
1.2. Rural 58
2. STUDY FINDINGS 58

2.1. Respondents' Profile ... 59
2.2. General Health & Healthy Practices ... 61
2.3. Knowledge of Anaemia & Nutrition ... 64
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets ... 66
2.5. Menstrual Health ... 70
2.6. HIV/ AIDS ... 72
2.7. Gender Status – Rights, Beliefs & Practices ... 74
3. Discussion: ... 76
4. Recommendation: ... 77
1. DEMOGRAPHIC PROFILE OF COOCH BEHAR ... 79
1.1. Urban ... 79
1.2. Rural ... 79
2. STUDY FINDINGS ... 80
2.1. Respondents' Profile ... 80
2.2. Genera Health & Healthy Practices ... 82
2.3Knowledge of Anaemia & Nutrition ... 84
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets ... 85
2.5. HIV/ AIDS ... 89
2.6. Gender Status – Rights, Beliefs & Practices ... 90
3. Discussion: ... 93
4. Recommendation: ... 93
1. DEMOGRAPHIC PROFILE OF JALPAIGURI ... 95
1.1. Urban ... 95
1.2. Rural ... 95
2. STUDY FINDINGS ... 96
2.1. Respondents' Profile ... 96
2.2. General Health & Healthy Practices ... 98
2.3. Knowledge of Anaemia & Nutrition ... 100
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets ... 101
2.5. Menstrual Health ... 105
2.6. HIV/ AIDS ... 107
2.7. Gender Status – Rights, Beliefs & Practices ... 109
3. Discussion: ... 111
4. Recommendation: ... 112

1. DEMOGRAPHIC PROFILE OF KOLKATA 114
1.1. Urban 114
2. STUDY FINDINGS 114
2.1. Respondents' Profile 114
2.2. General Health & Healthy Practices 117
2.3. Knowledge of Anaemia & Nutrition 120
2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets 121
2.5. Menstrual Health 124
2.6. HIV/ AIDS 127
2.7. Gender Status – Rights, Beliefs & Practices 128
3. Discussion: 131
4. Recommendations: 131
D: Discussion and Recommendation 133

Annexures:

1. List of Tables and Images
2. Fact Sheet
3. Log Frame
4. Study questionnaires
5. Interview Schedules

A: EXECUTIVE SUMMARY

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) - Sabla was started on in Nov, 2010 by the Ministry of Women and Child Development in selected 200 districts at different states of India. The scheme is aimed at addressing the multi-dimensional problems of adolescent girls between the age group of 11 to 18 years. The scheme is targeting to implement through the platform of integrated child Development Services Scheme (ICDS) projects and Anganwadi centres. The objectives of the scheme are to:

- Enable self-development and empowerment of Adolescent Girls;
- Improve their nutrition and health status;
- Spread awareness among them about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH), and family and child care;
- Upgrade their home-based skills, life skills and vocational skills;
- Mainstream out-of-school AGs into formal/non formal-education; and
- Inform and guide them about existing public services, such as PHC, CHC, Post Office, Bank, Police Station and various development scheme of Government etc.

The Government of West Bengal is committed to ensure holistic empowerment of the adolescent girls living in the state. In the first phase of intervention the state is planning to implement the SABLA scheme in six districts, namely namely Kolkata, Nadia, Malda, Purulia, Jalpaiguri and Coachbehar. Child In Need Institute (CINI) seeks to strengthen the output of the implementation of the scheme in selected 18 blocks of these six districts. CINI-YUBA has adopted Child and Woman Friendly Community (CWFC) approach to optimise the output through stakeholders' consultation with and involvement of community, panchayat/urban local bodies and local service providers. To track changes in any intervention it is essential to establish certain benchmarks against which progress is measured to ascertain the level of transition. Key indicators determining the benchmarks are required to be decided upon and assessed to verify the result. The current engagement is a Baseline Study meant for capturing the status quo in terms of assessing knowledge, attitude, belief and practices of adolescent girls (aged between 11-18 yrs) on nutrition and reproductive & sexual health.

The study has followed a mixed methodology – a combination of quantitative and different qualitative techniques – to design the study framework and to collect different range of information from different stakeholders. However, the principal component of the study is

covered through quantitative survey techniques like questionnaire administration with Adolescent Girls (11-18) years of age. The target sample figure for each category of respondent as per the nature and framework of the study and study components are 1080 Girls for questionnaire technique, 180 girls for FGDs (through 10 FGD), 108 Service provider (including AWW, ANM, Supervisor of ICDS, CDPO, Ponchayet members, Medical Officer etc. through interview technique). Total screening is done through different method varied with target sample as per availability of respondents, willingness to participate in the study and type of information targeted to collect from each category of respondent etc.

Study Findings & Recommendation:

Malda District **:**

- Data on personal background of the respondents in Malda district reveals that about half the respondents are Hindu and the remaining half are Muslims. The status of marriage among the respondents in the age group of 15 to 18 years. About 37% of them are married which claims dissemination of information on the proper age of marriage and its associated positive impact.
- Status of birth certificate is moderate. However, it needs strengthening to scale it up among those who are yet to get the same. Linkage with organisation and engagement for professional skill development is poor which needs to be addressed immediately so as to help them develop their respective skills to gradually streamline them in society.
- Status of missing cases (3% within age group 15-18 years) should be addressed with due attention to avoid any such incidents in future. Child labour is prevalent and it is more among the younger group of respondents. It needs to be addressed without delay. School dropout among the respondents is quite high 32% among (11-14) years of age group and 58% among (15-18) years of age group. It has to be addressed and resolved without delay.
- Regular nail cutting among the respondents with special focus on the age group of 15 to 18 years should be encouraged as it is largely absent among them. Gap in knowledge about general health and nutrition is pretty evident, especially in the areas of hand sanitation after evacuation and hand wash with soap before taking food. Necessary focus needs to be paid without delay as it might entail severe complications in health. Fever and Diarrhoea rule the roost among the general sickness which needs to be treated with due care to avoid any serious ramification.
- Refractive error (weak vision), though not wide spread, is prevalent among some of the respondents. Proper care with regard to this is urgently required as it may potentially lead to permanent weakening of vision. Knowledge on iron deficiency seems a critical concern as most of the respondents barely possess any idea on it. Source of IFA tablets is equally scarce with only private doctors and school serving as the chief source of the

tablets. Initiatives to beef up the status are urgently required. Excessive bleeding has been cited by the respondents as the most common reason of anaemia. Overall knowledge level of the respondents on anaemia is awfully superficial.

- Menstrual health, on the other hand, demands dedicated care as quite frequently the respondents are troubled by a number of associated complications. Local doctors and ANMs are the most preferred service points for treatment of menstrual problems. However, more strengthening of the service points–preventive, promotive & curative-is essential to adequately optimise the required service delivery in terms of equity, accessibility and affordability of the services offered.
- Another area of serious concern is the lack of basic knowledge of the respondents on HIV. Misconceptions like spread of the virus through mosquito bite and opinion against sharing of utensils and others are abundant. Information spread on routes of transmission and regular sensitisation programmes with strong IEC campaigning are urgently required to update their knowledge on HIV. Along with this, steps to dislodge misconceptions regarding the virus are equally needed.
- Gender disparity with regard to movement of the adolescent girls is rife. Despite endorsing access to education and the authority to decide on the age of marriage the respondents seem conditioned to accept the fact. They also believe childcare is the prime responsibility of mothers. Efforts to work on these areas are urgently required, which, however, have to be customised to have them adequately culturally sensitive and suitably responsive.

Nadia District

- Information on personal background of the respondents surfaces almost equal distribution of the respondents among Hindu and Muslim communities. Child marriage, though not rampant, cannot be overlooked, especially among the respondents of 15 to 18 years age group. Efforts to curb this practice are highly required. Information on physical unpreparedness and consequent health hazards of early marriage needs to be spread in the community.
- Importance of ration card as a valid official residential and identity proof has to be made known to notch up the coverage. Engagement for skill development needs to be encouraged to have the adolescent girls ready to utilise different job opportunities.
- Data on family background reveals that the families are largely nuclear with fathers mostly either into agriculture or daily labour. About one third of the mothers are working and most of them are daily wage labourers. Majority of the parents are literate. Parents can be sensitised on impact of education so that their children can be focused for the upliftment of their educational status. About 18% of the respondents in the age group of 15 to 18 years are into child labour and the trend is prevalent even among the younger age group which calls for immediate intervention. Along with this focus is also

needed to decrease the load of school dropout as it is quite prevalent among the respondents of both the age groups.

- Fever is most common ailment followed by Diarrhoea. Refractive error is present among some of the respondents. Healthy practices are largely present. However, washing hands with soap before taking food may be emphasised as it may yield better results in terms of reducing the cases of Diarrhoea and fever.
- A diet prescribing complete food with resources available may be shared to improve their nutritional status. Knowledge of anaemia is a concern. Sessions or meetings with special focus on the issue may be organised to increase their knowledge level on anaemia and the benefits of IFA tablets. Source of information on anaemia is equally poor.
- Menstrual health is an integral component of female adolescent health. Laying focus on information related to menarche and symptoms of menstruation and how to deal with the same is highly required. Complications like white discharge with odour, excessive bleeding, lower abdominal pain and some other are common among the adolescent girls. Preferred service points for the treatment of menstrual problems are largely absent. An enabling environment at Aneshwa clinic to discuss these issues and resolve related complications needs to be created immediately.
- Knowledge on HIV is another area of concern. Misconceptions regarding the virus are abundant. Spread of right information on HIV and sensitisation workshop to dismantle misconception need urgent attention.
- Gender disparity is deep rooted. Right from movement of girls to decision making within family are believed should be regulated by male members. However, the respondents are mostly in favour of deciding their age of marriage. Decision about physical relation and condom use is, quite frequently, supposed to be decided by male members. Sensitisation meeting involving local influential bodies may be organised as a top down approach to have an environment conducive to removing gender bias. Sessions on women empowerment and the capacity building of female adolescents on gender issues are highly recommended.

Purulia District

- Data on personal background of the respondents in the Purulia district reveals that percentage of reserved category (SC & ST) is quite high and about 4% in the age group of 15 to 18 years are married. Immediate intervention is needed to hold in check the prevailing practice of early marriage and for proper utilisation of protective philosophy of reservation among underprivileged.
- Birth certificate as an important document of age proof has to be popularised as the figure is pretty scarce among the respondents. The status of engagement for professional skill development is exceedingly small. Intervention

encouraging the same ensuring availability of related opportunities is highly required. About 19% of the respondents in the age group of 15 to 18 years are into child labour and the trend is prevalent even among the younger age group which calls for immediate intervention. School dropout is quite high in both the age group. Mothers are largely illiterate.

- Fever is most common ailment. Preventive and promotive measures call for urgent attention in the community. Hand sanitation needs to be widely encouraged as it is remarkably low among the respondents. It may be accountable for higher percentage of diarrhoea and fever among the respondents.
- Knowledge on programmes on eradication of malnutrition is awfully weak. Most of the respondents appreciating two time intake of food per day testify to their considerably low knowledge on nutrition. Knowledge on anaemia is equally low. It may be due to the scarcity of information and unavailability of source of information. Teachers and Angan Wari Workers (AWW) contribute to some extent. However, compared to the requirement it is considerably meagre. School and AWWs are the chief source of IFA tablets. Information session on iron deficiency and related issues with scheduled tools and well drawn out strategy may uplift the knowledge of the respondents on anaemia.
- Status of knowledge on menstrual health is also poor. Required information on menstrual health and its related complications demonstrating methods of treatment and service points need to be spread and shared among the respondents. Lower abdominal pain and white discharge with foul odour are some of the complications the respondents have cited as their problem and owing to the paucity of service points for treatment the situation is serious and it may soon get worse if focus is not paid immediately. IEC activities and more outreach programmes at the periphery level may be launched to gear up the effort.
- Information on HIV may be clubbed together in the outreach activities to raise awareness on the virus and dislodge misconceptions. Gender bias is ingrained. Household work has been accepted as the prime responsibility of females within families. However, opinion regarding the age of marriage advocates both male and female participation. Males, although, have been preferred to decide on physical relation.

<u>Cooch Behar District</u>

- Data on personal background of the respondents of Cooch Behar district in the age group of 15 to 18 years reveals that about 18% of the respondents are married. A few of the respondents belonging to the younger age group also have reported their married status. It establishes the trend of early marriage in the district. Intervention to spread awareness on the hazards of early marriage is highly required.

- Engagement for skill development is also recommended as the status is drastically poor. Women (mothers) are largely illiterate, though literacy among male members is also very low. School dropout is quite high. Focus on finding out the reasons behind it has to be paid and ways to resolve the issue have to be explored and implemented.
- Apart from fever which dominates general sickness skin disease too is also another disease burden. Diarrhoea is highly prevalent among the older age group. Prevalence of healthy practice is noteworthy. However, focus has to be paid to assess the reason of high prevalence of fever and skin disease among the respondents.
- Most of the respondents appreciating two time intake of food being sufficient for them indicates incomplete and poor knowledge on nutrition. However, status of knowledge and information on anaemia reads positive. Steps to strengthen knowledge on nutrition are required. Instructions on intake of complete food with available resources may be passed on to them. AWWs and NGO workers are chief source of information on anaemia. Roping in these two sources to optimise the information flow on nutrition and anaemia may be considered.
- AWWs are the main sources of IFA tablets. Their role in heightening the knowledge level of the respondents on anaemia, its reasons and symptoms along with issues on menstrual health is instrumental. Role of AWWs may be reconsidered and their integration for improving the scenario may be deliberated upon.
- Knowledge on HIV is moderate and misconceptions with regard to the spread of the virus are prevailing among the respondents. Necessary intervention along with focus on IEC activities and sensitisation programmes to raise awareness and eliminate misconceptions are highly required.
- Information on gender status reveals that the respondents are quite conservative with regard to movement of females outside home without guardians. A large number of them also favour boys having more access to education than girls. Intervention to raise awareness on the benefits of female literacy is essential. Meetings with the administrative departments are also required to create an enabling environment conducive to independent female movement and their overall development.

<u>Jalpaiguri District</u>

- In Jalpaiguri district about three fourth of the respondents are Hindu and the rest are Muslim. About 54% of them in the age group of 15 to 18 years are Scheduled Caste (SC) and about 10% belong to Other Backward Classes (OBC).
- Majority of the respondents have birth certificates and ration card. However, efforts for full coverage are needed. Engagement for professional skill development needs to be encouraged as the status is quite poor among the respondents. Mothers are largely illiterate, though about a quarter of the respondents have illiterate fathers.

- Fever is most dominant among common ailments and it is followed by diarrhoea and indigestion. There is an anomaly between the status of general health and healthy practices. More focussed efforts have to be put in to ascertain the reasons behind fever and diarrhoea. Regular nail cutting has to be encouraged as it may lessen the frequency of diarrhoea.
- Status on the knowledge of nutrition and anaemia is modest. However, efforts may be put in to increase the frequency of food intake per day. Almost half of the respondents have not heard of anaemia which calls for immediate intervention. Sources of information on anaemia are also exceedingly scarce. Primary Health Centre/ Sub Centre acts as source of IFA tablets, though it is awfully insufficient compared to the need.
- With regard to menstruation most of the respondents have undergone complications like lower abdominal pain, white discharge with bad odour and burning sensation during urination. The only service points available for treatment of menstrual complications is doctors who are quite less in number. Immediate intervention ensuring availability, affordability and accessibility of service points is needed.
- HIV is a high focus area. It seems to have remained unaddressed as the knowledge regarding the virus is very low and misconceptions are rampant. Information dissemination along with sensitisation programme is badly needed.
- Gender bias is observable. Restriction on movement of girls is high. Education is more accessible to boys than to the girls. Female responsibility seems confined within four walls of a family. Responses with regard to the authority to decide on the age of marriage and initiation of physical relation are aligned to the female choices. However, response like husband can beat his wife if she refuses sexual intercourse treads a different track. Respondents are beset with confusion with regard to their gender rights. Focus needs to be paid on demonstrating and illustrating their rights being female and as holistically beneficial for both family and society.

Kolkata District

- Respondents in Kolkata district are almost equally divided into Hindu and Muslim community. About 20% in the older age group of respondents are Other Backward Classes (OBC). Marriage at an early age is quite prevalent among the respondents belonging to the age group of 15 to 18 years. Status of ration card is concern and efforts are also necessary to increase the coverage of birth certificate. Linkage with organisation and engagement for professional skill development is poor.
- Large number of mothers are working, though illiteracy is quite high. Incidents of school drop outs are a real concern. Majority of the respondents in the older age group are drop outs and about a quarter of the respondents in the younger age group have also dropped out of school.

- Data regarding history of missing cases is quite alarming and it needs to be addressed immediately. Another striking finding is the status of child labour in Kolkata. In both the age group about 20% of the respondents are into child labour.
- Similar to the status of other districts fever is most common among general ailments, however, it is specifically concentrated among the younger group of respondents in Kolkata. Diarrhoea is another major sickness. What is unique is the status of problem in vision (refractive error) in Kolkata, which is as high as 22% in the younger age group and 15% in the other . It has huge scope for intervention.
- Knowledge on nutrition and anaemia is negligible. Reasons behind anaemia are largely unknown. AWWs chiefly works as source of IFA tablets, however, role and functionality of Aneshwa clinics may be focused. Most of the respondents have felt lower abdominal pain during menstruation and about a little less than quarter in the age group of 15 to 18 years have experienced excessive bleeding during menstruation. Lower abdominal pain and white discharge with bad odour are the most common menstrual complications experienced by the respondents. Preferred serviced points for the treatment of menstrual complications hardly exist.
- Knowledge on HIV is drastically poor and misconceptions with regard to the transmission of the virus are abundant. Gender disparity is quite high and female members seem conditioned to accept male dominance in various spheres of life ranging from access to education to decision making within family. With regard to reproductive health and rights large number of respondents advocate women independence and authority. However, in certain cases like acceptance of husband's authority to beat wife if she refuses sexual intercourse renders the scenario confusing and fuzzy.

B: DETAILED REPORT

B.1 Background:

[1]Maternal mortality in India is the second highest in the world, estimated to be between 385-487 per 100,000 live births. Close to 125,000 women die from pregnancy and pregnancy related causes each year. Antenatal services are poor with only 53.8 percent receiving tetanus toxoid injections and 46.8 per cent having their blood pressure measured. 80 per cent of women are anaemic. As much as 58 percent reduce their food intake during pregnancy instead of increasing it. Two-thirds of deliveries take place at home, with only 43 percent supervised by health professionals. Only 52 per cent of couples in the reproductive age groups use contraception. [2]A study conducted by AC Neilsen called "Sanitation protection: Every Women's Health Right", provides an in depth analysis of the prevalent unhygienic practices and their effect on women's health. The survey covers 1033 women in the menstrual age and 151 gynaecologists who studied them. Statistics from this survey says that Inadequate protection during the days of the menstrual cycle leads to adolescent girls in the (age group 12-18years) miss 5 days of school in a month (50 days annually). 23% of girls drop out of school after they start menstruating. Due to such practices, over 70% of the women have some kind of Reproductive Tract Infection (RTI) in their lifetime.

For young girls in India, poor nutrition, early child bearing, and reproductive health complications compound the difficulties of adolescent physical development. Nutritional deprivation, increased iron demand for adolescent growth, excessive menstrual losses of iron and early/frequent pregnancies aggravate and exacerbate pre-existing anemia and its effects. Most girls are not adequately aware of their increased nutritional needs for growth (especially increasing their food intake to meet calorie demands of pubertal growth), resulting in girls that are underweight and of short stature. According to CEDPA report, fifteen percent of ever-married adolescent girls are stunted; 40% have a body mass index below 18.5, and 20% have moderate or severe anaemia. The poor nutritional status of these adolescent mothers heightens obstetric risk during pregnancy and childbirth, contributes to maternal mortality, and puts their infants at risk. Neonatal and infant mortality rates among adolescent mothers are 60% higher than among infants born to mothers in the 20-29 age group.

[1]http://infochangeindia.org/women/backgrounder/women-background-a-perspective.html
[2]http://www.youthkiawaaz.com/2011/01/dismal-female-health-scenario-a-statistical-round-up/

In India, school systems are ambivalent about imparting sex education. Even in some schools where sexual and reproductive health education exists in the curriculum, teachers are often too embarrassed and uncomfortable to effectively instruct. On an average, most adolescent girls in India have little knowledge of menstruation, sexuality and reproduction. Large numbers of rural and urban populations believe that menstruation contaminates the body and makes it unholy. As a consequence, the girl often sees herself as impure, unclean and dirty. This is true for rural as well as the urban poor. The lack of information can be attributed to a veil of secrecy that surrounds menarche. From the beginning of their lives, girls are socialized to accept male domination and ignore their own needs. Discrimination against the girl child in health, nutrition and education is heightened in adolescence. Onset of puberty decreases autonomy and mobility, with increasing restrictions on speech, appearance, conduct and interaction with the opposite sex. Girls inherit their mother's domestic chores and adopt stereotypical gender roles. Low self-esteem and self-worth are common. After marriage, her husband and in-laws control the bride's life. Consequently, the girls enter the "culture of silence."In India, early marriage for girls receives religious and social sanction. Despite laws raising the legal age of marriage to 18 for girls, there are strong cultural pressures on parents to marry their daughters early.[3]The median age at first marriage among women 20-49 in India is 16.7 with a two-year difference between urban and rural women (18.7 versus 16.0). [4]Among married young women aged 15-19, autonomous decision making and freedom of movement is very low with only 38.6% involved in decisions about their own health care and 86% needing permission to go to the market. In addition to the psychological immaturity of an adolescent bride, very often her body is not prepared to accommodate the early onset of childbearing. Knowledge about care needed during pregnancy, lactation for health of mother and child, and access to prenatal & postnatal services is limited. Besides, high rate of drop out from school of the adolescent girls limits their educational growth. Despite the presence of different schemes involving various life skill education and vocational training to enable the adolescent girls and women to earn their livelihood and make independent choices about their life, long held social customs and prejudices stalls the opportunities of their growth in every sphere of their lives.

In 2006 Government of India proposed the adoption of the Integrated Child Protection Scheme and in 2009 with the approval of the Central Government the scheme was

[3]National Family Health Survey 1998-1999 (NFHS-2), IIPS, Mumbai, 2000
[4]NFHS - 2

launched. It focused on providing children with a protection and safe environment to help them develop and flourish as well as to reduce the risks and vulnerabilities children face in various situations and actions that lead to abuse, neglect, exploitation, abandonment and separation of children.

In 1975 Government of India had launched Integrated Child Development Scheme which represents one of the world's largest and most unique programmes for early childhood development. ICDS is foremost symbol of India's commitment to her children – India's response to the challenge of providing pre-school education on one hand and breaking the cycle of malnutrition, morbidity, reduced learning capacity and mortality on the other.

The project at issue is about a scheme which seeks to ensure empowerment of adolescent girls in India. There are two major components under the scheme: one, a nutrition component for 'out-of-school girls' in the age group of 11 to 14 years and for 'all the girls' in the age group of 14 to 18 years, and second, non-nutrition component for 'out-of-school' adolescent girls in the age group of 11 to 18 years and a vocational training under National Skill Development Programme for girls in the age group of 16 to 18 years.

The basic objectives of the scheme are to enable self-development and empowerment of adolescent girls, improvement in their health and nutrition status, spread awareness about health, hygiene, nutrition, adolescent reproductive and sexual health, family and child care. The programme also aims at upgrading their home-based skills, life skills and vocational skills. The project will also include bringing back the out-of-school adolescent girls under the ambit of formal and non-formal education. The adolescent girls will also be guided about the existing public services, such as primary health centres, post offices, banks, police stations and others.

A 'Kishori card' will be given to each adolescent girl, wherein details about her weight, height, body mass index, iron and folic acid supplementation, referrals and services received under SABLA will be written. The card will also contain information about important milestones in the girl's life, like joining school, leaving school, marriage etc.

'Kishori Diwas' will also be celebrated as a special health day once in three months, where their general health check-up will be done. 'Kishori Samooh', a group of 15 to 25

girls, will be formed at the anganwadi centre level. One girl from amongst them will be selected as 'sakhi', the peer monitor, who will be assisted by two other 'Saheli', i.e. girls assisting the Sahki. The responsibility will be rotated and this will follow for one year. After the completion of the year selection for fresh Sakhi and Saheli's will take place. Sakhi will be responsible for providing guidance and motivation to peers. Convergence and/ or integration or utilisation of the ICDS structure has been decided upon. Angan Wari Workers are supposed to oversee the running of the project.

The Government of West Bengal is committed to ensure holistic empowerment of the adolescent girls living in the state. In the first phase of intervention the state is planning to implement the SABLA scheme in six districts, namely namely Kolkata, Nadia, Malda, Purulia, Jalpaiguri and Coachbehar. Child In Need Institute (CINI) seeks to strengthen the output of the implementation of the scheme in selected 18 blocks of the six districts. CINI-YUBA has adopted Child and Woman Friendly Community (CWFC) approach to optimise the output through stakeholders' consultation with and involvement of community, panchayat/urban local bodies and local service providers. The project, supported by Ford Foundation, is slated to reinforce the systems & structures and capacitate the stakeholders to facilitate the effective implementation of the SABLA scheme establishing a well coordinated and synergised partnership between Government bodies and Civil Society Organisations. The long and short term indicators set to measure change are as follows:

- Short Term Indicators:
    - Empowered adolescent girls to emerge as leaders with increased knowledge and capacity to prevent cases of early marriage, early pregnancy etc
    - Ensures increased technical capacity of the adolescent girls to participate in decision making bodies. It also worked to enhance skills of these girls to demand and access services from a range of local level services and clinics
    - Enhanced technical capacity of the local self-government and service providers to lead a sustainable process of adolescent development in their area
    - Addressing gender issues through scaling up SRHR health services, nutrition and education development initiatives for adolescent girls

- Long Term Indicators

- Improved enabling environment at the community level for promotion of adolescent sexual and reproductive health and rights and adolescent-friendly services
- Decrease the cases of gender discrimination at the community level enabling adolescent girls to participate in the decision making processes on age of marriage, early pregnancy, right to education and right to quality services

To track changes in any intervention it is essential to establish certain benchmarks against which progress is measured to ascertain the level of transition. Key indicators determining the benchmarks are required to be decided upon and assessed to verify the result. The current engagement is a Baseline Study meant for capturing the status quo in terms of assessing knowledge, attitude, belief and practices of adolescent girls (aged between 11-18 yrs) on nutrition and reproductive & sexual health.

B.2 Methodology:

The study has followed a mixed methodology – a combination of quantitative and different qualitative techniques – to design the study framework and to collect different range of information from different stakeholders. To design the study frame work the following steps were taken into consideration-

1. Situation/ Problem analysis – considering the Adolescent girls at the centre of query the following steps were taken: i) identification of stakeholders, ii) nature and level of their influence to the life of the adolescent girls, iii) identification of constraints and opportunities, iv) determining cause and effect relationships between different levels of problems etc

2. **Analysis of objectives, Strategy andTechnique analysis** - identifying the different strategies to achieve objectives; determining the major techniques to illicit information as per nature of desired information and respondents

3. **PreparingLogical Framework** - defining the research framework, putting its internal logic, defining potential techniques and estimating sample size for each technique,

4. **Resource scheduling** - assigning responsibility, preparing timeframe

Techniques and sample size for the study:

The principal component of the study is covered through –

- Quantitative survey techniques like **questionnaire administration** with Adolescent Girls (11-18) years of age.

- Qualitative survey techniques like **Focus Group Discussion** (with Adolescent Girls 11-18 years of age and their parents) and **Interview (**with **s**ervice provider, including AWW, ANM, Supervisor of ICDS, CDPO, Ponchayet members, Medical Officer etc.)

The study has select non-probability purposive sampling procedure, with a maximum sample range of 1080 girls for questionnaire technique, 180 girls for FGDs (through 10 FGD), 108 Service provider. The distribution of target sample size for each categories of respondents are shown in the following table-

<table>
<tr><th>Target Group (Respondent)</th><th colspan="7">Category</th><th>Total Respondent</th><th>Method Proposed</th></tr>
<tr><td rowspan="2">1. Adolescent Girl (11-18 yrs)</td><td colspan="3">Un- Married in school (20 girls/Block)</td><td colspan="2">Un-Married out school (10girls/Block)</td><td colspan="2">Married out school (15 girls/Block)</td><td rowspan="2">1080 Heads</td><td rowspan="2">Quantitative :
Questionnaire Administration
Qualitative:
FDGs*</td></tr>
<tr><td colspan="3">20*18 blocks=360 Heads</td><td colspan="2">20*18 blocks=360 Heads</td><td colspan="2">20*18 blocks=360 Heads</td></tr>
<tr><td rowspan="2">2. Community members</td><td colspan="3">Parents</td><td colspan="2">Community leaders (Ponchayet members/ Councilor))</td><td colspan="2" rowspan="2"></td><td rowspan="2">72 Heads</td><td rowspan="2">Qualitative :
Interview</td></tr>
<tr><td colspan="3">3/block=3*18block= 54 Heads</td><td colspan="2">1/18 blocks=18 Heads</td></tr>
<tr><td rowspan="2">3. Service Providers</td><td>AWWs</td><td>Supervisors</td><td>CDPOs</td><td>RMPs</td><td>BMOHs /MOs</td><td>ANM</td><td>Anwesha Counsellor</td><td rowspan="2">108 Heads</td><td rowspan="2">Qualitative :
Interview</td></tr>
<tr><td>2 AWW*6 Dist. =12 heads</td><td>2 Supervisor*6 Dist. = 12 heads</td><td>2 CDPOs* 6 dist. = 12 heads</td><td>1 from each study block *18 block = 18 heads</td><td>BMOH /MO of each study block* 18 block= 18 heads</td><td>1 from each study block *18 block = 18 heads</td><td>1 from each study block*18 block= 18 heads</td></tr>
</table>

Total screening is done through different methods varied with target sample as per availability of respondents, willingness to participate in the study and type of information targeted to collect from each category of respondent. The result is derived on the sample figure actually screened at field which differ from target sample for

questionnaire administration. The achieved figure is 804 instead of 1080. The distribution is as follows-

District	School Going	Out of School	Total
Cooch Behar	68	36	104
Jalpaiguri	64	1	65
Kolkata	90	58	148
Maldah	81	108	189
Nadia	95	55	150
Purulia	75	73	148
Total			**804**

C: Overall Findings

1 DEMOGRAPHIC PROFILE OF MALDA

According to Census data 2011, Malda had population of 3,997,970 of which male and female were 2,061,593 and 1,936,377 respectively. Sex ratio is 948. , child sex ratio is 945 girls per 1000 boys compared to figure of 964 girls per 1000 boys of 2001 census data.

IMAGE 1: MALDA DISTRICT MAP

1.1. Urban

Out of the total Maldah population for 2011 census, 13.80 percent lives in urban regions of district. In total 551,914 people lives in urban areas of which males are 291,615 and females are 260,299. Sex Ratio in urban region of Maldah district is 893 as per 2011 census data. Similarly child sex ratio in Maldah district is 872 in 2011 census. Child population (0-6) in urban region is 76,420 of which males and females are 40,812 and 35,608. This child population figure of Maldah district is 14.00 % of total urban population. Average literacy rate in Maldah district as per census 2011 is 76.82 % of which males and females are 78.71 % and 74.71 % literates respectively. In actual number 365,271 people are literate in urban region of which males and females are 197,405 and 167,866 respectively.

1.2. Rural

As per 2011 census, 86.20 % population of Maldah districts lives in rural areas of villages. The total Maldah district population living in rural areas is 3,446,056 of which males and females are 1,769,978 and 1,676,078 respectively. In rural areas of Maldah district, sex ratio is 947 females per 1000 males. If child sex ratio data of Maldah district is considered, figure is 956 girls per 1000 boys. Child population in the age 0-6 is 513,817 in rural areas of which males and females are 262,728 and 251,089 respectively. The child population comprises 14.84 % of total rural population of Maldah district. Literacy rate in rural areas of Maldah district is 60.42 % as per census data 2011. Gender wise, male and female literacy stood at 65.37 and 55.18 percent respectively. In total, 1,771,627 people are literate of which males and females are 985,267 and 786,360 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 1: PERSONAL BACKGROUND (N=189)

Age group	11-14 yrs.	15-18 yrs
Religion	55% Hindu, 45% Muslim	53% Hindu, 47% Muslim
Caste	11% SC, 4% ST, 2% OBC	19% SC, 18% ST, 6% OBC
Marital status	100% unmarried	37% married
Children having Birth Certificate	68%	70%
Children having ration Card	78%	89%
Linkage with any organisation/association	Nil	Only one person has linkage with Library and one with club
Engagement for professional skill development	Only one person has linkage with handloom work	7% is in handloom work

A close look at the personal background of the respondents reveals that marriage starts taking place from 15 years. About 37% of the respondents in the age group of 15 to 18 are married. Linkage with any organisation and association is either nil or negligible. Status of engagement for skill development is almost alike, except for seven percent of the respondents in the age group of 15 to 18 who are associated with handloom work.

Table 2 FAMILY BACKGROUND (N=189)

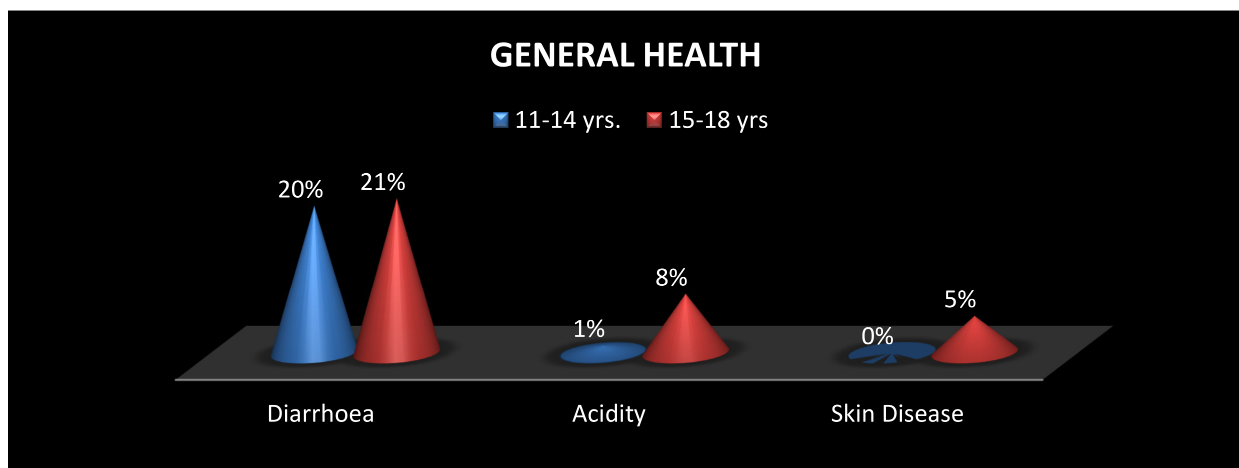
Age group	11-14 yrs.	15-18 yrs
Type of family	20% belongs to joint family	30% belongs to joint family
Fathers Occupation (with %)	35% daily labour, 7% small business	24% daily labour, 14% small businessman
Percentage of children having working mother	42%	27%
Mothers Occupation (with %)	32% daily labour	11% daily labour
Literacy rate of Father	48% illiterate	54% illiterate
Literacy rate of Mother	66% illiterate	65% illiterate
Percentage of Families having history of migration	20%	22%
Percentage of Families having history of missing cases	1%	3%
School Drop out	32%	58%
Child Labour	16%	13%

A sharp difference is observable with regard to percentage of children having working mother. About 42% of the respondents in the age group of 11 to 14 years have working mothers, while in the age group of 15 to 18 it is 27%. Migration is evident in both the age groups. Though marginal, history of missing cases is there and it is more in the age group of 15 to 18 years. School dropout is quite high among the respondents and child labour is also prevalent among them.

2.2. General Health & Healthy Practices

Table 3: GENERAL HEALTH(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	3%	3%
Fever	41%	47%
Diarrhoea	16%	29%
Indigestion	5%	3%
Acidity	8%	4%
Skin Disease	2%	0%
Dental Problem	1%	2%
Oral thresh	1%	2%
Problem in eye (other than refractive error)	1%	2%



Fever and Diarrhoea dominate general sickness in both the age groups. Among the rest acidity and indigestion are common problems.

Table 4: HEALTHY PRACTICES(N=189)

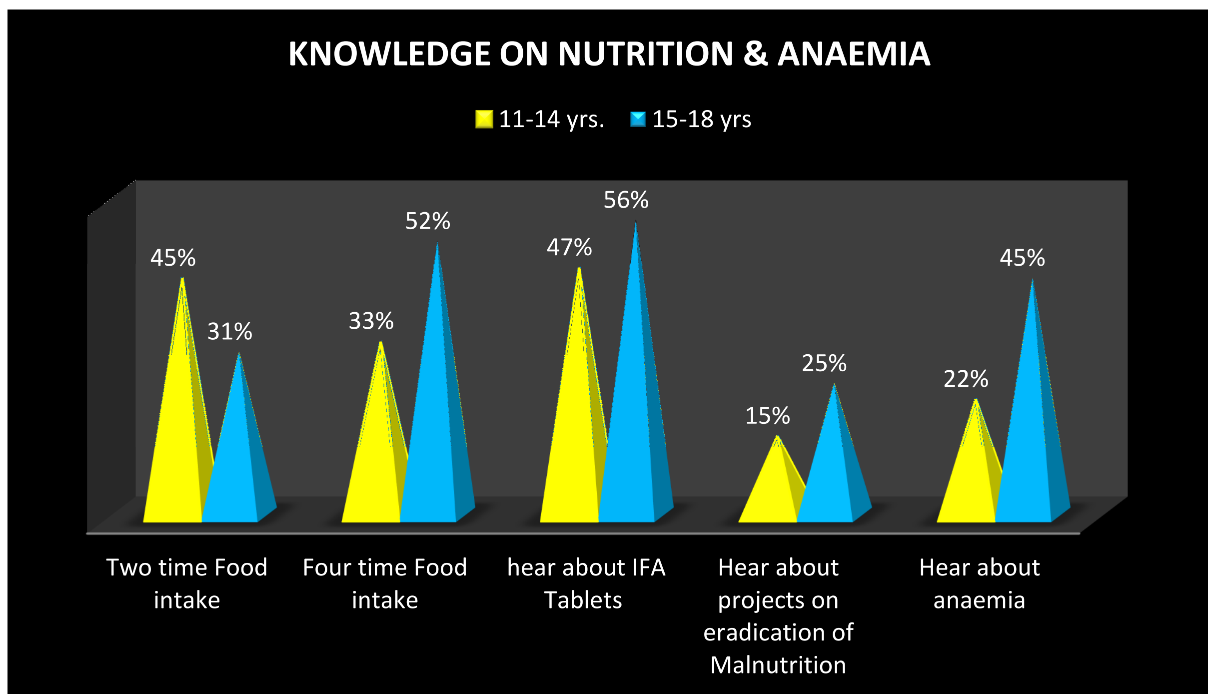
Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	98%	100%
Regular hair comb	95%	95%
Taking bath daily	93%	97%
Hand Sanitisation after evacuation	73%	87%
Washing hand before taking food with soap	66%	65%
Washing mouth with normal water after taking food (Meal)	77%	65%
Regular nail cutting	90%	68%
Avg. time of taking food	2%-Once, 23%-twice, 64%-three times	20%-twice,60% three times, 15% four times

Data regarding healthy practices of the respondents reveals that practice of washing hands before taking food is poor. Practice regarding hand sanitation after evacuation among the age group of 11 to 14 years is less than that in the other age group. Regular nail cutting is more frequent in the age group of 11 to 14 years than that in the other age group. Average frequency of taking food is three for all the respondents, though about 15% among age group of 15to 18 years take food four times a day.

2.3. Knowledge of Anaemia & Nutrition

Table 5: KNOWLEDGE ON NUTRITION & ANAEMIA(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	63%	51%
Percentage of Girls appreciating Four time intake of food is sufficient for them	28%	30%
Percentage of girls hear about IFA Tablets	38%	75%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	12%	33%
Percentage of girls hear about anaemia	24%	56%



Two time intake of food is more common among the respondents of both the age groups. The percentage falls down when it the frequency of taking food is four times. Respondents belong to

15 to 18 years have heard more about IFA tablets than the younger age group. Knowledge about projects on eradication of malnutrition among adolescent girls is poor among all the respondents. Status of awareness on anaemia is more or less same.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 6: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=189)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	0%	6%
ANM/Govt Doctor	2%	11%
RMP/Quack Doctor	0%	3%
Local Medicine Shop	0%	1%
NGO Worker	0%	3%
AWW	2%	9%
Friend	4%	15%
Teacher/Ponchayet Member	6%	5%
Family Member	7%	1%
Others	0%	1%

ANM, Government doctors, and friends are the chief source of information regarding anaemia. Angan Wari Workers are another major source of information on anaemia for them.

Table 7: KNOWLEDGE ON REASON FOR ANAEMIA(N=189)

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	0%	8%
Excessive hard work	2%	7%
For any infection	0%	9%
Lack of iron rich food	0%	9%
Infection for which body release iron more than it required	0%	3%
Excessive Bleeding	0%	12%
Malaria	0%	1%
Rapid growth in adolescent coupled with insufficient iron rich food	2%	8%
Pregnancy	0%	12%
Not Known	12%	15%
Others	2%	0%

Reason for anaemia is mostly unknown to the respondents. Age group of 15 to 18 years are more aware of the reasons than the younger age group of 11 to 14 years. Most common reason known to the respondents for anaemia is excessive bleeding.

Table 8: SYMPTOMS OF ANAEMIA(N=189)

Age group	11-14 yrs.	15-18 yrs
Weakness	4%	27%
Tiredness/Feelings of imbalance	4%	26%
Vomiting tendency	2%	16%
Pale appearance of reddish part of body, like- throat, eye etc	4%	14%
Breathing problem after any work	0%	10%
Headache	3%	15%
Black out	0%	10%
Feeling not to take food/rejection of food	4%	11%
Not Known	35%	10%
Others	0%	0%

Weakness, tiredness and feeling of imbalance is the most common symptom of anaemia known to the respondents. Loss of appetite is another symptom cited by the respondents. However, majority of the respondents are not aware of the symptoms of anaemia.

Table 9: SOURCE TO RECEIVE IFA TABLETS(N=189)

Age group	11-14 yrs.	15-18 yrs
Private doctor	1%	6%

Age group	11-14 yrs.	15-18 yrs
Primary health centre/sub centres	0%	3%
RMP	1%	1%
Local medicine shop	0%	5%
School	13%	22%
AWW	4%	8%
Youth meeting	0%	0%
Industry	0%	0%
Home	0%	2%
Village health mela	0%	0%
Others	0%	1%

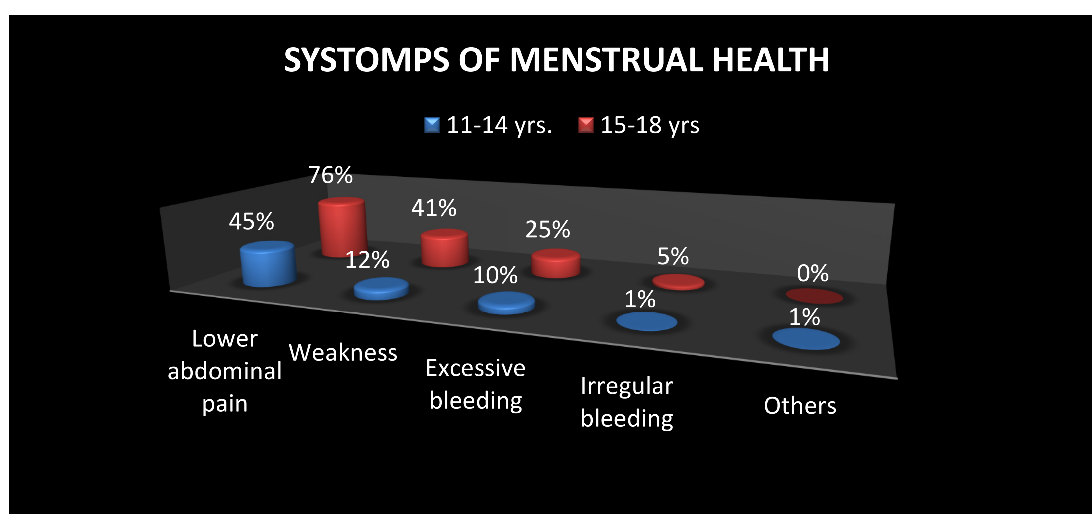
School comes out to be the major source of IFA tables for all of the respondents, and it is followed by the private doctors who come next to the school as source of IFA tablets.

2.5. Menstrual Health

Table 10: SYSTOMPS OF MENSTRUAL HEALTH(N=189)

Age group	11-14 yrs.	15-18 yrs
Lower abdominal pain	45%	76%
Weakness	12%	41%

Age group	11-14 yrs.	15-18 yrs
Excessive bleeding	10%	25%
Irregular bleeding	1%	5%
Others	1%	0%



Lower abdominal pain is experienced by most of the respondents during menstrual period. Excessive bleeding and weakness are other experiences the respondents undergo during menstrual period. Irregular bleeding is not very common.

Table 11: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=189)

Age group	11-14 yrs.	15-18 yrs
White discharge with bad odour	23%	40%
Abdominal pain except during menstruation	10%	19%
Itching in genital area	2%	13%

Burning sensation during urination	3%	11%
Rashes in genital area	1%	7%
Pain during urination	1%	8%
Others	0%	0%

White discharge with bad odour has been experienced by most of the respondents in last six months during menstrual period. Large number of respondents has suffered abdominal pain as well. Itching is more common among the respondents of 15 to 19 years age group. Burning sensation and pain during urination are other problems faced by some of the respondents.

Table 12: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=189)

Age group	11-14 yrs.	15-18 yrs
Local doctor	1%	21%
Anwesha clinic	0%	1%
ANM/ Govt. doctor	1%	6%
RMP	0%	5%
Local medicine shop	0%	0%
NGO staff	0%	0%
AWW	0%	0%
Teacher	0%	0%
Others	1%	0%

Local doctors are major source of treatment for menstrual problems followed by ANM and Government doctors.

2.6. HIV/ AIDS

Table 13: KNOWLEDGE ON HIV/AIDS(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	3%	12%
Percentage of Girls having complete information on HIV transmission	0%	1%
Percentage of Girls having complete information on HIV prevention	0%	1%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	0%

Knowledge of HIV is poor among the respondents. Some respondents of the older group of 15 to 18 years know about HIV as virus.

Table 14: MISCONCEPTIONS REGARDING HIV/AIDS(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	0%	27%
Percentage of girls believe HIV could spread through Mosquito bite	15%	50%
Percentage of girls believe HIV could transmit through sharing of food	12%	31%
Percentage of girls believes Usage of condom could reduce HIV infection.	7%	17%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe HIV infected person cannot live with other person in family	9%	33%
Percentage of girls believe HIV infected person should not share utensils with others.	10%	34%
Percentage of girls believes HIV infected person should not mix with other member in village.	3%	26%

Misconception about HIV getting transmitted through mosquito is quite high among the respondents. That HIV can spread by sharing of food and utensils is another misconception prevailing among the most of the respondents. A large number of respondents in the age group of 15 to 18 years believe that an HIV infected person should not mix with other persons in the village.

2.7. Gender Status - Rights, Beliefs & Practices

Table 15: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	52%	44%
Percentage of girls believe girls should not have access to higher education than boys	25%	27%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	66%	69%
Percentage of girls believe decision should be taken by male members within family	50%	50%

Gender disparity in right from decision making to movement outside home is prevalent among the respondents. About 52% of the respondents in the age group of 11 to 14 years believe they should not move outside home without guardians. Another age group has also shared almost same opinion regarding movement outside home. Most of the respondents believe that household chores are the prime responsibility of girls and that final decision in any family should be made by male members. However, in access to education, very few of them believe that boys should have more access to education than girls.

Table 16: REPRODUCTIVE HEALTH & RIGHTS(N=189)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to take decision not to marry	56%	45%
Percentage of girls believe girls should have right to say about her preferred age of marriage	59%	51%
Percentage of girls believe boys should have right to say about her preferred age of marriage	40%	33%
Percentage of girls believe boys should have right to take decision not to marry	43%	29%
Percentage of girls believe male should have right to take decision about physical relationship with his mate	28%	68%
Percentage of girls believe female have the responsibility not to conceive	0%	76%
Percentage of girls believe female should not negotiate condom use with her husband/mate	19%	37%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	0%	48%
Percentage of girls believe husband and wife should take joint decision about	0%	8%

Age group	11-14 yrs.	15-18 yrs
their child birth		
Percentage of girls believe husband and wife should take joint decision about their use for contraception	0%	8%
Percentage of girls believe mothers should have all responsibility for childcare	79%	54%

Almost half of the respondents in both of the age groups believe that girls should be entitled to take decision about their age of marriage. They also believe their marriage should depend on their consent. Percentage of respondents in the age group of 15 to 18 years is very less when it comes to the question of boys to be entitled to take decision regarding marriage. A high percentage of respondents in the age group of 15 to 18 years believe that males should have right to decide about physical relation and about 76% of them believe that the girls should decide when to conceive. However, a large number of respondents are of the opinion that males can beat their wives if they refuse sexual intercourse. A large number of them also believe that females should not negotiate condom use with her husband or mate. Majority of the respondents in the age group of 11 to 14 years are in favour of mothers taking all the responsibilities for child care. About 54% of the respondents in the age group of 15 to 19 years are also of the same opinion.

3. Discussion:

Data on personal background of the respondents in Malda district reveals that about half the respondents are Hindu and the remaining half are Muslims. What catches notice is the status of marriage among the respondents in the age group of 15 to 18 years. About 37% of them are married which claims dissemination of information on the proper age of marriage and its associated positive impact. Status of birth certificate is moderate. However, it needs strengthening to scale it up among those who are yet to get the same. Linkage with organisation and engagement for professional skill development is poor which needs to be addressed immediately so as to help them develop their respective skills to gradually streamline them in society. Status of missing cases, though not grave, should also be addressed with due attention to avoid any such incidents in future. Child labour is prevalent and it is more among the younger group of respondents. It needs to be addressed without delay. School dropout among the respondents is quite high and the trend is on the increase as they grow older. It has to be addressed and resolved without delay. Regular nail cutting among the respondents with special focus on the age group of 15 to 18 years should be encouraged as it is largely absent among them. Gap in knowledge about general health and nutrition is pretty evident, especially in the

areas of hand sanitation after evacuation and hand wash with soap before taking food. Necessary focus needs to be paid without delay as it might entail severe complications in health. Fever and Diarrhoea rule the roost among the general sickness which needs to be treated with due care to avoid any serious ramification. Refractive error (weak vision), though not wide spread, is prevalent among some of the respondents. Proper care with regard to this is urgently required as it may potentially lead to permanent weakening of vision. Knowledge on iron deficiency seems a critical concern as most of the respondents barely possess any idea on it. Source of IFA tablets is equally scarce with only private doctors serving as the chief source of the tablets. Initiatives to beef up the status are urgently required. Excessive bleeding has been cited by the respondents as the most common reason of anaemia. Overall knowledge level of the respondents on anaemia is awfully superficial. Menstrual health, on the other hand, demands dedicated care as quite frequently the respondents are troubled by a number of associated complications. Local doctors and ANMs are the most preferred service points for treatment of menstrual problems. However, more strengthening of the service points–preventive, promotive & curative-is essential to adequately optimise the required service delivery in terms of equity, accessibility and affordability of the services offered. Another area of serious concern is the lack of basic knowledge of the respondents on HIV. Misconceptions like spread of the virus through mosquito bite and opinion against sharing of utensils and others are abundant. Information spread on routes of transmission and regular sensitisation programmes with strong IEC campaigning are urgently required to update their knowledge on HIV. Along with this, steps to dislodge misconceptions regarding the virus are equally needed. Gender disparity with regard to movement of the adolescent girls is rife. Despite endorsing access to education and the authority to decide on the age of marriage and conceiving a child as equal rights of both the sexes, the respondents seem conditioned to accept male dominance within families. Most of them do not support negotiation of condom use with their husbands and they accept physical violence if a female refuses sexual intercourse with her husband at any point of time. Besides, they also believe childcare is the prime responsibility of mothers. Efforts to work on these areas are urgently required, which, however, have to be customised to have them adequately culturally sensitive and suitably responsive.

4. Recommendation:

The baseline study tried to focus on some specific areas to strengthen the out of the scheme among the adolescent girls. The areas focused are critically instrumental in assessing the status quo and developing a to-do list exclusively for each of the six study districts. Issues focused are knowledge on nutrition, anaemia and integral components of female adolescent health like menstrual health and related complications. Efforts have also been made to ascertain the reasons of gaps in terms of knowledge, service points as well as service delivery. Other areas examined thoroughly are associated with assessing the leadership skills of the adolescent girls as the scheme is largely meant for creating a cadre of trained human resource from the adolescent girls to provide information and guidance to peers. The study also tried to capture

the functionality of the Aneswa clinics to assess the effectiveness of the component. Focus on assessing the knowledge level of the respondents about the existing Government schemes and programmes has also been paid. The study also delved deep in eliciting information on prevailing gender rights and and decision making process within the family and community.

Malda is one of the six study districts and issues that can be focused to strengthen the results of the programme are as follows:

- Focus on notching up coverage of ration card and birth certificates is necessary. Importance of these two cards as age and identity proof has to be made known to the community and efforts have to be put in to encourage and facilitate coverage without delay.
- Child labour and incidents of school drop outs are real concern. Focus on these two aspects are highly required.
- Training on general health and healthy practices with special focus on nutrition and anaemia
- Efforts need to be put in strengthening the functionality of Aneswa clinics
- Workshop to spread awareness on the hazards of early child labour and early marriage
- Strong surveillance on the sources of IFA tablets as private doctors have been found as the chief source of IFA tablets.
- Efforts encouraging engagement with professional association to develop professional skills
- Workshop and sensitisation programmes on HIV intended to update knowledge level on the virus and dislodge misconceptions regarding the same.
- Special efforts are needed on elimination of gender disparity and capacities building of the adolescent girls to enable them to deal with gender issues efficiently and have them equip themselves with leadership qualities and capable of taking decisions independently.

1. DEMOGRAPHIC PROFILE OF NADIA

According to Census data 2011, Nadia had a population of 4,604,827 of which males were 2,366,853 and remaining 2,237,974 were females.

IMAGE 2: NADIA DISTRICT MAP

1.1. Urban

Out of the total Nadia population for 2011 census, 27.81 percent lives in urban regions of district. In total 1,437,591 people lives in urban areas of which males are 732,478 and females are 705,113. Sex Ratio in urban region of Nadia district is 963 as per 2011 census data. Similarly child sex ratio in Nadia district was 945 in 2011 census. Child population (0-6) in urban region was 113,452 of which males and females were 58,328 and 55,124. This child population figure of Nadia district is 7.96 % of total urban population. Average literacy rate in Nadia district as per census 2011 is 85.88 % of which males and females are 89.63 % and 81.98 % literates respectively. In actual number 1,137,131 people are literate in urban region of which males and females are 604,245 and 532,886 respectively.

1.2. Rural

As per 2011 census, 72.19 % population of Nadia districts lives in rural areas of villages. The total Nadia district population living in rural areas is 3,730,897 of which males and females are 1,922,578 and 1,808,319 respectively. In rural areas of Nadia district, sex ratio is 941 females per 1000 males. If child sex ratio data of Nadia district is considered, figure is 958 girls per 1000 boys. Child population in the age 0-6 is 392,543 in rural areas of which males were 200,525 and females were 192,018. The child population comprises 10.43 % of total rural population of Nadia district. Literacy rate in rural areas of Nadia district is 71.50 % as per census data 2011. Gender wise, male and female literacy stood at 75.65 and 67.08 percent respectively. In total, 2,386,942 people were literate of which males and females were 1,302,721 and 1,084,221 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 17: PERSONAL BACKGROUND (N=150)

Age group	11-14 yrs.	15-18 yrs
Religion	54% Hindu, 46% Muslim	49% Muslim, 51% Hindu
Caste	10% OBC	
Marital status	2% married	16% married
Children having Birth Certificate	90%	64%
Children having ration Card	79%	77%
Linkage with any organisation/association	Nil	Nil
Engagement for professional skill development	2% is in Handloom work	Nil

Data regarding marital status reveals that about 16% of the respondents in the age group of 15 to 18 years are married, while it is 2% in the younger age group. The percentage of respondents with birth certificates is higher in the age group of 11 to 14 years than that in the age group of 15 to 18 years. No linkage with any organisation or association has been found among the respondents and about 2% belong to the younger age group are engaged in handloom work.

Table 18: FAMILY BACKGROUND (N=150)

Age group	11-14 yrs.	15-18 yrs
Type of family	4% belongs to joint family	11% belongs to joint family
Fathers Occupation (with %)	36% daily labour, 25% agricultural labourer, 12% small businessman	30% daily labour, 32% agricultural labourer, 16% small businessman
Percentage of children having working mother	24%	30%
Mothers Occupation (with %)	13% daily labour	13% daily labour
Literacy rate of Father	59 illiterate	50% illiterate
Literacy rate of Mother	60% illiterate	60% illiterate
Percentage of Families having history of migration	14%	11%
Percentage of Families having history of missing cases	Nil	1%
School Drop out	34%	34%
Child Labour	6%	18%

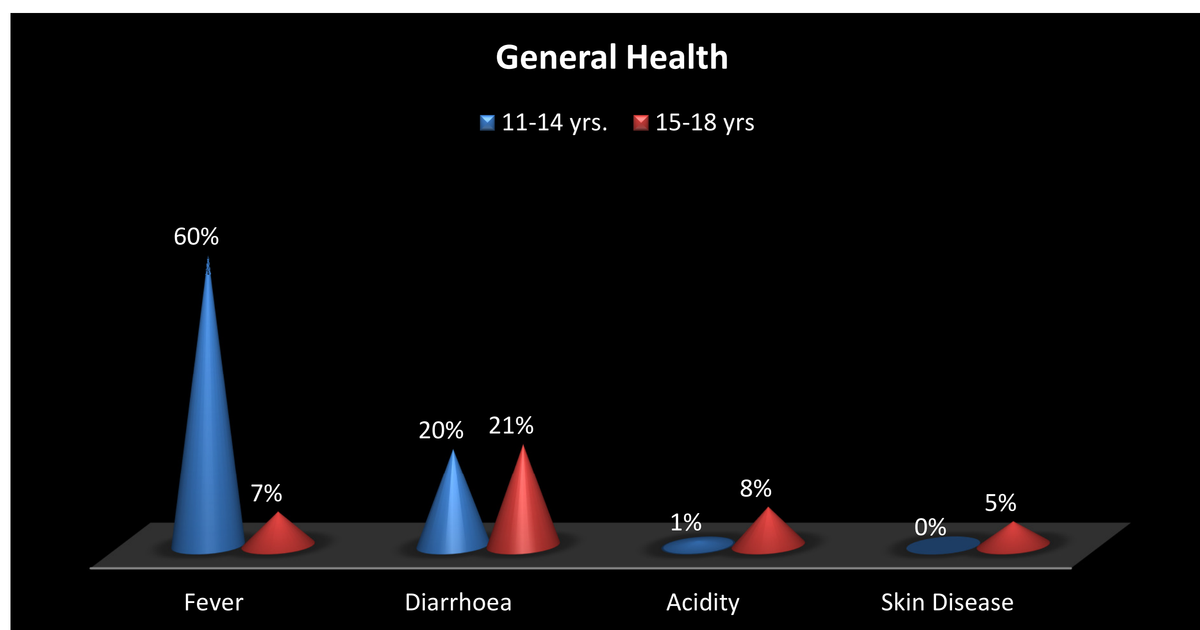
More respondents of the age group of 15 to 18 years belong to joint family, though in terms of overall scenario it is very less. Fathers of most of the respondents are largely daily labourers or are into agriculture. Some of the mothers of the respondents are working and they are daily labourers. Percentage of illiterate mothers is more than that of the fathers of the respondents. Some of the respondents have history of migration. Some cases of missing have been recorded

among the respondents belonging to the age group of 15 to 18 years. About 34% of the respondents in both the age groups have dropped out of school and child labour is more prevalent in the older age group of respondents.

2.2. General Health & Healthy Practices

Table 19: GENERAL HEALTH(N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	4%	2%
Fever	40%	43%
Diarrhoea	9%	3%
Indigestion	0%	1%
Acidity	0%	2%
Skin Disease	0%	1%
Dental Problem	0%	1%
Oral thresh	0%	1%
Problem in eye (other than refractive error)	2%	0%



Fever is the most common illness among the respondents. It is followed by diarrhoea, though it is less in the age group of 15 to 19 years than the younger age group. Though not wide spread, 4% of the respondents belong to the age group of 11 to 14 years and about 2% of the other age group's respondents have problems of refractive error.

Table 20: HEALTHY PRACTICES (N=150)

Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	98%	99%
Regular hair comb	100%	99%
Taking bath daily	98%	98%
Hand Sanitisation after evacuation	98%	97%
Washing hand before taking food with soap	85%	86%
Washing mouth with normal water after taking food (Meal)	94%	98%
Regular nail cutting	97%	91%

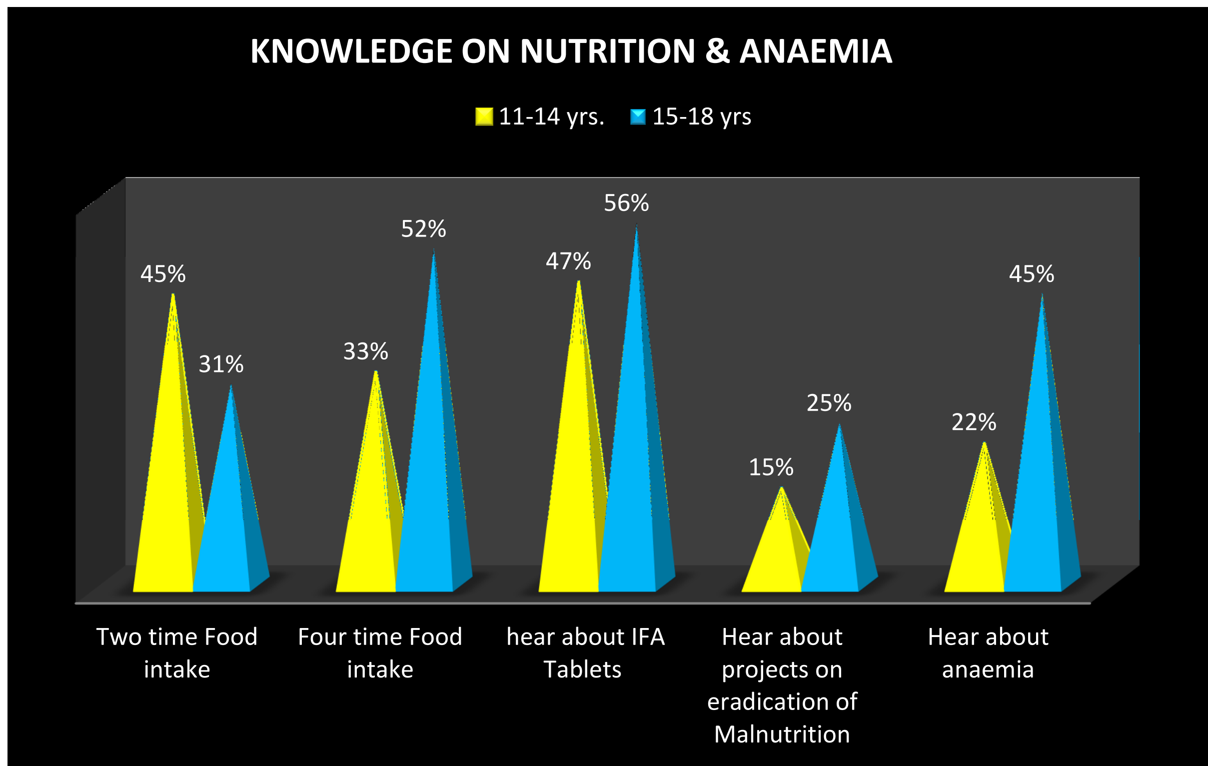
Age group	11-14 yrs.	15-18 yrs
Avg. time of taking food	83%-three times, 2% four times	85%-three times, 3%-four times

Overall health practices are prevalent among the respondents. Majority of the respondents have food three times a day.

2.3. Knowledge of Anaemia & Nutrition

Table 21: KNOWLEDGE ON NUTRITION & ANAEMIA (N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	83%	73%
Percentage of Girls appreciating Four time intake of food is sufficient for them	10%	23%
Percentage of girls hear about IFA Tablets	70%	89%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	17%	25%
Percentage of girls hear about anaemia	21%	49%



Majority of the respondents appreciate food intake twice per day. However, about 10% of the respondents of the age group of 11 to 14 years and about 23% of the respondents belonging to the age group of 15 to 18 years favour taking food four times a day. Awareness of IFA tablets is more in the age group of 15 to 18 years than that in the age group of 11 to 14 years. Most of the respondents are not aware of projects on eradication of malnutrition. About 49% of the respondents belonging to the age group of 15 to 18 years have heard about anaemia, though it is very less among the respondents of the younger age group.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 22: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=150)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	0%	9%
ANM/Govt Doctor	8%	4%
RMP/Quack Doctor	0%	2%
Local Medicine Shop	0%	0%
NGO Worker	2%	0%
AWW	2%	6%
Friend	2%	6%
Teacher/Ponchayet Member	0%	3%
Family Member	8%	5%
Others	2%	1%

Private doctors are the chief source of information on anaemia for the adolescent girls of the older age group of the study. ANM and Government doctors also play a crucial role in this. Family members and friends are also good source of information regarding anaemia. Angan Wari Workers also have their role in it. However, overall information source on anaemia is poor.

Table 23: KNOWLEDGE ON REASON FOR ANAEMIA (N=150)

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	2%	4%
Excessive hard work	2%	1%
For any infection	2%	4%
Lack of iron rich food	2%	3%
Infection for which body release iron more than it required	0%	0%
Excessive Bleeding	0%	3%
Malaria	0%	0%
Rapid growth in adolescent coupled with insufficient iron rich food	2%	1%
Pregnancy	0%	1%
Not Known	47%	28%
Others	0%	0%

Reason for anaemia is mostly unknown to the respondents. Age group of 15 to 18 years are more aware of the reasons than the younger age group of 11 to 14 years. Common reasons known to the respondents for anaemia are insufficient intake of food, infection, lack of iron rich food and excessive bleeding.

Table 24: SYMPTOMS OF ANAEMIA(N=150)

Age group	11-14 yrs.	15-18 yrs
Weakness	2%	10%
Tiredness/Feelings of imbalance	6%	10%
Vomiting tendency	0%	5%
Pale appearance of reddish part of body, like- throat, eye etc	0%	0%
Breathing problem after any work	0%	2%
Headache	0%	0%
Black out	0%	0%
Feeling not to take food/rejection of food	0%	0%
Not Known	49%	33%
Others	0%	0%

Weakness, tiredness, vomiting tendency and feeling of imbalance are the most common symptom of anaemia known to the respondents. However, majority of the respondents are not aware of the symptoms of anaemia.

Table 25: SOURCE TO RECEIVE IFA TABLETS(N=150)

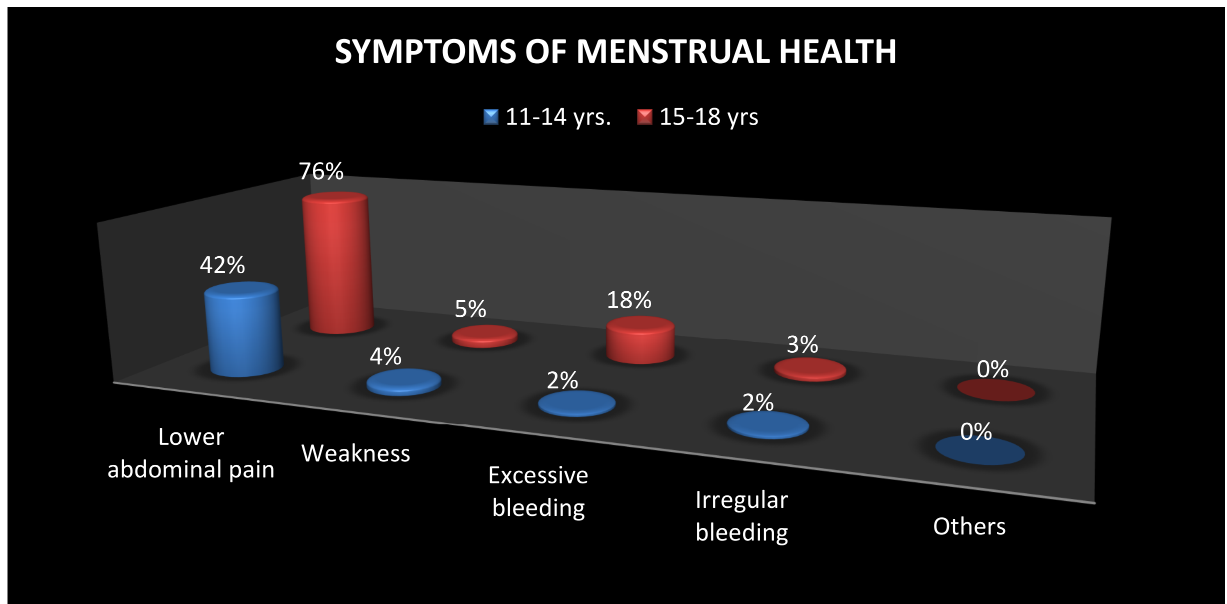
Age group	11-14 yrs.	15-18 yrs
Private doctor	0%	0%
Primary health centre/sub centres	13%	6%
RMP	0%	1%
Local medicine shop	0%	1%
School	30%	18%
AWW	21%	9%
Youth meeting	0%	0%
Industry	0%	0%
Home	0%	2%
Village health mela	2%	0%
Others	0%	0%

School comes out to be the major source of IFA tables for all of the respondents, and it is followed by Angan Wari Workers.

2.5. Menstrual Health

Table 26: SYMPTOMS OF MENSTRUAL HEALTH(N=150)

Age group	11-14 yrs.	15-18 yrs
Lower abdominal pain	42%	76%
Weakness	4%	5%
Excessive bleeding	2%	18%
Irregular bleeding	2%	3%
Others	0%	0%



Lower abdominal pain is experienced by most of the respondents during menstrual period. Excessive bleeding especially by the older age group of respondents and weakness for all are other experiences the respondents undergo during menstrual period. Cases of irregular bleeding are less than the other symptoms.

Table 27: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=150)

Age group	11-14 yrs.	15-18 yrs
White discharge with bad odour	17%	45%
Abdominal pain except during menstruation	4%	9%
Itching in genital area	2%	2%
Burning sensation during urination	6%	6%
Rashes in genital area	0%	1%
Pain during urination	0%	5%
Others	0%	0%

White discharge with bad odour has been experienced by most of the respondents, especially by the age group of 15 to 18 years in last six months during menstrual period. Some of the respondents have suffered abdominal pain as well. Burning sensation during urination has been faced by some of the respondents. Pain during urination has been felt by the older age group of the respondents.

Table 28: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=150)

Age group	11-14 yrs.	15-18 yrs
Local doctor	6%	12%
Anwesha clinic	0%	0%
ANM/ Govt. doctor	0%	2%
RMP	0%	1%

Age group	11-14 yrs.	15-18 yrs
Local medicine shop	0%	0%
NGO staff	0%	0%
AWW	0%	0%
Teacher	0%	0%
Others	0%	0%

Local doctors are major source of treatment for menstrual problems followed by ANM and Government doctors. Some of the respondents have mentioned about RMP as well.

2.6. HIV/ AIDS

Table 29: KNOWLEDGE ON HIV/AIDS (N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	2%	9%
Percentage of Girls having complete information on HIV transmission	0%	0%
Percentage of Girls having complete information on HIV prevention	0%	0%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	0%

Knowledge of HIV is poor among the respondents. Some respondents of the older group of 15 to 18 years know about HIV as virus.

Table 30: MISCONCEPTIONS REGARDING HIV/AIDS(N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	0%	34%
Percentage of girls believe HIV could spread through Mosquito bite	21%	30%
Percentage of girls believe HIV could transmit through sharing of food	21%	27%
Percentage of girls believes Usage of condom could reduce HIV infection.	15%	13%
Percentage of girls believe HIV infected person cannot live with other person in family	28%	36%
Percentage of girls believe HIV infected person should not share utensils with others.	34%	45%
Percentage of girls believes HIV infected person should not mix with other member in village.	28%	32%
Percentage of girls believes HIV infected person should not access to medical Treatment services.	4%	25%

About 34% of the respondents belonging to the age group of 15 to 18 years believe that normal and healthy looking person cannot have HIV infection. Misconception about HIV getting transmitted through mosquito is quite high among the respondents. Misconception regarding spread of HIV through sharing of food also exists among the respondents. Most of the respondents are not aware of condom as a safe method against HIV transmission. A large number of respondents in the age group of 15 to 18 years believe that an HIV infected person cannot live with other person in the family and that they should not mix with other persons in the village. Misconception against sharing of utensils with HIV infected person also prevails. About 25% of the respondents of the age group of 15 to 18 years believe that HIV infected person should not have access to medical services.

2.7. Gender Status – Rights, Beliefs & Practices

Table 31: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	70%	70%
Percentage of girls believe girls should not have access to higher education than boys	70%	79%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	60%	73%
Percentage of girls believe decision should be taken by male members within family	43%	57%

Majority of the respondents believe that they should not move outside home without guardians. Most of them also believe that girls should not have access to higher education than that of boys. Most of the respondents believe that household works are the prime responsibility of girls. Regarding final decision making authority within family most of the respondents belonging to the age group of 15 to 18 years are in favour of male members. About 43% of the respondents of the younger age group believe the same.

Table 32: REPRODUCTIVE HEALTH & RIGHTS(N=150)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to take decision not to marry	57%	54%
Percentage of girls believe girls should have right to say about her preferred age of marriage	58%	57%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe boys should have right to say about her preferred age of marriage	29%	26%
Percentage of girls believe boys should have right to take decision not to marry	36%	27%
Percentage of girls believe male should have right to take decision about physical relationship with his mate	0%	40%
Percentage of girls believe female have the responsibility not to conceive	0%	50%
Percentage of girls believe female should not negotiate condom use with her husband/mate	0%	30%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	0%	48%
Percentage of girls believe husband and wife should take joint decision about their child birth	0%	8%
Percentage of girls believe husband and wife should take joint decision about their use for contraception	0%	8%
Percentage of girls believe mothers should have all responsibility for childcare	70%	57%

Majority of the respondents believe that girls should have the freedom to decide when to marry. Very few of them are in favour of boys having the same freedom. About half of the respondents of the age group of 15 to 18 years want boys should have the right to decide about physical relation with his mate. Half of them also are in favour of girls being entitled to decide when to conceive. About 30% of them believe that female should not negotiate condom use during sexual intercourse with her mate and about half of them believe that males have the right to beat his wife if she refuses sexual intercourse. Majority of the respondents in the age group of 11 to 14 years are in favour of mothers taking all the responsibilities for child care. About 57% of the respondents in the age group of 15 to 19 years are also of the same opinion

3. Discussion:

Information on personal background of the respondents surfaces almost equal distribution of the respondents among Hindu and Muslim communities. Child marriage, though not rampant, cannot be overlooked, especially among the respondents of 15 to 18 years age group. Efforts to curb this practice are highly required. Information on physical unpreparedness and consequent health hazards of early marriage needs to be spread in the community. Liasioning with community key influential persons may be considered to optimise the impact. Importance of ration card as a valid official residential and identity proof has to be made known to notch up the coverage. Engagement for skill development needs to be encouraged to have the adolescent girls ready to utilise different job opportunities. Data on family background reveals that the families are largely nuclear with fathers mostly either into agriculture or daily labour. About one third of the mothers are working and most of them are daily wage labourers. Majority of the parents are literate. However, illiteracy is equally high. Parents can be sensitised on impact of education so that their children can be focused for the upliftment of their educational status. About 18% of the respondents in the age group of 15 to 18 years are into child labour and the trend is prevalent even among the younger age group which calls for immediate intervention. Along with this focus is also needed to decrease the load of school dropout as it is quite prevalent among the respondents of both the age groups. Fever is most common ailment followed by Diarrhoea. Refractive error is present among some of the respondents. Healthy practices are largely present. However, washing hands with soap before taking food may be emphasised as it may yield better results in terms of reducing the cases of Diarrhoea and fever. A diet prescribing complete food with resources available may be shared to improve their nutritional status. Knowledge of anaemia is a concern . Sessions or meetings with special focus on the issue may be organised to increase their knowledge level on anaemia and the benefits of IFA tablets. Source of information on anaemia is equally poor. Tying up with different NGOs and Government health functionaries roping in doctors ensuring their active involvement may be considered. Involvement of family members in it may also prove beneficial. Menstrual health is an integral component of female adolescent health. Laying focus on information related to menarche and symptoms of menstruation and how to deal with the same is highly required.

Complications like white discharge with odour, excessive bleeding, lower abdominal pain and some other are common among the adolescent girls. Preferred service points for the treatment of menstrual problems are largely absent. Secretive behaviour is pretty evident. An enabling environment to discuss these issues and resolve related complications needs to be created immediately. Knowledge on HIV is another area of concern. Misconceptions regarding the virus are abundant. Spread of right information on HIV and sensitisation workshop to dismantle misconception need urgent attention. Gender disparity is deep rooted. Right from movement of girls to decision making within family are believed should be regulated by male members. However, the respondents are mostly in favour of deciding their age of marriage. Decision about physical relation and condom use is, quite frequently, supposed to be decided by male members. These core gender issues need to be dealt with efficiently. Sensitisation meeting involving local influential bodies may be organised as a top down approach to have an environment conducive to removing gender bias. Sessions on women empowerment and the capacity building of female adolescents on gender issues are highly recommended.

4. Recommendation:

- Efforts at curbing early marriage are highly recommended. Information on health hazards due to early marriage needs to be disseminated in the community.
- Meetings focusing on the importance of ration card as valid residential as well as identity proof need to be organised.
- Efforts encouraging engagement with professional association to develop professional skills are highly recommended.
- Prevention of child labour is urgently required. Intervention putting emphasis on the seamy side of child labour and how it destroys their future is urgently needed.
- Incidents of school drop outs are real concern. Reasons have to be found out and the issue has to be resolved immediately.
- Workshops addressing importance of hand sanitation need to be arranged as diarrhoea is quite high among the respondents. It may also focus on prescribing the process of making complete food with available resources. Information on nutrition may also be clubbed together.
- Targeting anaemia is a prompt need. Strengthening the source of IFA tablets is equally required. Aneswa clinics may be considered to be properly utilised in this.
- Menstrual complications largely remain unaddressed. In needs immediate intervention. Involvement of Aneswa clinics may prove instrumental in optimising the impact.
- Workshop and sensitisation programmes on HIV intended to update knowledge level on the virus and dislodge misconceptions regarding the same.
- Special efforts have to be rendered on elimination of gender disparity and capacities building of the adolescent girls to enable them to deal with gender issues efficiently and have them equip themselves with leadership qualities and capable of taking decisions independently.

1. DEMOGRAPHIC PROFILE OF PURULIA

According to Census data 2011, Puruliya had population of 2,927,965 of which male and female were 1,497,656 and 1,430,309 respectively.

IMAGE 3: PURULIA DISTRICT MAP

1.1. Urban

Out of the total Puruliya population for 2011 census, 12.75 percent lives in urban regions of district. In total 373,381 people lives in urban areas of which males are 192,836 and females are 180,545. Sex Ratio in urban region of Puruliya district is 936 as per 2011 census data. Similarly child sex ratio in Puruliya district was 938 in 2011 census. Child population (0-6) in urban region was 42,492 of which males and females were 21,928 and 20,564. This child population figure of Puruliya district is 11.37 % of total urban population. Average literacy rate in Puruliya district as per census 2011 is 76.24 % of which males and females are 84.68 % and 67.21 % literates respectively. In actual number 252,254 people are literate in urban region of which males and females are 144,727 and 107,527 respectively.

1.2. Rural

As per 2011 census, 87.25 % population of Puruliya districts lives in rural areas of villages. The total Puruliya district population living in rural areas is 2,554,584 of which males and females are 1,304,820 and 1,249,764 respectively. In rural areas of Puruliya district, sex ratio is 958 females per 1000 males. If child sex ratio data of Puruliya district is considered, figure is 948 girls per 1000 boys. Child population in the age 0-6 is 351,070 in rural areas of which males were 180,237 and females were 170,833. The child population comprises 13.81 % of total rural population of Puruliya district. Literacy rate in rural areas of Puruliya district is 63.75 % as per census data 2011. Gender wise, male and female literacy stood at 77.96 and 48.93 percent respectively. In total, 1,404,686 people were literate of which males and females were 876,728 and 527,958 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 33: PERSONAL BACKGROUND (N=148)

Age group	11-14 yrs.	15-18 yrs
Religion	85% Hindu	88% Hindu
Caste	54% SC, 10% ST	58% SC, 12% ST
Marital status	100% Unmarried	4% married
Children having Birth Certificate	69%	53%
Children having ration Card	48%	67%
Linkage with any organisation/association	Nil	Nil
Engagement for professional skill development	2% computer	2% computer

Interpretation of data regarding personal background of the respondents shows that overall status of birth certificate is poor among the respondents in Purulia district. The younger age group of 11 to 14 years have more birth certificates than the other group of respondents. About 4% of the respondents in the age group of 15 to 18 years are married. More than half of the respondents are SC and about 11% are ST. Computer literacy among 2% of the respondents of both the groups has been reported.

Table 34: FAMILY BACKGROUND (N=148)

Age group	11-14 yrs.	15-18 yrs
Type of family	31% belongs to joint family	22% belongs to joint family
Fathers Occupation (with %)	18% daily labour, 52% agricultural labourer	41% in agriculture
Percentage of children having working mother	73%	40%
Literacy rate of Father	57% illiterate	45% illiterate
Literacy rate of Mother	82% illiterate	73% illiterate
Percentage of Families having history of migration	8%	10%
Percentage of Families having history of missing cases	Nil	3%
School Drop out	33%	45%
Child Labour	8%	19%

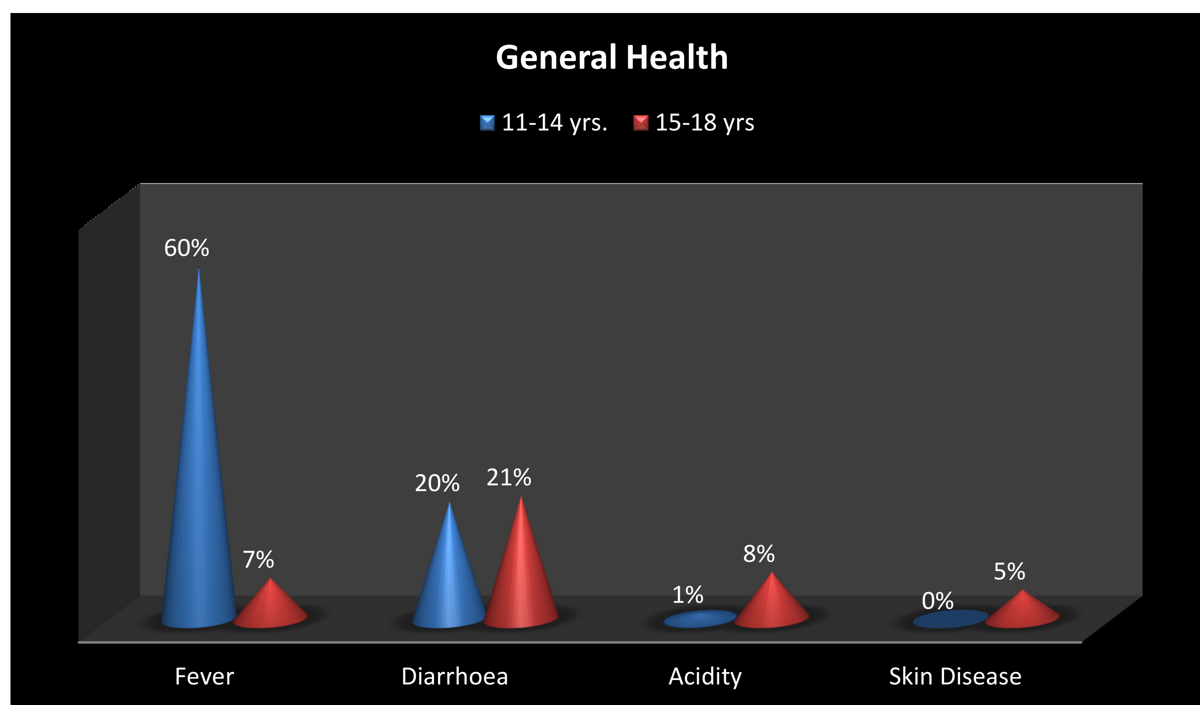
A large number of the respondents in Purulia district belong to joint family and occupation is largely agriculture. However, it is followed by daily wage labourer. More working mothers have been found among the group of 11 to 14 years, though in the other group it is about 40%. Number of illiterate mothers is more than that of the illiterate fathers. Very few of the families of the respondents in both the age groups have history of migration. About 3% history of missing cases have been reported in the age group of 15 to 18 years. About half of the respondents in the older age group have dropped out of school and a little less in number of respondents in the

other age group are also school drop outs. Child labour is quite high among the respondents of the older age group.

2.2. General Health & Healthy Practices

Table 35: GENERAL HEALTH(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	4%	1%
Fever	56%	49%
Diarrhoea	5%	17%
Indigestion	3%	5%
Acidity	0%	1%
Skin Disease	0%	1%
Dental Problem	1%	1%
Oral thresh	0%	1%
Problem in eye (other than refractive error)	1%	1%



Fever is the most common sickness among the respondents followed by diarrhoea and indigestion. Refractive error, though less number, is more among the younger age group of respondents in Purulia.

Table 36: HEALTHY PRACTICES (N=148)

Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	97%	92%
Regular hair comb	97%	97%
Taking bath daily	97%	95%
Hand Sanitisation after evacuation	67%	65%
Washing hand before taking food with soap	62%	62%
Washing mouth with normal water after taking food (Meal)	63%	83%

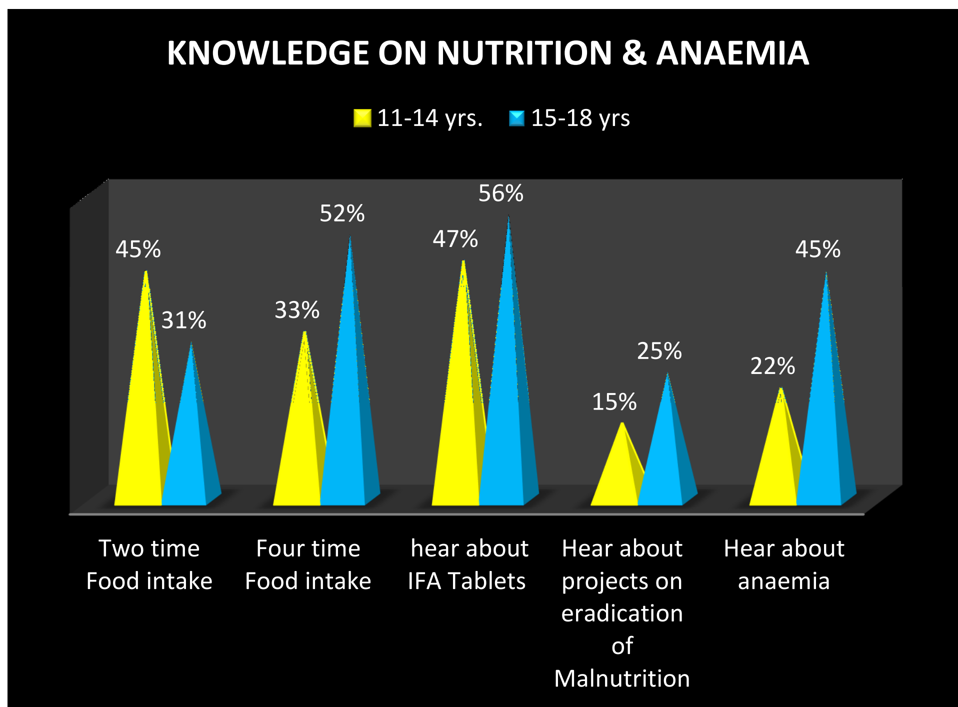
Regular nail cutting	84%	88%
Avg. time of taking food	80%-three times	66%-three times, 29%-four times

Healthy practice shows a mixed response. Brushing teeth, regular hair comb and taking bath regularly are practiced. However, hand sanitation before and after taking food is not practiced by a large number of respondents. Washing mouth after taking food is more prevalent among the older group than that in the younger group of respondents. Regular nail cutting is generally practiced. However, it is not followed by about 14% of the respondents. Average frequency of taking food trice a day among the respondents of the 11 to 14 years' age group is about 80% and the same is about 66% in the other age group. About 29% of them take food four times a day.

2.3. Knowledge of Anaemia & Nutrition

Table 37: KNOWLEDGE ON NUTRITION & ANAEMIA(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	78%	64%
Percentage of Girls appreciating Four time intake of food is sufficient for them	11%	29%
Percentage of girls hear about IFA Tablets	73%	89%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	0%	37%
Percentage of girls hear about anaemia	18%	49%



Majority of the respondents appreciate intake of food twice a day. However, more than a quarter of the respondents in the older age group appreciate the same four times a day. Overall awareness of IFA tablet is high and it is higher in the age group of 15 to 19 years. About 37% of the respondents in the same age group have heard of projects on eradication of malnutrition among adolescent girls. Awareness of anaemia is prevalent among 49% of the respondents in the older age group. About 18% in the other age group are also aware of anaemia.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 38: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=148)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	0%	0%
ANM/Govt Doctor	2%	%
RMP/Quack Doctor	0%	1%
Local Medicine Shop	0%	0%
NGO Worker	0%	0%
AWW	7%	13%
Friend	4%	7%
Teacher/Ponchayet Member	1%	17%
Family Member	1%	7%
Others	0%	1%

Source of information on anaemia for adolescent girls is poor in Purulia district. However, Angan Wari Workers are the chief source of information for the same in the distirct. Panchayat members and teachers also play a significant role in it in the scarce availability of source.

Table 39: KNOWLEDGE ON REASON FOR ANAEMIA(N=148)

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	3%	9%
Excessive hard work	3%	8%
For any infection	0%	1%
Lack of iron rich food	0%	4%
Infection for which body release iron more than it required	0%	5%
Excessive Bleeding	0%	3%
Malaria	0%	1%
Rapid growth in adolescent coupled with insufficient iron rich food	0%	0%
Pregnancy	3%	5%
Not Known	49%	49%
Others	4%	0%

Mostly reason for anaemia is unknown among the respondents. With the little information on reason of anaemia available, the age group of 15 to 18 years are more aware of the reasons than the other group of respondents. Insufficient intake of food and excessive hard work are the main reasons known to the older age group of respondents. Lack of iron rich food, infection causing iron release from body, excessive bleeding are some of the other reasons known to the same age group.

Table 40: SYMPTOMS OF ANAEMIA(N=148)

Age group	11-14 yrs.	15-18 yrs
Weakness	4%	9%
Tiredness/Feelings of imbalance	7%	21%
Vomiting tendency	7%	8%
Pale appearance of reddish part of body, like- throat, eye etc	1%	7%
Breathing problem after any work	0%	4%
Headache	0%	7%
Black out	3%	13%
Feeling not to take food/rejection of food	1%	3%
Not Known	44%	35%
Others	0%	0%

Symptoms of anaemia are largely unknown to the respondents. Tiredness, feeling of imbalance, weakness, vomiting tendency and black out are some of the symptoms responded mostly by the age group of 15 to 18 years age.

Table 41: SOURCE TO RECEIVE IFA TABLETS(N=148)

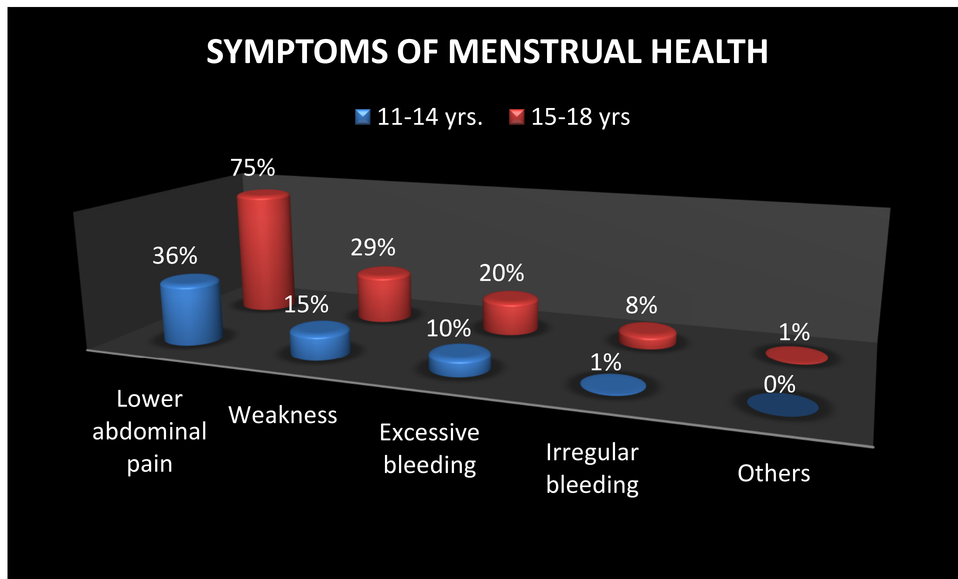
Age group	11-14 yrs.	15-18 yrs
Private doctor	0%	1%
Primary health centre/sub centres	1%	3%
RMP	0%	0%
Local medicine shop	0%	3%
School	38%	41%
AWW	26%	29%
Youth meeting	0%	0%
Industry	0%	0%
Home	0%	1%
Village health mela	0%	3%
Others	3%	0%

School is the major source of IFA tablets. Angan Wari Workers also play a significant role in distributing IFA tablets.

2.5. Menstrual Health

Table 42: SYMPTOMS OF MENSTRUAL HEALTH(N=148)

Age group	11-14 yrs.	15-18 yrs
Lower abdominal pain	18%	45%
Weakness	3%	5%
Excessive bleeding	1%	1%
Irregular bleeding	0%	0%
Others	0%	0%



Lower abdominal pain is mostly experienced by the respondents during menstrual period and it is more prevalent among the respondents belonging to the age group of 15 to 18 years than the other age group. Weakness and excessive bleeding are also experienced by them on fewer occasions.

Table 43: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=148)

Age group	11-14 yrs.	15-18 yrs
White discharge with bad odour	12%	21%
Abdominal pain except during menstruation	18%	24%
Itching in genital area	3%	8%
Burning sensation during urination	4%	4%
Rashes in genital area	3%	4%
Pain during urination	1%	4%
Others	0%	0%

Abdominal pain and white discharge with foul odour have been generally experience by the respondents in the last six months during menstruation and it is more common in the age group of 15 to 18 years. Itching in genital areas has also been felt some of the respondents during menstruation in the last six months and the older age group of respondents have experienced it more than the respondents of other age group. Burning sensation during urination and rashes in the genital area have been experienced by some of the respondents of both the age groups. Some of them have suffered pain during urination.

Table 44: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=148)

Age group	11-14 yrs.	15-18 yrs
Local doctor	0%	4%
Anwesha clinic	1%	0%
ANM/ Govt. doctor	0%	9%

Age group	11-14 yrs.	15-18 yrs
RMP	0%	0%
Local medicine shop	0%	0%
NGO staff	0%	0%
AWW	0%	0%
Teacher	0%	0%
Others	0%	0%

Service points for treatment of menstrual problem are marked by their absence in the district. Doctors and ANM have been mentioned by some of the respondents as preferred service points for treatment of menstrual complications.

2.6. HIV/ AIDS

Table 45: KNOWLEDGE ON HIV/AIDS(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	4%	15%
Percentage of Girls having complete information on HIV transmission	0%	0%
Percentage of Girls having complete information on HIV prevention	0%	0%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	0%

Knowledge on HIV/AIDS among the respondents is very poor. About 9.5% of the all respondents have heard of HIV as a virus.

Table 46: MISCONCEPTIONS REGARDING HIV/AIDS(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	22%	25%
Percentage of girls believe HIV could spread through Mosquito bite	10%	47%
Percentage of girls believe HIV could transmit through sharing of food	8%	37%
Percentage of girls believes Usage of condom could reduce HIV infection.	15%	21%
Percentage of girls believe HIV infected person cannot live with other person in family	18%	39%
Percentage of girls believe HIV infected person should not share utensils with others.	21%	39%
Percentage of girls believes HIV infected person should not mix with other member in village.	12%	30%
Percentage of girls believes HIV infected person should not access to medical Treatment services.	12%	32%

About 25% of the respondents belonging to the age group of 15 to 18 years and 22% of the other group believe that normal and healthy looking person cannot have HIV infection. Misconception about HIV getting transmitted through mosquito is quite high among the respondents of the older age group. Misconception regarding spread of HIV through sharing of food also exists among the respondents and it is also high in the same age group. Most of the respondents are not aware of condom as a safe method against HIV transmission. A large number of respondents in the age group of 15 to 18 years believe that an HIV infected person cannot live with other person in the family and that they should not mix with other persons in the village. Misconception against sharing of utensils with HIV infected person largely prevails among all the respondents. About 32% of the respondents of the age group of 15 to 18 years believe that HIV infected person should not have access to medical services.

2.7. Gender Status – Rights, Beliefs & Practices

Table 47: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	27%	24%
Percentage of girls believe girls should not have access to higher education than boys	23%	28%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	46%	53%
Percentage of girls believe decision should be taken by male members within family	32%	29%

Gender discrimination leads to restriction of movement among the adolescent girls in Purulia district.

About 27% of the respondents in the age group of 11 to 14 years and 24% of the other age group believe they should not move outside home without guardians. Most of the respondents believe that household duties are the prime responsibility of girls. About 32% of the younger age group and 29% belonging to the age group of 15 to 18 years believe that decisionshould be taken by male members within family. A considerable number of respondents in both the age groups are of the view that boys should have more access to education than girls.

Table 48: REPRODUCTIVE HEALTH & RIGHTS(N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to take decision not to marry	48%	20%
Percentage of girls believe girls should have right to say about her preferred age	43%	23%

Age group	11-14 yrs.	15-18 yrs
of marriage		
Percentage of girls believe boys should have right to say about her preferred age of marriage	26%	30%
Percentage of girls believe boys should have right to take decision not to marry	22%	9%
Percentage of girls believe male should have right to take decision about physical relationship with his mate	26%	27%
Percentage of girls believe female have the responsibility not to conceive	14%	33%
Percentage of girls believe female should not negotiate condom use with her husband/mate	0%	38%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	0%	65%
Percentage of girls believe husband and wife should take joint decision about their child birth	0%	65%
Percentage of girls believe husband and wife should take joint decision about their use for contraception	0%	17%
Percentage of girls believe mothers should have all responsibility for	25%	31%

Age group	11-14 yrs.	15-18 yrs
childcare		

A major deviation catches notice when it comes to the authority to decide on marriage. Almost half of the respondents in the younger age group believe that girls should have the authority to decide the same while the percentage of respondents of the older age group opining on the same issue is very low. 30% of the respondents in the age group of 15 to 18 years admit that they like boys to decide on their age of marriage while it is 26% among the other age group answering the same. About one fourth of the respondents believe that boys should decide on physical relation. However, about 33% of the respondents in older age group want girls to be able to decide on when to conceive. About 38% of them do not like to negotiate condom use with husband or mate. Majority of the respondents do not mind husbands beating his wife if she refuses sexual intercourse, although, equal number of respondents are in favour of jointly taking decision on their child birth. A little more than a quarter believe that mothers should have all responsibility for childcare.

3. Discussion:

Data on personal background of the respondents in the Purulia district reveals that about 4% (refer to table no 41) of them in the age group of 15 to 18 years are married. Percentage, though not high among the number of respondents interviewed, may become significantly large when applied to the whole district. Immediate intervention is needed to hold in check the prevailing practice of early marriage. Birth certificate as an important document of age proof has to be popularised as the figure is pretty scarce among the respondents (refer to table no 41). The status of engagement for professional skill development is exceedingly small. Intervention encouraging the same ensuring availability of related opportunities is highly required. About 19% of the respondents in the age group of 15 to 18 years are into child labour and the trend is prevalent even among the younger age group which calls for immediate intervention. School dropout is quite high in both the age group. Reasons behind it have to be found out and resolved as soon as possible. Agriculture is chief occupation. Mothers are largely illiterate. Fever is most common ailment (refer to table no 43). Preventive and promotive measures call for urgent attention in the community. Hand sanitation needs to be widely encouraged as it is remarkably low among the respondents. It may be accountable for higher percentage of diarrhoea and fever among the respondents. Knowledge on programmes on eradication of malnutrition is awfully weak. Most of the respondents appreciating two time intake of food per day testify to their considerably low knowledge on nutrition. Knowledge on anaemia is equally low. It may be due to the scarcity of information and unavailability of source of information. Teachers and Angan Wari Workers (AWW) contribute to some extent. However, compared to the requirement it is considerably meagre. School and AWWs are the chief source of IFA tablets. Information session on iron deficiency and related issues with scheduled tools and well drawn out strategy may

uplift the knowledge of the respondents on anaemia. Status of knowledge on menstrual health is also poor. Required information on menstrual health and its related complications demonstrating methods of treatment and service points need to be spread and shared among the respondents. Lower abdominal pain and white discharge with foul odour are some of the complications the respondents have cited as their problem and owing to the paucity of service points for treatment the situation is serious and it may soon get worse if focus is not paid immediately. IEC activities and more outreach programmes at the periphery level may be launched to gear up the effort. Information on HIV may be clubbed together in the outreach activities to raise awareness on the virus and dislodge misconceptions. Gender bias is ingrained . Household work has been accepted as the prime responsibility of females within families. However, opinion regarding the age of marriage advocates both male and female participation. Males, although, have been preferred to decide on physical relation.

4. Recommendation:

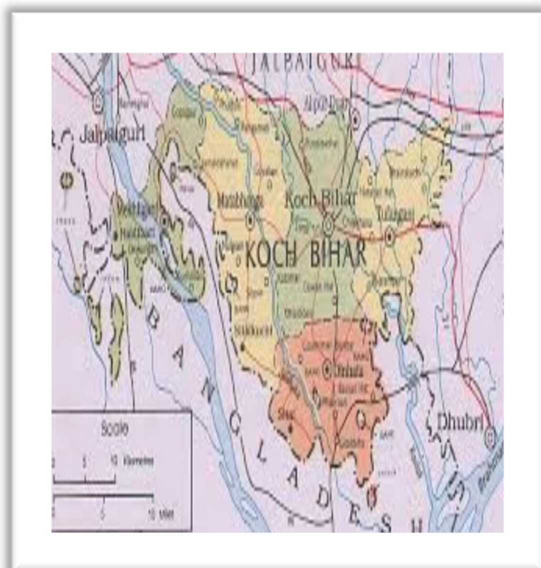
- Efforts at curbing early marriage are highly recommended. Information on health hazards due to early marriage needs to be disseminated in the community.
- Focus on notching up coverage of ration card and birth certificates is necessary. Importance of these two cards as age and identity proof has to be made known to the community and efforts have to be put in to encourage and facilitate coverage without delay.
- Meetings focusing on the importance of birth certificate as valid age proof need to be organised.
- Efforts encouraging engagement with professional association to develop professional skills are highly recommended.
- Prevention of child labour is urgently required. Intervention putting emphasis on the seamy side of child labour and how it destroys their future is urgently needed.
- Incidents of school drop outs are real concern. Reasons have to be found out and the issue has to be resolved immediately.
- Focus on increasing female literacy is essential. Parents are to be included and sensitised as without their support it remains a far cry.
- Workshops addressing nutrition and anaemia need to be organised as the existing knowledge on these topics is considerably low among the respondents.
- Sessions on menstrual health is urgently required. Strengthening the Aneswa clinics and their extensive involvement in disseminating information on adolescent health may prove beneficial. Sources of IFA tablets need strengthening.
- Workshop and sensitisation programmes on HIV intended to update knowledge level on the virus and dislodge misconceptions regarding the same.
- Sessions on eradication of gender disparity focussing on gender rights and related issues are essential to even out the gender inequality.

- Functionality of Aneswa clinic needs to be looked into and their involvement in imparting education related to adolescent health is essential.

1. DEMOGRAPHIC PROFILE OF COOCH BEHAR

According to Census data 2011, In 2011, Cooch Behar had population of 2,822,780 of which male and female were 1,453,590 and 1,369,190 respectively.

IMAGE 4: COOCH BEHAR DISTRICT MAP



1.1. Urban

Out of the total Cooch Behar population for 2011 census, 10.25 percent lives in urban regions of district. In total 289,300 people lives in urban areas of which males are 146,592 and females are 142,708. Sex Ratio in urban region of Cooch Bihar district is 974 as per 2011 census data. Similarly child sex ratio in Cooch Behar district was 934 in 2011 census. Child population (0-6) in urban region was 23,882 of which males and females were 12,351 and 11,531. This child population figure of Cooch Behar district is 8.43 % of total urban population. Average literacy rate in Cooch Behar district as per census 2011 is 89.01 % of which males and females are 92.41 % and 85.54 % literates respectively. In actual number 236,261 people are literate in urban region of which males and females are 124,052 and 112,209 respectively.

1.2. Rural

As per 2011 census, 89.75 % population of Cooch Bihar districts lives in rural areas of villages. The total Cooch Behar district population living in rural areas is 2,533,480 of which males and females are 1,306,998 and 1,226,482 respectively. In rural areas of Cooch Behar district, sex ratio is 938 females per 1000 males. If child sex ratio data of Cooch Behar district is considered, figure is 949 girls per 1000 boys. Child population in the age 0-6 is 308,473 in rural areas of which males were 158,247 and females were 150,226. The child population comprises 12.11 % of total rural population of Cooch Behar district. Literacy rate in rural areas of Koch Bihar district is 73.87 % as per census data 2011. Gender wise, male and female literacy stood at 80.25 and 67.07 percent respectively. In total, 1,643,723 people were literate of which males and females were 921,851 and 721,872 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 49: PERSONAL BACKGROUND (N=104)

Age group	11-14 yrs.	15-18 yrs
Religion	79% Hindu, 21% Muslim	22% Muslim, 78% Hindu
Caste	60% SC	57% SC
Marital status	3% Married	18% married
Children having Birth Certificate	Nil	95%
Children having ration Card	91%	97%
Engagement for professional skill development	6% vocational	10% vocational, 3% computer training, 4% handloom work

Information on Personal background of the respondents reveals that most of the respondents in the age group of 15 to 18 years have birth certificates and the same for the another group of respondents is nil. However, ration is card is available with almost all of them. Marriage at the age of 11 to 14 years has been found in the Cooch Behar district and it is quite prevalent in the age group of 15 to 18 years. Engagement with professional skill development programmes is noticeable among both the groups. But, it is less in the younger age group. Some of the respondents of the older age group of 15 to 18 years are engaged with either vocational programmes or computer training or handloom work.

Table 50: FAMILY BACKGROUND (N=104)

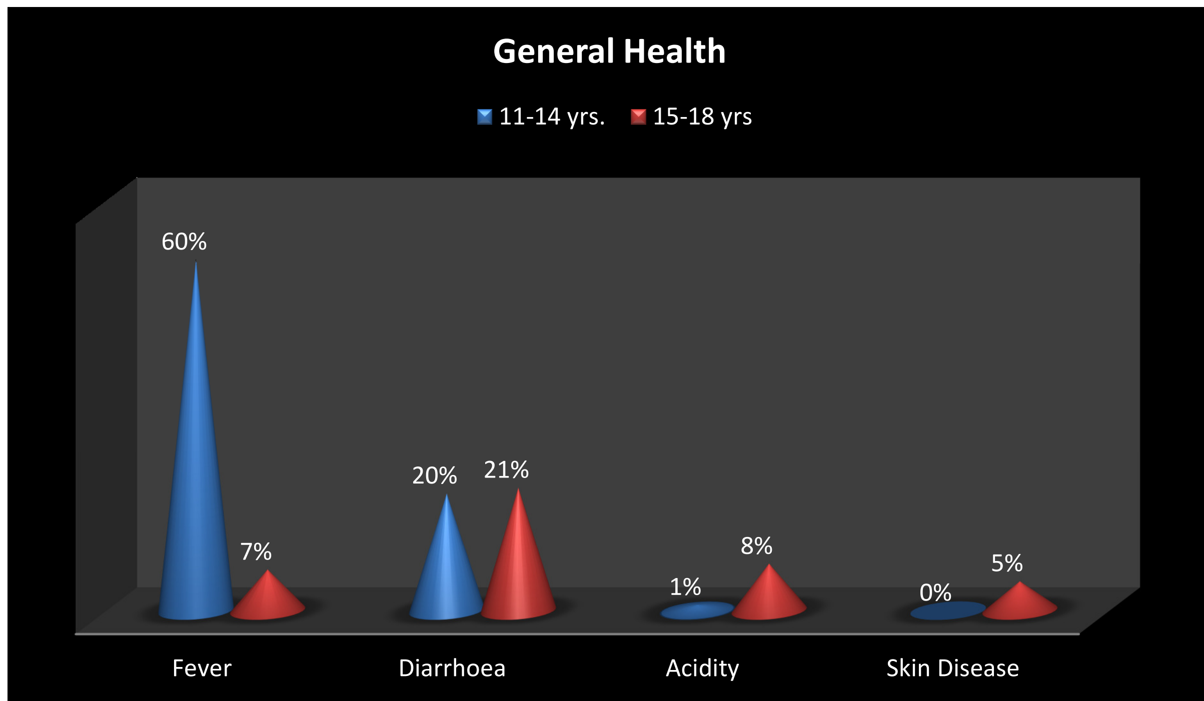
Age group	11-14 yrs.	15-18 yrs
Type of family	6% belongs to joint family	1% belongs to joint family
Fathers Occupation (with %)	72% daily labour	60% daily labourer
Percentage of children having working mother	55%	47%
Mothers Occupation (with %)	39% domestic labourer	30% domestic labourer
Literacy rate of Father	30% illiterate	33% illiterate
Literacy rate of Mother	45% illiterate	58% illiterate
Percentage of Families having history of migration	6%	7%
Percentage of Families having history of missing cases	6%	0%
School Drop out	30%	35%

Family background of the respondents shows that they largely belong to nuclear families. Fathers of the respondents are in most cases daily labourers. About half of the respondents' mothers are working and mostly they are domestic labourers. Literacy is more to be found in the fathers than that in the mothers of the respondents. Some of the families in the younger age group have history of missing cases.

2.2. Genera Health & Healthy Practices

Table 51: GENERAL HEALTH (N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	0%	2%
Fever	63%	53%
Diarrhoea	9%	22%
Indigestion	0%	0%
Acidity	0%	0%
Skin Disease	35%	0%
Dental Problem	0%	3%
Oral thresh	3%	0%
Problem in eye (other than refractive error)	0%	2%



Fever and Diarrhoea are the most common general sickness in both the age groups. Among the rest acidity and indigestion are common problems. Skin disease is major cause of concern among the respondents of the younger age group.

Table 52: HEALTHY PRACTICES (N=104)

Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	100%	100%
Regular hair comb	100%	100%
Taking bath daily	100%	100%
Hand Sanitisation after evacuation	100%	100%
Washing hand before taking food with soap	85%	97%
Washing mouth with normal water after taking food (Meal)	97%	100%

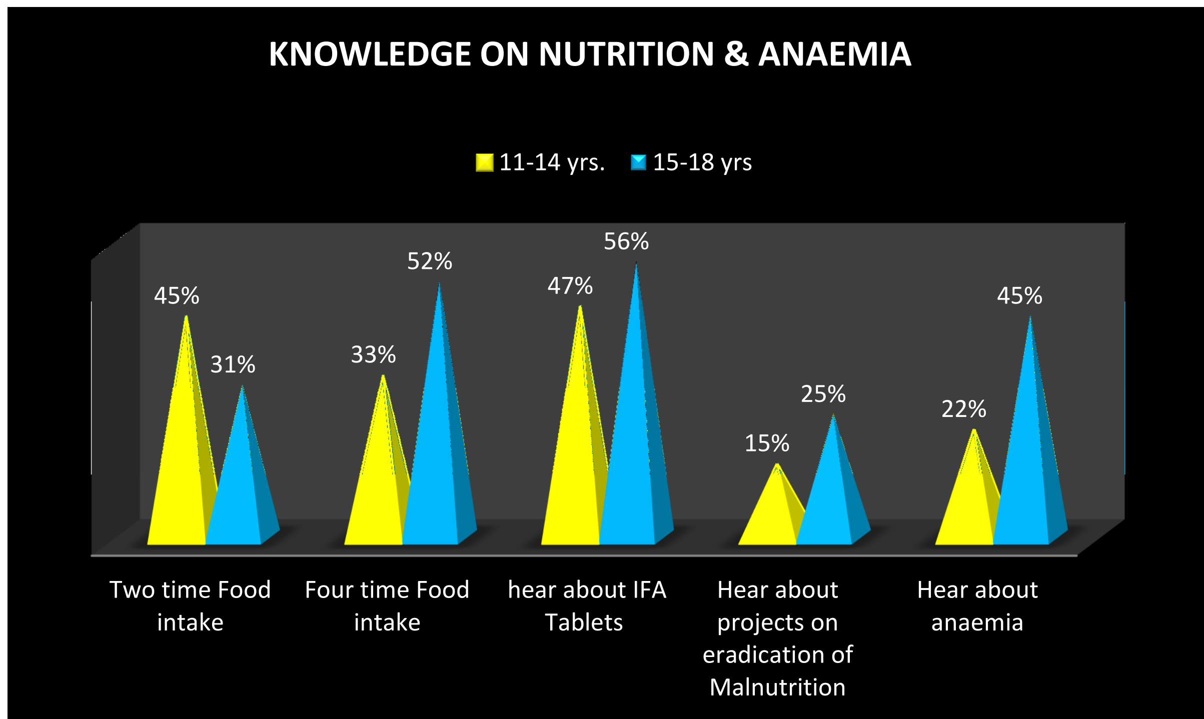
Age group	11-14 yrs.	15-18 yrs
Regular nail cutting	100%	100%
Avg. time of taking food	91%-three times, 6%-four times	94%-three times, 2%-four times

Overall healthy practices prevail among the respondents. Average frequency of taking food is thrice a day for most of the respondents.

2.3Knowledge of Anaemia & Nutrition

Table 53: KNOWLEDGE ON NUTRITION & ANAEMIA(N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	97%(3 times)	97%(3 times)
Percentage of Girls appreciating Four time intake of food is sufficient for them	3%	3%
Percentage of girls hear about IFA Tablets	94%	100%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	58%	75%
Percentage of girls hear about anaemia	79%	92%



Most of the respondents in both the age groups appreciate taking food three times a day and most of them have heard of IFA tablets. Quite a number of respondents in both the age group are aware of projects on eradication of Malnutrition among adolescent girls, thought it is higher among the older age group. About 79% of the respondents in the younger age group have heard about anamia and the percentage for the same among the other age group is about 92%.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 54: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=104)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	0%	1%
ANM/Govt Doctor	0%	0%
RMP/Quack Doctor	0%	1%
Local Medicine Shop	0%	0%
NGO Worker	58%	61%

Age group	11-14 yrs.	15-18 yrs
AWW	76%	75%
Friend	3%	0%
Teacher/Ponchayet Member	0%	0%
Family Member	0%	6%
Others	0%	4%

Angan Wari Workers are the chief source of information on anaemia for adolescent girls followed by NGO Workers.

Table 55: KNOWLEDGE ON REASON FOR ANAEMIA(N=104)

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	73%	79%
Excessive hard work	70%	80%
For any infection	58%	58%
Lack of iron rich food	61%	65%
Infection for which body release iron more than it required	58%	59%
Excessive Bleeding	58%	58%
Malaria	58%	56%

Age group	11-14 yrs.	15-18 yrs
Rapid growth in adolescent coupled with insufficient iron rich food	58%	56%
Pregnancy	58%	56%
Not Known	18%	10%
Others	57%	59%

Excessive hard work and insufficient intake of food are the chief reasons for anaemia known to the respondents. Lack of iron rich food, any kind of infection, infection causing iron release form body, excessive bleeding, malaria and pregnancy are some other reasons for anaemia known to the respondents. A large number of respondents have cited some others behind the same as well, although, some of the respondents, especially those belonging to the younger group do not know any reason for the same.

Table 56: SYMPTOMS OF ANAEMIA(N=104)

Age group	11-14 yrs.	15-18 yrs
Weakness	73%	89%
Tiredness/Feelings of imbalance	73%	87%
Vomiting tendency	61%	59%
Pale appearance of reddish part of body, like- throat, eye etc	58%	62%
Breathing problem after any work	58%	62%
Headache	61%	65%

Black out	58%	59%
Feeling not to take food/rejection of food	58%	58%
Not Known	21%	10%
Others	58%	58%

Weakness, tiredness and feeling of imbalance are the major symptoms of anaemia cited by the respondents. Vomiting tendency, pale appearance of reddish part of body, breathing problem after work, black out, and loss of appetite are some of the other symptoms shown by respondents. About a quarter of the respondents in the age group of 11 to 14 years are not aware of any symptoms.

Table 57: SOURCE TO RECEIVE IFA TABLETS(N=104)

Age group	11-14 yrs.	15-18 yrs
Private doctor	0%	0%
Primary health centre/sub centres	3%	3%
RMP	0%	0%
Local medicine shop	0%	0%
School	0%	0%
AWW	85%	83%
Youth meeting	0%	0%
Industry	0%	0%
Home	0%	0%

Age group	11-14 yrs.	15-18 yrs
Village health mela	0%	0%
Others	0%	1%

Anganwari Workers are the chief source of IFA tablets for all of the respondents.

2.5. HIV/ AIDS

Table 58: KNOWLEDGE ON HIV/AIDS(N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	60%	65%
Percentage of Girls having complete information on HIV transmission	58%	56%
Percentage of Girls having complete information on HIV prevention	57%	57%
Percentage of Girls having complete information on relation of HIV and AIDS	58%	58%

Overall the respondents have moderate knowledge of HIV/ AIDS. About 65% of the respondents in the age group of 15 to 18 years have heard of HIV as a virus and the percentage for the same is about 60% in the younger age group. About 57% of the respondents possess complete information on prevention and relation of HIV.

Table 59: MISCONCEPTIONS REGARDING HIV/AIDS(N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	15%	14%

Percentage of girls believe HIV could spread through Mosquito bite	0%	20%
Percentage of girls believe HIV could transmit through sharing of food	3%	4%
Percentage of girls believes Usage of condom could reduce HIV infection.	12%	6%
Percentage of girls believe HIV infected person cannot live with other person in family	12%	1%
Percentage of girls believe HIV infected person should not share utensils with others.	12%	1%
Percentage of girls believes HIV infected person should not mix with other member in village.	12%	1%
Percentage of girls believes HIV infected person should not access to medical Treatment services.	9%	3%

Some misconceptions regarding HIV exist among the respondents. Some of the respondents believe that normal and healthily looking persons cannot have HIV. Misconception of HIV transmission through mosquito is prevalent among some of the respondents in the age group of 15 to 18 years. About 12% of the respondents in the younger age group of 11 to 14 years believe in the safe use of condom. However, equal number of respondents in the same age group has following misconceptions regarding the virus:

- HIV infected person cannot live with other person in family
- HIV infected person should not share utensils with others.
- HIV infected person should not mix with other member in village.

2.6. Gender Status – Rights, Beliefs & Practices

Table 60: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	73%	73%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not have access to higher education than boys	73%	76%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	21%	16%
Percentage of girls believe decision should be taken by male members within family	3%	8%

About three fourth of the respondents believe that they should not move out of their homes without guardians and that they should not have access to education more than boys. However, majority of them do not endorse household works as the prime responsibilities of females of family. Majority of them also do not think that only male members should take finals decision within family.

Table 61: REPRODUCTIVE HEALTH & RIGHTS(N=104)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to take decision not to marry	15%	13%
Percentage of girls believe girls should have right to say about her preferred age of marriage	67%	86%
Percentage of girls believe boys should have right to say about her preferred age of marriage	0%	11%
Percentage of girls believe boys should have right to take decision not to marry	0%	0%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe male should have right to take decision about physical relationship with his mate	15%	13%
Percentage of girls believe female have the responsibility not to conceive	18%	11%
Percentage of girls believe female should not negotiate condom use with her husband/mate	22%	13%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	15%	7%
Percentage of girls believe husband and wife should take joint decision about their child birth	15%	13%
Percentage of girls believe husband and wife should take joint decision about their use for contraception	67%	86%
Percentage of girls believe mothers should have all responsibility for childcare	0%	11%

About 86% of the respondents in the older age group believe that girls should have the right to decide when to marry and about 67% in the other age group support them. Majority of the respondents do not favour boys taking decision about physical relationship. However, they also do not think that girls should not decide when to conceive. Most of the respondents in both the age group are in favour of joint decision by husband and wife about contraception.

3. Discussion:

Data on personal background of the respondents of Cooch Behar district in the age group of 15 to 18 years reveals that about 18% of the respondents are married. A few of the respondents belonging to the younger age group also have reported their married status. It establishes the trend of early marriage in the district. Intervention to spread awareness on the hazards of early marriage is highly required. Engagement for skill development is also recommended as the status is drastically poor. Women are largely illiterate, though literacy among male members is also very low. School dropout is quite high. Focus on finding out the reasons behind it has to be paid and ways to resolve the issue have to be explored and implemented. Apart from fever which dominates general sickness skin disease too is also another disease burden. Diarrhoea is highly prevalent among the older age group. Prevalence of healthy practice is noteworthy. However, focus has to be paid to assess the reason of high prevalence of fever and skin disease among the respondents. Most of the respondents appreciating two time intake of food being sufficient for them indicates incomplete and poor knowledge on nutrition. However, status of knowledge and information on anaemia reads positive. Steps to strengthen knowledge on nutrition are required. Instructions on intake of complete food with available resources may be passed on to them. AWWs and NGO workers are chief source of information on anaemia. Roping in these two sources to optimise the information flow on nutrition and anaemia may be considered. AWWs are the main sources of IFA tablets. Their role in heightening the knowledge level of the respondents on anaemia, its reasons and symptoms along with issues on menstrual health is instrumental. Role of AWWs may be reconsidered and their integration for improving the scenario may be deliberated upon. However, some of the functional areas may be reengineered along with necessary capacity building and required incentivization to motivate them and have them actively contribute to the expected results. Knowledge on HIV is moderate and misconceptions with regard to the spread of the virus are prevailing among the respondents. Necessary intervention along with focus on IEC activities and sensitisation programmes to raise awareness and eliminate misconceptions are highly required. Information on gender status reveals that the respondents are quite conservative with regard to movement of females outside home without guardians. A large number of them also favour boys having more access to education than girls. Intervention to raise awareness on the benefits of female literacy is essential. Meetings with the administrative departments are also required to create an enabling environment conducive to independent female movement and their overall development.

4. Recommendation:

- Efforts at curbing early marriage are highly recommended. Information on health hazards due to early marriage needs to be disseminated in the community.
- Focus on increasing female literacy is essential. Parents are to be included and sensitised as without their support it remains a difficult task to be accomplished.

- Importance of Birth Certificates has to be made known to the community as the status is alarming among the younger age group of respondents. Efforts have to be put in to increase the coverage without delay.
- Scholl drop out has to be addressed without delay. Community meetings may be arranged with special focus on reasons behind school dropout and exploring ways to prevent the same.
- Functionality of Aneswa clinic needs to be looked into and their involvement in imparting education related to adolescent health is essential.
- Personal care on skin disease has to be focused as it is quite high among the respondents. Workshops with emphasis on nutrition need to be organised and intake of complete food with available resources needs to be encouraged.
- Workshop and sensitisation programmes on HIV intended to update knowledge level on the virus and dislodge misconceptions regarding the same.
- Sessions on eradication of gender disparity focussing on gender rights and related issues are essential to even out the gender inequality.

1. DEMOGRAPHIC PROFILE OF JALPAIGURI

According to Census data 2011, Jalpaiguri had population of 3,869,675 of which male and female were 1,980,068 and 1,889,607 respectively.

IMAGE 5: JALPAIGURI DISTRICT MAP

1.1. Urban

Out of the total Jalpaiguri population for 2011 census, 27.00 percent lives in urban regions of district. In total 1,044,674 people lives in urban areas of which males are 534,277 and females are 510,397. Sex Ratio in urban region of Jalpaiguri district is 955 as per 2011 census data. Similarly child sex ratio in Jalpaiguri district was 943 in 2011 census. Child population (0-6) in urban region was 104,363 of which males and females were 53,704 and 50,659. This child population figure of Jalpaiguri district is 10.05 % of total urban population. Average literacy rate in Jalpaiguri district as per census 2011 is 82.33 % of which males and females are 86.69 % and 77.78 % literates respectively. In actual number 774,196 people are literate in urban region of which males and females are 416,629 and 357,567 respectively.

1.2. Rural

As per 2011 census, 73.00 % population of Jalpaiguri districts lives in rural areas of villages. The total Jalpaiguri district population living in rural areas is 2,825,001 of which males and females are 1,445,791 and 1,379,210 respectively. In rural areas of Jalpaiguri district, sex ratio is 954 females per 1000 males. If child sex ratio data of Jalpaiguri district is considered, figure is 950 girls per 1000 boys. Child population in the age 0-6 is 340,662 in rural areas of which males were 174,677 and females were 165,985. The child population comprises 12.08 % of total rural population of Jalpaiguri district. Literacy rate in rural areas of Jalpaiguri district is 70.55 % as per census data 2011. Gender wise, male and female literacy stood at 78.31 and 62.43 percent respectively. In total, 1,752,822 people were literate of which males and females were 995,436 and 757,386 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 62: PERSONAL BACKGROUND (N=65)

Age group	11-14 yrs.	15-18 yrs
Religion	75% Hindu, 25% Muslim	73% Hindu, 27% Muslim
Caste	21% SC, 15% OBC	54% SC, 9% OBC
Marital status	Nil	3% Married
Children having Birth Certificate	88%	88%
Children having ration Card	87%	94%
Linkage with any organisation/association	Nil	Nil
Engagement for professional skill development	18% computer	9% Vocational, 21% Computer

The table on personal background reveals that most of the respondents in both the age group are having birth certificates. However, some of them do not have the same. Ration card is mostly available and the availability of is more with the older group of respondents than the younger one. Status of engagement for professional skill development is poor among the respondents, though the older group is more engaged than the younger of respondents.

Table 63:FAMILY BACKGROUND (N=65)

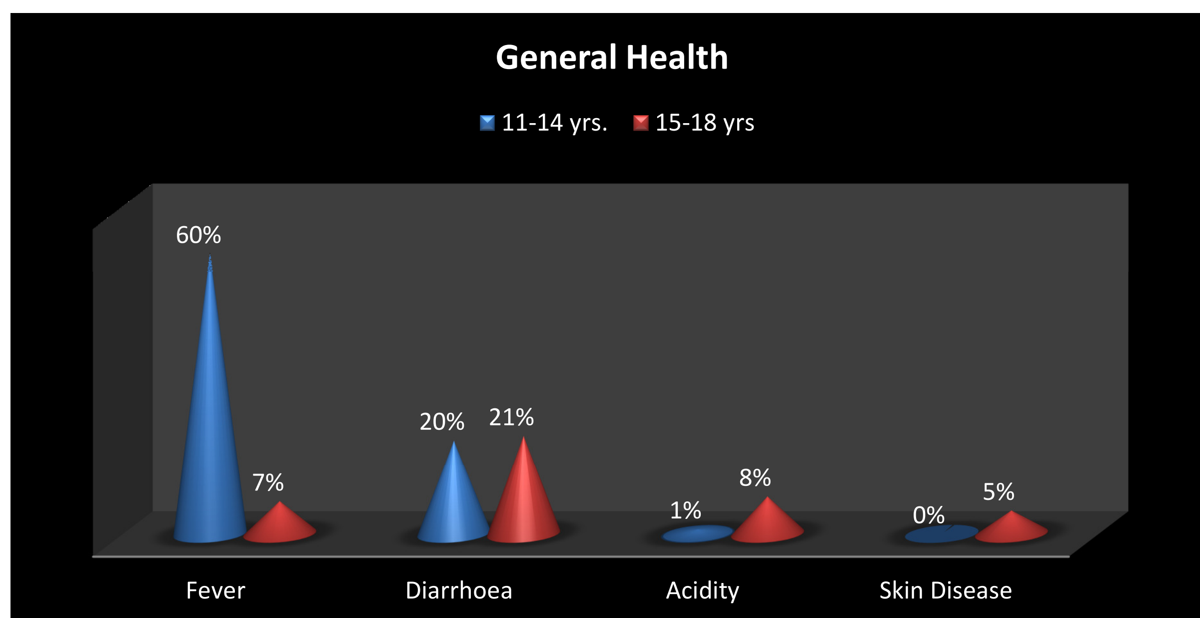
Age group	11-14 yrs.	15-18 yrs
Type of family	12% belongs to joint family	12% belongs to joint family
Fathers Occupation (with %)	15% govt. employee, 25% daily labour, 15% small business	12% daily labour, 36% small businessman
Percentage of children having working mother	25%	42%
Mothers Occupation (with %)	6% daily labour	9% daily labour
Literacy rate of Father	25% illiterate	27% illiterate
Literacy rate of Mother	40% illiterate	42% illiterate
Percentage of Families having history of migration	Nil	3%
Percentage of Families having history of missing cases	Nil	Nil
School Drop out	3%	9%

Family background of the respondents shows that they largely belong to nuclear families. Some of the respondents of the age group of 11to 14 years have fathers working as Government employees and among the rest some have fathers either working as daily labourers or small businessmen. Fathers of the other age group are either small businessmen or daily labourers. Mothers are largely daily labourers. Number of illiterate mothers is more than that of the fathers.

2.2. General Health & Healthy Practices

Table 64: GENERAL HEALTH (N=65)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	6%	0%
Fever	25%	51%
Diarrhoea	12%	18%
Indigestion	6%	6%
Acidity	9%	3%
Skin Disease	3%	3%
Dental Problem	0%	0%
Oral thresh	6%	6%
Problem in eye (other than refractive error)	0%	0%



Fever is most common illness among the respondents followed by diarrhoea. The respondents sometimes suffer from indigestion and acidity also. Skin disease is less prevalent. However, some of the respondents of the younger age group suffer from refractive error.

Table 65: HEALTHY PRACTICES(N=65)

Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	100%	100%
Regular hair comb	100%	100%
Taking bath daily	100%	100%
Hand Sanitisation after evacuation	100%	94%
Washing hand before taking food with soap	90%	88%
Washing mouth with normal water after taking food (Meal)	100%	91%
Regular nail cutting	81%	73%

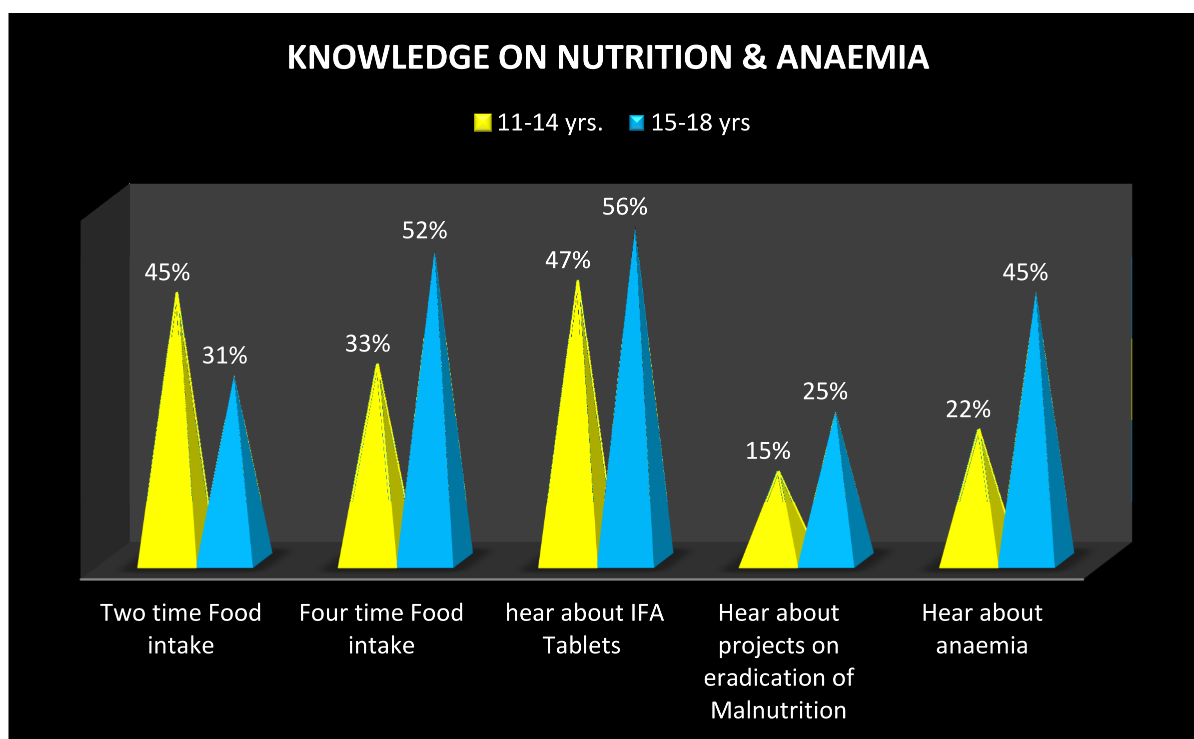
Avg. time of taking food	9%-twice, 84%-three times, 6%- four times	66%-twice, 94%- three times

Status of healthy practice is good among the respondents, though washing hand before taking food and regular nail cutting is relatively less. Average frequency of taking food is twice a day among the respondents of the younger age group and it is three times a day for the age group of 15 to 18 years.

2.3. Knowledge of Anaemia & Nutrition

Table 66:KNOWLEDGE ON NUTRITION & ANAEMIA(N=65)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	91%(3 times)	76%(3 times)
Percentage of Girls appreciating Four time intake of food is sufficient for them	9%	15%
Percentage of girls hear about IFA Tablets	50%	61%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	13%	42%
Percentage of girls hear about anaemia	38%	52%



Most of the respondents appreciate two time intake of food being sufficient for them and it the percentage is higher among the age group of 11 to 14 years. About half of the respondents have heard about IFA tablets. The age group of 15 to 18 years know more about the projects on eradication of malnutrition for adolescent girls than the respondents of the younger age group. Knowledge of anaemia is more among the older age group of respondents than the other one.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 67: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=65)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	6%	0%
ANM/Govt Doctor	0%	0%
RMP/Quack Doctor	0%	0%
Local Medicine Shop	0%	3%
NGO Worker	6%	9%

Age group	11-14 yrs.	15-18 yrs
AWW	3%	18%
Friend	6%	15%
Teacher/Ponchayet Member	3%	0%
Family Member	6%	6%
Others	6%	0%

Source of information on anaemia is scarcely available. Among the sources available Angan Wari Workers top the list followed by friends and family members.

Table 68:KNOWLEDGE ON REASON FOR ANAEMIA(N=65)

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	3%	3%
Excessive hard work	3%	15%
For any infection	3%	3%
Lack of iron rich food	3%	3%
Infection for which body release iron more than it required	3%	0%
Excessive Bleeding	6%	12%

Age group	11-14 yrs.	15-18 yrs
Malaria	0%	3%
Rapid growth in adolescent coupled with insufficient iron rich food	3%	0%
Pregnancy	0%	0%
Not Known	47%	39%
Others	3%	0%

Knowledge on reason for anaemia is largely absent among the respondents. However, some of the major reasons cited by them are excessive hard work and excessive bleeding. Among other reasons they have mentioned insufficient intake of food, infection, lack of iron rich food, malaria and Rapid growth in adolescent coupled with insufficient iron rich food.

Table 69:SYMPTOMS OF ANAEMIA(N=65)

Age group	11-14 yrs.	15-18 yrs
Weakness	3%	12%
Tiredness/Feelings of imbalance	9%	12%
Vomiting tendency	0%	0%
Pale appearance of reddish part of body, like- throat, eye etc	0%	0%
Breathing problem after any work	0%	6%
Headache	6%	3%

Age group	11-14 yrs.	15-18 yrs
Black out	0%	0%
Feeling not to take food/rejection of food	3%	0%
Not Known	50%	39%
Others	3%	0%

Symptoms of anaemia too are mostly unknown to the respondents. However, weaknesses, tiredness, feeling of imbalance, headache and breathing problem are some of the symptoms cited by them.

Table 70:SOURCE TO RECEIVE IFA TABLETS(N=65)

Age group	11-14 yrs.	15-18 yrs
Private doctor	3%	0%
Primary health centre/sub centres	16%	3%
RMP	0%	0%
Local medicine shop	0%	0%
School	3%	6%
AWW	3%	0%
Youth meeting	0%	0%
Industry	0%	0%
Home	0%	0%

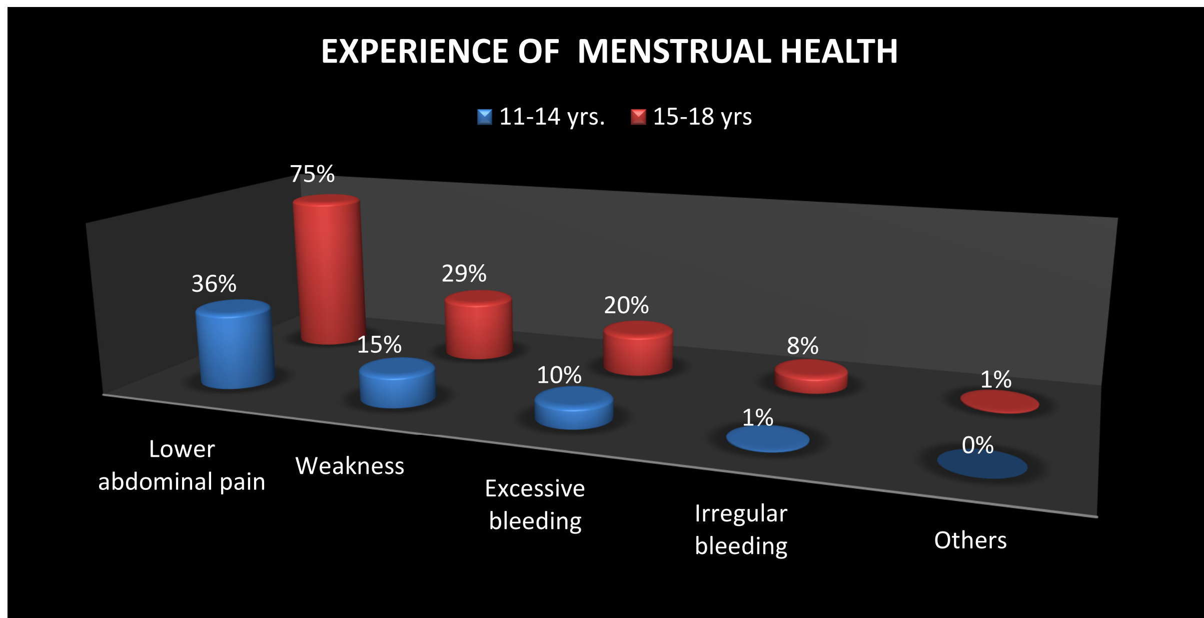
Age group	11-14 yrs.	15-18 yrs
Village health mela	0%	0%
Others	0%	0%

Source to receive IFA tables is hardly available. Primary health centre, sub centre, school and Angan Wari Workers make a little contribution to this.

2.5. Menstrual Health

Table 71:EXPERIENCE OF MENSTRUAL HEALTH(N=65)

Age group	11-14 yrs.	15-18 yrs
Lower abdominal pain	40%	61%
Weakness	28%	30%
Excessive bleeding	3%	3%
Irregular bleeding	0%	6%
Others	0%	0%



Lower abdominal pain is chiefly felt by the respondents during menstruation and it is followed by a feeling of weakness. However, some of them also experience excessive and irregular bleeding sometimes.

Table 72: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=65)

Age group	11-14 yrs.	15-18 yrs
White discharge with bad odour	15%	30%
Abdominal pain except during menstruation	13%	21%
Itching in genital area	3%	0%
Burning sensation during urination	3%	15%
Rashes in genital area	0%	0%
Pain during urination	0%	0%
Others	0%	0%

White discharge with bad odour has been felt by a number of respondents in last six months during menstruation. Lower abdominal pain is also common among some of them. Burning sensation during urination is another experience felt by the respondents in last six months during menstruation. Very few of the respondents in the age group of 11 to 14 years have undergone experience of itching in genital area sometimes.

Table 73: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=65)

Age group	11-14 yrs.	15-18 yrs
Local doctor	3%	9%
Anwesha clinic	0%	0%
ANM/ Govt. doctor	9%	9%
RMP	0%	0%
Local medicine shop	0%	0%
NGO staff	0%	0%
AWW	0%	0%
Teacher	0%	0%
Others	0%	0%

Service points for menstrual problems are largely unavailable. Some of the respondents prefer to visit doctors or ANMs.

2.6. HIV/ AIDS

Table 74: KNOWLEDGE ON HIV/AIDS(N=65)

Age group	11-14 yrs.	15-18 yrs

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	31%	21%
Percentage of Girls having complete information on HIV transmission	3%	9%
Percentage of Girls having complete information on HIV prevention	3%	6%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	0%

Knowledge of HIV is moderate among the respondents. About 30% of the respondents in the age group of 11 to 14 years and 21% of the respondents in the other age group have heard of HIV as a virus. Number of respondents with full knowledge on HIV and the ways it can be prevented is barely countable.

Table 75: MISCONCEPTIONS REGARDING HIV/AIDS(N=65)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	47%	39%
Percentage of girls believe HIV could spread through Mosquito bite	28%	49%
Percentage of girls believe HIV could transmit through sharing of food	31%	9%
Percentage of girls believes Usage of condom could reduce HIV infection.	6%	51%
Percentage of girls believe HIV infected person cannot live with other person in family	9%	15%
Percentage of girls believe HIV infected person should not share utensils with others.	19%	27%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believes HIV infected person should not mix with other member in village.	12%	18%
Percentage of girls believes HIV infected person should not access to medical Treatment services.	3%	24%

Misconception regarding HIV is quite high among the respondents. A little less than half of them believe that normal and healthy looking individual cannot have HIV. Misconception of HIV Transmission through mosquito bite is pretty high among the older age group of respondents. That HIV can spread through touch, food and sharing of utensils also exist among the respondents. About 24% of the respondents in the age group of 15 to 18 years are not in favour of HIV infected persons getting access to medical services.

2.7. Gender Status – Rights, Beliefs & Practices

Table 76: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=65)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	34%	45%
Percentage of girls believe girls should not have access to higher education than boys	59%	61%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	41%	39%
Percentage of girls believe decision should be taken by male members within family	22%	27%

Restriction on movement of girls outside home without guardians fairly exists among the respondents and it is more in the older age group. Majority of them also believe that boys should be preferred to girls when it comes to getting access to higher education. They also opine

that household works are the main responsibilities of the female members in the family. About a quarter of the respondents also believe that male members should take final call on decision making within family.

Table 77: REPRODUCTIVE HEALTH & RIGHTS (N=65)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to take decision not to marry	16%	36%
Percentage of girls believe girls should have right to say about her preferred age of marriage	19%	30%
Percentage of girls believe boys should have right to say about her preferred age of marriage	16%	12%
Percentage of girls believe boys should have right to take decision not to marry	16%	9%
Percentage of girls believe male should have right to take decision about physical relationship with his mate	6%	18%
Percentage of girls believe female have the responsibility not to conceive	25%	55%
Percentage of girls believe female should not negotiate condom use with her husband/mate	41%	34%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	100%	82%

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe husband and wife should take joint decision about their child birth	25%	36%
Percentage of girls believe husband and wife should take joint decision about their use for contraception	0%	27%
Percentage of girls believe mothers should have all responsibility for childcare	28%	46%

All of the respondents in the age group of 11 to 14 years and about 82% in the other age group believe that husband can beat wife if she refuses to have sexual intercourse. However, about 36% of the respondents in the older age group support getting authority to decide when to marry. About 30% of them also believe in deciding the age of marriage. The other group of respondents are relatively less in number in endorsing these two remarks. More than half of the respondents in the age group of 15 to 18 years and about a quarter in the other age group want to take final call on when to conceive. However, some of among them are in favour of joint decision by both husband and wife. Percentage is quite high among the respondents of the older age group when it comes to child care being the prime responsibility of mothers.

3. Discussion:

In Jalpaiguri district about three fourth of the respondents are Hindu and the rest are Muslim. About 54% of them in the age group of 15 to 18 years are Scheduled Caste (SC) and about 10% belong to Other Backward Classes (OBC). More than a quarter of the respondents in the younger age group belong to SC and OBC. Majority of the respondents have birth certificates and ration card. However, efforts for full coverage are needed. Engagement for professional skill development needs to be encouraged as the status is quite poor among the respondents. Among occupation mention must be made of daily labour and small business. Mothers are largely illiterate, though about a quarter of the respondents have illiterate fathers. Fever is most dominant among common ailments and it is followed by diarrhoea and indigestion. There is an anomaly between the status of general health and healthy practices. More focussed efforts have to be put in to ascertain the reasons behind fever and diarrhoea. Regular nail cutting has to be encouraged as it may lessen the frequency of diarrhoea.

Status on the knowledge of nutrition and anaemia is modest. However, efforts may be put in to increase the frequency of food intake per day. Almost half of the respondents have not heard of anaemia which calls for immediate intervention. Sources of information on anaemia is also exceedingly scarce. Strategy to address the issue has to be developed and implemented. Primary Health Centre/ Sub Centre acts as source of IFA tablets, though it is awfully insufficient compared to the need. With regard to menstruation most of the respondents have undergone complications like lower abdominal pain, white discharge with bad odour and burning sensation during urination. The only service points available for treatment of menstrual complications is doctors who are quite less in number. Immediate intervention ensuring availability, affordability and accessibility of service points is needed. HIV is a high focus area. It seems to have remained unaddressed as the knowledge regarding the virus is very low and misconceptions are rampant. Information dissemination along with sensitisation programme is badly needed. Gender bias is observable. Restriction on movement of girls is high. Education is more accessible to boys than to the girls. Female responsibility seems confined within four walls of a family. Responses with regard to the authority to decide on the age of marriage and initiation of physical relation are aligned to the female choices. However, response like husband can beat his wife if she refuses sexual intercourse treads a different track. Respondents are beset with confusion with regard to their gender rights. Focus needs to be paid on demonstrating and illustrating their rights being female and as holistically beneficial for both family and society.

4. Recommendation:

- Focus on notching up coverage of ration card and birth certificates is necessary. Importance of these two cards as age and identity proof has to be made known to the community and efforts have to be put in to encourage and facilitate coverage without delay.
- Efforts encouraging engagement with professional association to develop professional skills are highly recommended.
- Focus on increasing female literacy is essential. Parents are to be included and sensitised as without their support it remains a far cry.
- Workshops addressing importance of hand sanitation need to be arranged as diarrhoea is quite high among the respondents. It may also focus on prescribing the process of making complete food with available resources. Information on nutrition may also be clubbed together
- Focussing on anaemia is a prompt need. Strengthening the source of IFA tablets is equally required. Aneswa clinics may be considered to be properly utilised in this.
- Menstrual complications largely remain unaddressed. In needs immediate intervention. Involvement of Aneswa clinics may prove instrumental in optimising the impact.

- Workshop and sensitisation programmes on HIV is highly to update knowledge level on the virus and dislodge misconceptions regarding the same
- Special efforts have to be rendered on elimination of gender disparity and capacities building of the adolescent girls to enable them to deal with gender issues efficiently and have them equip themselves with leadership qualities and capable of taking decisions independently. Almost all of the respondents accepting husband's authority to beat his wife if she refuses sexual intercourse make them exceedingly vulnerable to gender disparity. It has to be addressed and resolved immediately.

1. DEMOGRAPHIC PROFILE OF KOLKATA

According to Census data 2011, In 2011, Kolkata had population of 4,486,679 of which male and female were 2,362,662 and 2,124,017 respectively.

IMAGE 6: KOLKATA DISTRICT MAP

1.1. Urban

Out of the total Kolkata population for 2011 census, 100.00 percent lives in urban regions of district. In total 4,486,679 people lives in urban areas of which males are 2,362,662 and females are 2,124,017. Sex Ratio in urban region of Kolkata district is 899 as per 2011 census data. Similarly child sex ratio in Kolkata district was 930 in 2011 census. Child population (0-6) in urban region was 300,052 of which males and females were 155,475 and 144,577. This child population figure of Kolkata district is 6.58 % of total urban population. Average literacy rate in Kolkata district as per census 2011 is 87.14 % of which males and females are 89.08 % and 84.98 % literates respectively. In actual number 3,648,210 people are literate in urban region of which males and females are 1,966,122 and 1,682,088 respectively.

2. STUDY FINDINGS

2.1. Respondents' Profile

Table 78: PERSONAL BACKGROUND (N=148)

Age group	11-14 yrs.	15-18 yrs
Religion	49% Muslim, 51% Hindu	49% Muslim, 51% Hindu
Caste	3% ST, 13% OBC	20% OBC
Marital status	1% Married	13% Married
Children having Birth Certificate	80%	75%
Children having ration Card	59%	60%

Age group	11-14 yrs.	15-18 yrs
Linkage with any organisation/association	1% library, 12% club, 1% sports association	3% library, 4% club, 1% NGO, 1% sports
Engagement for professional skill development	10% computer, 7% handloom	1% vocational training, 13% computer, 10% handloom work

About 49% of the respondents in Kolkata are Muslim and the rest are Hindu. About 13% in the older age group are married. Birth certificates are more available among the younger age group than the other. Status of ration card is moderate. Respondents of the age group of 11 to 14 years have more linkages with organisation or association than the respondents of the other age group. About 24% of the respondents in the age group of 15 to 18 years are engaged with some professional skill development especially in the field of computer. Status of the same in the other age group is relatively poor.

Table 79: FAMILY BACKGROUND (N=148)

Age group	11-14 yrs.	15-18 yrs
Type of family	19% belongs to joint family	22% belongs to joint family
Fathers Occupation (with %)	21% daily labour, 11% rickshawpuller, 5% small businessman	9% daily labour, 11% rickshawpullar, 5%small business
Percentage of children having working mother	44%	40%
Mothers Occupation (with %)	10% daily labour	7% daily labour
Literacy rate of Mother	26% illiterate	37% illiterate

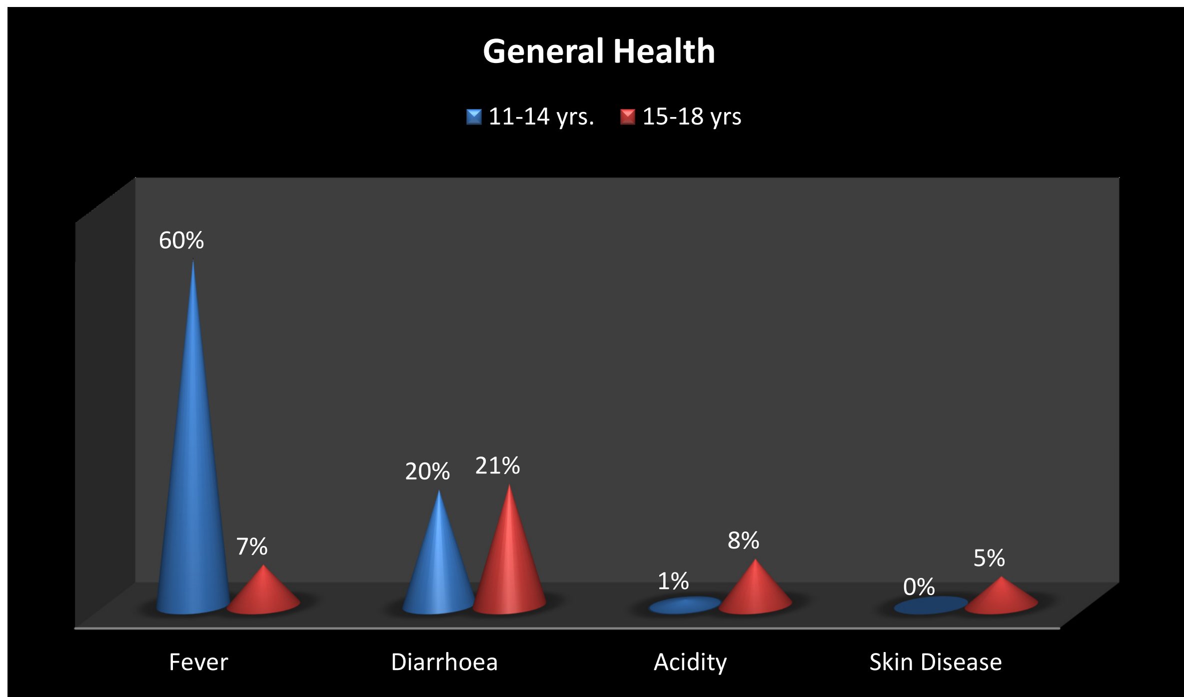
Age group	11-14 yrs.	15-18 yrs
Type of family	19% belongs to joint family	22% belongs to joint family
Percentage of Families having history of migration	31% illiterate	48% illiterate
Percentage of Families having history of missing cases	11%	21%
School Drop out	23%	53%
Child Labour	20%	20%

Reasonably good number of respondents in the older age group of 15 to 18 years belongs to joint family and the same is little less in the younger age group. About 36% of the fathers of the younger age group of respondents are working and most of them are daily labourers followed by rickshaw pullers. In the older age group fathers of the respondents are mostly rickshaw pullers. Some of the fathers of the respondents in both the age group are small businessmen. About 42% of the respondents have working mothers. Migration is more evident in the older age group than the younger one. History of missing cases is quite prominent in both the age groups and it is considerably high among the respondents pertaining to the age group of 15 to 18 years. School dropout is alarmingly high and child labour is highly prevalent among respondents of both the age groups.

2.2. General Health & Healthy Practices

Table 80: GENERAL HEALTH (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage having problem in vision (Refractive error)	22%	15%
Fever	60%	7%
Diarrhoea	20%	21%
Indigestion	3%	3%
Acidity	1%	8%
Skin Disease	0%	5%
Dental Problem	1%	3%
Oral thresh	4%	5%
Problem in eye (other than refractive error)	4%	7%



Fever is the most common illness among the respondents followed by refractive error and diarrhoea. Vision problem chiefly refractive error exists more in the younger age group than the other. Indigestion, acidity, skin disease, dental problem and oral thresh have been found among some of them.

Table 81: HEALTHY PRACTICES (N=148)

Age group	11-14 yrs.	15-18 yrs
Brushing of teeth in morning	100%	100%
Regular hair comb	100%	100%
Taking bath daily	99%	100%

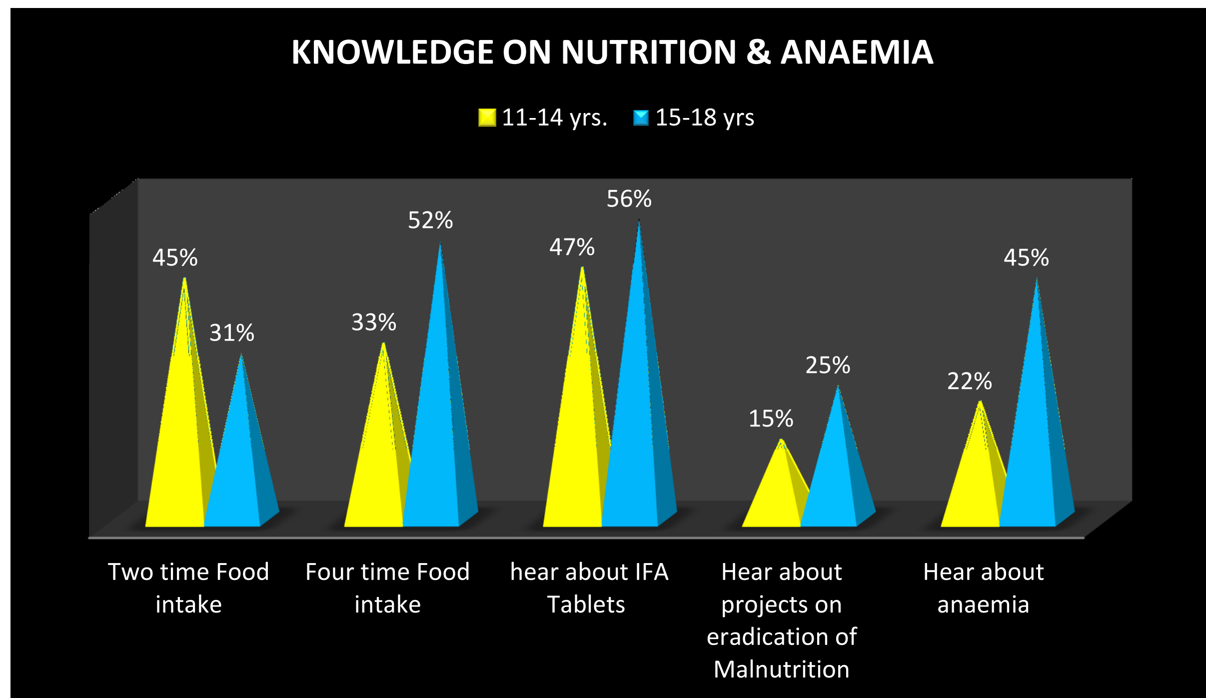
Age group	11-14 yrs.	15-18 yrs
Hand Sanitisation after evacuation	88%	100%
Washing hand before taking food with soap	60%	55%
Washing mouth with normal water after taking food (Meal)	88%	100%
Regular nail cutting	88%	81%
Avg. time of taking food	1%-Once, 11%-twice,50%-three times,33% four times	5%-twice,57%-three times,35%-four times

Overall healthy practice is observable among the respondents except in some cases of washing hands with soap before taking food. Washing mouth with normal water has scope for improvement among some of the respondents in the younger age group. Regular nail cutting is fairly visible. However, some of the respondents do not practice the same. Majority of the respondents take food thrice a day and about 34% of them have food four times a day.

2.3. Knowledge of Anaemia & Nutrition

Table 82: KNOWLEDGE ON NUTRITION & ANAEMIA (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls appreciating two time intake of food is sufficient for them	45%	31%
Percentage of Girls appreciating Four time intake of food is sufficient for them	33%	52%
Percentage of girls hear about IFA Tablets	47%	56%
Percentage of girls hear about projects on eradication of Malnutrition among adolescent girls	15%	25%
Percentage of girls hear about anaemia	22%	45%



About 45% of the respondents in the age group of 11 to 14 years appreciate taking food two times a day and about 31% of the respondents of the other age group appreciate the same. Majority of the respondents in the older age group, however, appreciate four time intake of food

per day. Knowledge about anaemia is moderate and about one fourth of the respondents in the older age group have heard about projects on eradication of malnutrition among adolscent girls. Knowdege of anaemia is more in the older age group than that in the age group of 11 to 14 years.

2.4. Status of Anaemia, Iron Deficiency & Source of IFA Tablets

Table 83: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS (N=148)

Age group	11-14 yrs.	15-18 yrs
Pvt Doctor	0%	3%
ANM/Govt Doctor	1%	0%
RMP/Quack Doctor	0%	0%
Local Medicine Shop	0%	0%
NGO Worker	0%	1%
AWW	8%	17%
Friend	12%	15%
Teacher/Ponchayet Member	0%	8%
Family Member	8%	8%
Others	0%	3%

Sources of information are hardly available with respondents. Angan Wari Workers and Friend happen to contribute largely in this. Family members play a small role in the same.

Table 84: KNOWLEDGE ON REASON FOR ANAEMIA (N=148)

Age group	11-14 yrs.	15-18 yrs

Age group	11-14 yrs.	15-18 yrs
Insufficient food intake	7%	20%
Excessive hard work	4%	12%
For any infection	0%	1%
Lack of iron rich food	5%	5%
Infection for which body release iron more than it required	1%	3%
Excessive Bleeding	3%	11%
Malaria	1%	0%
Rapid growth in adolescent coupled with insufficient iron rich food	4%	0%
Pregnancy	3%	3%
Not Known	56%	43%
Others	0%	1%

Largely knowledge on reasons of anaemia is low among the respondents. Insufficient food intake, excessive hard work and excessive bleeding are some of the reasons known to the respondents.

Table 85: SYMPTOMS OF ANAEMIA (N=148)

Age group	11-14 yrs.	15-18 yrs
Weakness	11%	29%

Age group	11-14 yrs.	15-18 yrs
Tiredness/Feelings of imbalance	8%	19%
Vomiting tendency	4%	8%
Pale appearance of reddish part of body, like- throat, eye etc	3%	8%
Breathing problem after any work	3%	5%
Headache	0%	5%
Black out	1%	5%
Feeling not to take food/rejection of food	3%	0%
Not Known	57%	43%
Others	0%	1%

Majority of the respondents are not aware of any symptoms of anaemia. Some of them consider weakness, tiredness and feeling of imbalance as the major symptoms. Vomiting tendency, pale appearance, breathing problem during hard work, headache and black out are some other symptoms of anaemia cited by the respondents.

Table 86: SOURCE TO RECEIVE IFA TABLETS (N=148)

Age group	11-14 yrs.	15-18 yrs
Private doctor	0%	0%
Primary health centre/sub centres	4%	3%

Age group	11-14 yrs.	15-18 yrs
RMP	3%	1%
Local medicine shop	1%	0%
School	3%	0%
AWW	33%	33%
Youth meeting	0%	7%
Industry	0%	0%
Home	0%	3%
Village health mela	0%	0%
Others	7%	4%

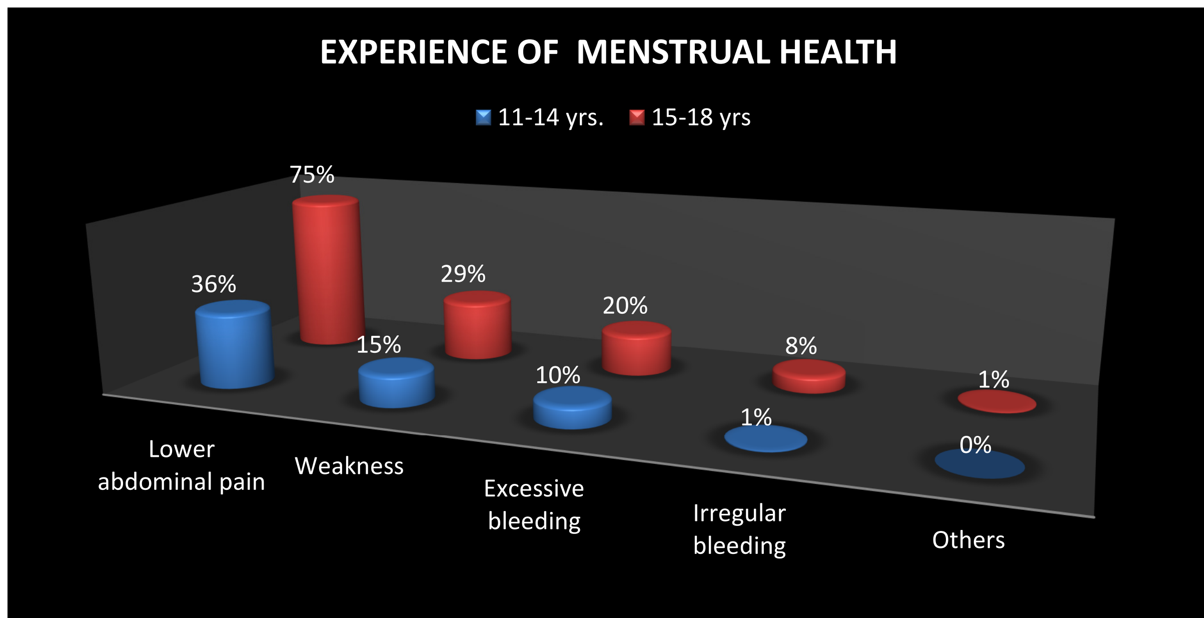
Angan Wari Workers are the chief source of IFA tablest as cited by the respondents. Primary health centre/ sub centre, school and youth meeting are some of the sources of IFA tablets as reported by the respondents.

2.5. Menstrual Health

Table 87: EXPERIENCE OF MENSTRUAL HEALTH (N=148)

Age group	11-14 yrs.	15-18 yrs
Lower abdominal pain	36%	75%
Weakness	15%	29%

Age group	11-14 yrs.	15-18 yrs
Excessive bleeding	10%	20%
Irregular bleeding	1%	8%
Others	0%	1%



Lower abdominal pain has been the most common experience of the respondents during menstruation and it is fairly high among the older group of respondents. Considerable number of respondents undergoes a feeling of weakness also. About 20% of the respondents in the age group of 15 to 18 years have experienced excessive bleeding during menstruation and about half of them in the other age group have had similar experience. Irregular bleeding, though relatively less, has been experienced by some of the respondents, especially in the older age group.

Table 88: PERCENTAGE OF GIRLS EXPERIECNING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS (N=148)

Age group	11-14 yrs.	15-18 yrs
White discharge with bad odour	10%	28%

Abdominal pain except during menstruation	11%	24%
Itching in genital area	3%	8%
Burning sensation during urination	4%	5%
Rashes in genital area	0%	5%
Pain during urination	0%	4%
Others	0%	4%

Majority of the respondents have not cited any problems felt by them during menstruation in last six months. However, there are some who have suffered problem of white discharge with bad odour during menstruation and it is prevalent more among the respondents of the older age group. Almost equal number of respondents in both the age group has suffered abdominal pain during menstruation in last six months. Itching in the genital area during menstruation is common among the respondents of the older age group than those of the other age group. Burning sensation during urination has been felt by small number of respondents in both the age groups. Rashes in the genital area and pain during urination have been felt by some of the respondents of the older age group.

Table 89: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS (N=148)

Age group	11-14 yrs.	15-18 yrs
Local doctor	1%	7%
Anwesha clinic	0%	0%
ANM/ Govt. doctor	1%	1%
RMP	0%	0%

Age group	11-14 yrs.	15-18 yrs
Local medicine shop	0%	0%
NGO staff	0%	0%
AWW	0%	0%
Teacher	0%	0%
Others	4%	4%

Majority of the respondents have not cited any preferred service points for treatment of menstrual problems. However, local doctors and ANM have been cited by some of them.

2.6. HIV/ AIDS

Table 90: KNOWLEDGE ON HIV/AIDS (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of Girls knew HIV is a virus	3%	9%
Percentage of Girls having complete information on HIV transmission	0%	0%
Percentage of Girls having complete information on HIV prevention	0%	0%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	4%

Overall status of knowledge on HIV is poor among the respondents.

Table 91: MISCONCEPTIONS REGARDING HIV/AIDS (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe Normal and healthy look individual does not have HIV infection	10%	15%
Percentage of girls believe HIV could spread through Mosquito bite	15%	20%
Percentage of girls believe HIV could transmit through sharing of food	5%	10%
Percentage of girls believes Usage of condom could reduce HIV infection.	3%	13%
Percentage of girls believe HIV infected person cannot live with other person in family	16%	16%
Percentage of girls believe HIV infected person should not share utensils with others.	20%	19%
Percentage of girls believes HIV infected person should not mix with other member in village.	18%	12%

Misconceptions regarding HIV exist among some of the respondents. Misconception of HIV transmission through mosquito bite, touch and HIV spread thorough sharing of utensils exist among a number of respondents. Some of the respondents also believe that a healthy looking person cannot have HIV infection. About 18% of the respondents in the age group of 11 to 14 years and 12% of respondents in the other age group do not want HIV infected persons to mix with other members in society.

2.7. Gender Status – Rights, Beliefs & Practices

Table 92: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should not move outside home without any companionship of their guardians	37%	56%
Percentage of girls believe girls should not have	34%	40%

Age group	11-14 yrs.	15-18 yrs
access to higher education than boys		
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	67%	84%
Percentage of girls believe decision should be taken by male members within family	60%	59%

More than half of the respondent in the older age group believe that girls should not move out of their houses without guardians and about 37% in the younger age group believe the same. A large number of respondents in both the age groups want boys to get higher access to education than girls and this opinion is more prevalent in the older age group of respondents. Most of the respondents in the age group of 15 to 18 years consider household works as the prime responsibilities of females within a family and the number for the same in the younger age group is relatively less. Majority of the respondents also believe that decision within a family should be taken by its male members.

Table 93: REPRODUCTIVE HEALTH & RIGHTS (N=148)

Age group	11-14 yrs.	15-18 yrs
Percentage of girls believe girls should have right to say about her preferred age of marriage	57%	40%
Percentage of girls believe boys should have right to say about her preferred age of marriage	38%	31%
Percentage of girls believe boys should have right to take decision not to marry	41%	32%
Percentage of girls believe male should have right to take decision about physical	23%	25%

Age group	11-14 yrs.	15-18 yrs
relationship with his mate		
Percentage of girls believe female have the responsibility not to conceive	36%	36%
Percentage of girls believe female should not negotiate condom use with her husband/mate	11%	21%
Percentage of girls believe male have right to beating her wife if she refuses in intercourse	20%	50%
Percentage of girls believe husband and wife should take joint decision about their child birth	8%	9%
Percentage of girls believe husband and wife should take joint decision about their use for contraception	7%	9%
Percentage of girls believe mothers should have all responsibility for childcare	48%	47%

Majority of the respondents in the age group of 11 to 14 years and about 40% in the other age group believe that girls should be able to decide when to marry. Relatively less number of respondents, however, is ready to accept that boys too should have the right to decide on their age of marriage. A mixed response has been noticed when it comes to boys having authority to decide when to marry. About a one fourth of the respondents believe that boys should have the right to decide on physical relation. About 36% of respondents in both the age groups want females to decide when to conceive. About 50% of the respondents in the older age group believe that husband can beat wife if she refuses sexual intercourse. About half of the respondents want mothers to take childcare as their prime responsibility.

3. Discussion:

Respondents in Kolkata district are almost equally divided into Hindu and Muslim community. About 20% in the older age group of respondents are Other Backward Classes (OBC). Marriage at an early age is quite prevalent among the respondents belonging to the age group of 15 to 18 years. Status of ration card is concern and efforts are also necessary to increase the coverage of birth certificate. Linkage with organisation and engagement for professional skill development is poor. About a quarter of the respondents in the age group of 15 to 18 years belong to joint family and a little less in the younger age group too also hail from joint families. Large number of mothers are working, though illiteracy is quite high. Incidents of school drop outs are a real concern. Majority of the respondents in the older age group are drop outs and about a quarter of the respondents in the younger age group have also dropped out of school. Data regarding history of missing cases is quite alarming and it needs to be addressed immediately. Another striking finding is the status of child labour in Kolkata. In both the age group about 20% of the respondents are into child labour. Similar to the status of other districts fever is most common among general ailments, however, it is specifically concentrated among the younger group of respondents in Kolkata. Diarrhoea is another major sickness. What is unique is the status of problem in vision (refractive error) in Kolkata, which is as high as 22% in the younger age group and 15% in the other. It has huge scope for intervention. Knowledge on nutrition and anaemia is negligible. Reasons behind anaemia are largely unknown. AWWs chiefly works as source of IFA tablets, however, role and functionality of Aneswa clinics may be focused. Most of the respondents have felt lower abdominal pain during menstruation and about a little less than quarter in the age group of 15 to 18 years have experienced excessive bleeding during menstruation. Lower abdominal pain and white discharge with bad odour are the most common menstrual complications experienced by the respondents. Preferred serviced points for the treatment of menstrual complications hardly exist . Knowledge on HIV is drastically poor and misconceptions with regard to the transmission of the virus are abundant. Gender disparity is quite high and female members seem conditioned to accept male dominance in various spheres of life ranging from access to education to decision making within family. With regard to reproductive health and rights large number of respondents advocate women independence and authority. However, in certain cases like acceptance of husband's authority to beat wife if she refuses sexual intercourse renders the scenario confusing and fuzzy.

4. Recommendations:

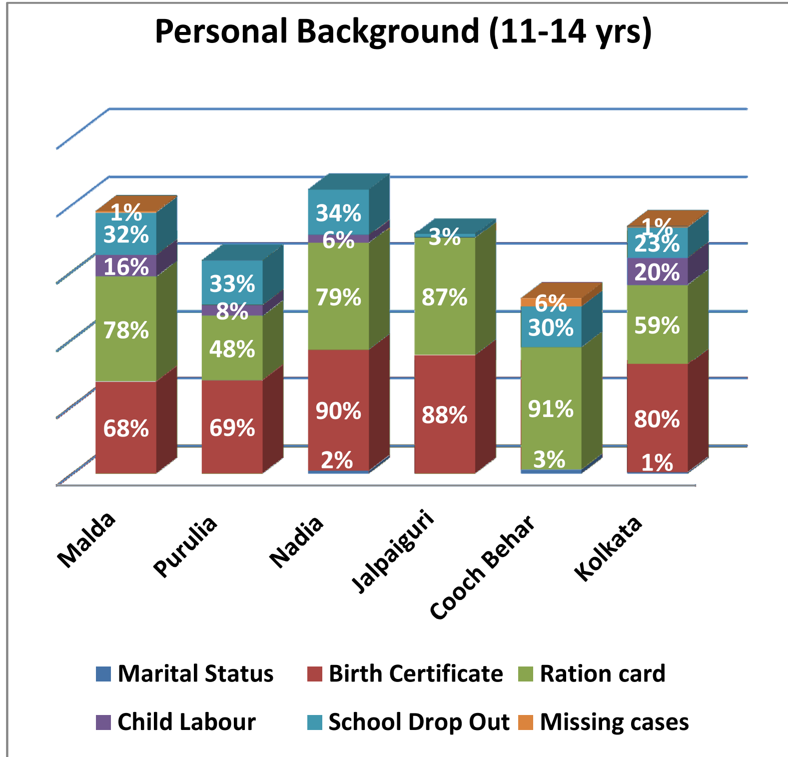
- Efforts at curbing early marriage are highly recommended. Information on health hazards due to early marriage needs to be disseminated in the community.
- Focus on notching up coverage of ration card and birth certificates is necessary. Importance of these two cards as age and identity proof has to be made known to the

community and efforts have to be put in to encourage and facilitate coverage without delay.

- Efforts encouraging engagement with professional association to develop professional skills are highly recommended.
- Focus on increasing female literacy is essential. Parents are to be included and sensitised as without their support it remains a far cry.
- Prevention of child labour is urgently required. Intervention putting emphasis on the seamy side of child labour and how it destroys their future is urgently needed.
- History of missing cases is alarming which has to be looked into immediately. Networking with Government administrative bodies and police department will prove fruitful.
- Effort to reduce the incidents of Diarrhoea and fever is highly required. Special focus on eye care is essential as it is widely prevalent among the respondents in both the age groups. Workshops need to be organised to address nutritional deficiencies.
- Menstrual complications largely remain unaddressed owing to paucity of service points. In needs immediate intervention. Involvement of Aneswa clinics may prove instrumental in optimising the impact.
- Incidents of school drop outs are real concern. Reasons have to be found out and the issue has to be resolved immediately.
- Special efforts have to be rendered on elimination of gender disparity and capacity building of the adolescent girls is essential to enable them to deal with gender issues efficiently and have them equip themselves with leadership qualities and capable of taking decisions independently.

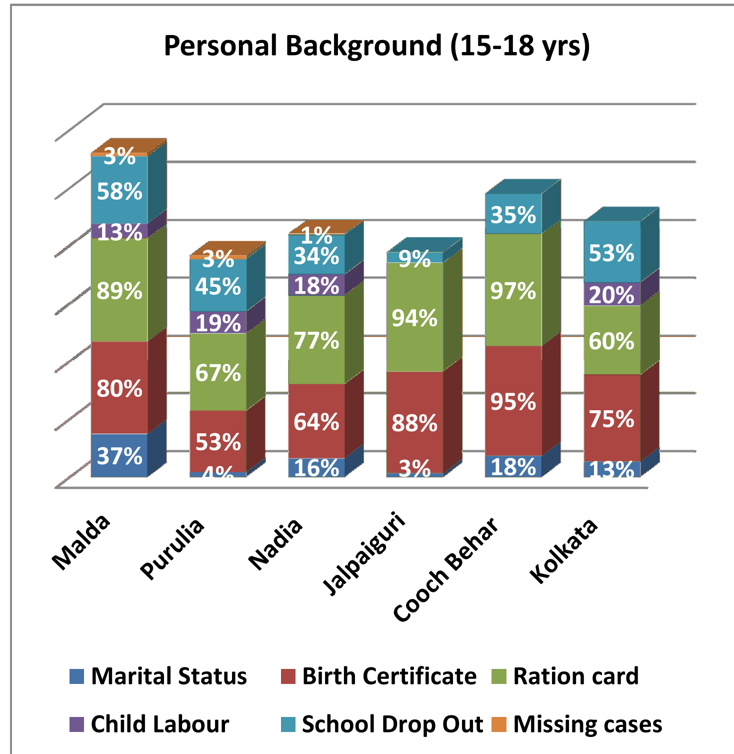
D: Discussion and Recommendation

Figure 1: PERSONAL BACKGROUND AT A GLANCE (11-14 YRS)



Data regarding the status of personal background reveals that in Cooch Behar district 91 percent of girls have ration card. In Purulia less than 48 percent of the respondents have birth certificate and the status of respondents having ration card is about 48 percent. Child labour is more in Kolkata and Malda district. However, in Jalpaiguri and Cooch Behar no child labour has been reported from the respondents of this group. Cooch Behar records about 6% of missing cases. Except Jalpaiguri, school dropout is common in all the districts.

Figure 2: PERSONAL BACKGROUND AT A GALCNE (15-18 YRS)



Another group of respondents in the age group of 15 to 18 years across the six districts depict a different scenario in terms of marital status. In all the districts marriage at an early age is quite observable, especially in Malda which records about 37 percent between the age group of 15 years and 18 years. It is followed by Cooch Behar where about 18% of the respondents interviewed were married. Putulia cuts a sorry figure in terms of availability of ration card and birth certificate. Kolkata records about 20 percent child labour and an alarming school dropout rate of 53 percent. Nadia tops the list in school dropout and it is as high as 58

percent. Districts like Purulia, Nadia and Cooch Behar also report a very high percentage of school dropouts. Jalpaiguri is the only district where school dropout rate is about nine percent.

Table 94: KNOWLEDGE ON NUTRITION & ANAEMIA (11- 14 YRS)

Respondents	Malda	Purulia	Nadia	Kolkata	Jalpaiguri	Cooch Behar
Girls appreciating two time intake of food	63%	78%	83%	45%	91%	97%
Girls appreciating Four time intake of food	28%	11%	10%	33%	9%	3%
Girls hear about IFA Tablets	38%	73%	70%	47%	50%	94%
Girls hear about projects on eradication of Malnutrition	12%	0%	17%	15%	13%	58%
Girls hear about anaemia	24%	18%	21%	22%	38%	79%

Data with regard to the status of knowledge on nutrition and anaemia among the age group of 11 to 14 years reveals that most of the respondents across all the study districts appreciate two time intake of food per day and four times intake of food per day has been appreciated by a very less number of respondents. Cooch Behar district records a better status of awareness on IFA tablets than other districts and the status of the same in Kolkata is quite grave. Only about 38 percent of the respondents in Malda report to have heard about anaemia. About 58 percent of the respondents in this age group in Cooch Behar district have responded that they have heard about projects on eradication of malnutrition. In all other districts this knowledge is quite low. 79 percent of the respondents in Cooch Behar district have heard about anaemia. Other districts report a very low knowledge of the same.

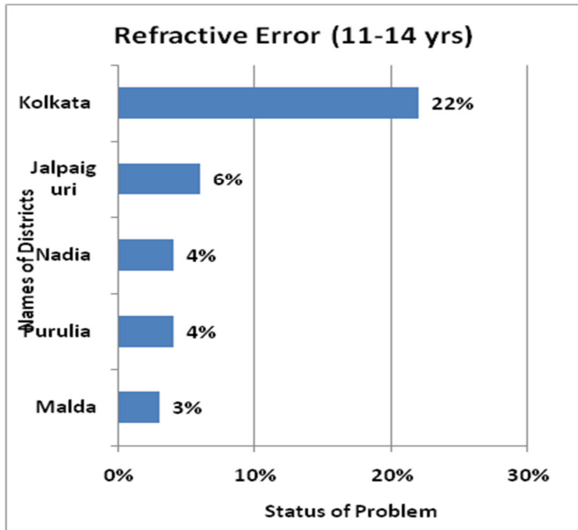
Table 95: KNOWLEDGE ON NUTRITION & ANAEMIA (15-18 YRS)

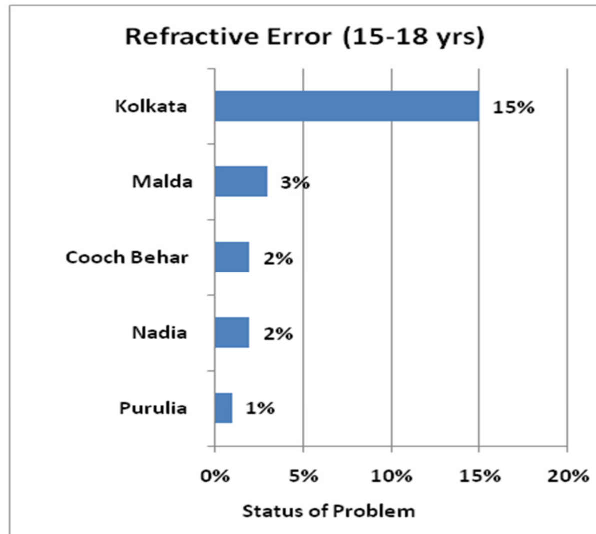
Respondents	Malda	Purulia	Nadia	Kolkata	Jalpaiguri	Cooch Behar
Girls appreciating two time intake of food	51%	64%	73%	31%	75%	97%
Girls appreciating Four time intake of food	30%	29%	23%	52%	25%	3%
Girls hear about IFA Tablets	75%	89%	89%	56%	61%	100%
Girls hear about projects on eradication of Malnutrition	33%	37%	25%	25%	42%	75%
Girls hear about anaemia	56%	49%	49%	45%	52%	92%

Regarding same indicators in the other age group of the respondents across all the study districts reveal a different scenario. About 97 percent of the respondents in Cooch Bear district appreciate two time intake of food per day. More than 70 percent of the respondents in Jalpaiguri and Nadia districts are of the same opinion. However, in Kolkata district more than 50 percent of the respondents appreciate four time intake of food per day. Cooch Behar records

100 percent awareness on IFA tablets and it is followed by Purulia and Nadia where an equal percentage of respondents have heard of IFA tablets. Awareness of IFA tablets in Jalpaiguri district is relatively low. With regard to the knowledge on projects on eradication of malnutrition Cooch Behar district fares better than other districts and also awareness on anaemia in Cooch Behar is about 92 percent. Awareness on anaemia in other districts is far less than that in Cooch Behar district.

Figure 3: REFRACTIVE ERROR (11- 14 YRS) **Figure 4: REFRACTIVE ERROR (15-18 YRS)**

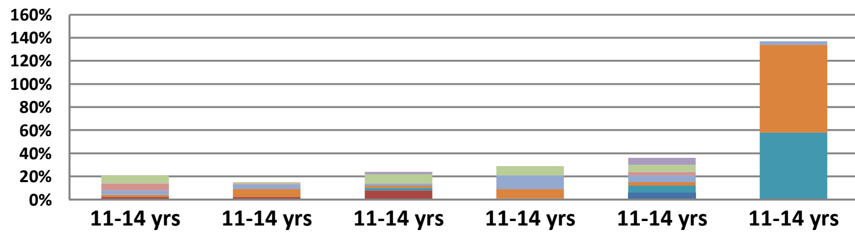




The two figures above show that in both the age groups refractive error is prevalent among the respondents of the Kolkata district. The figure below shows the status of sources of information on anaemia across all the six study districts. Overall the status is poor. However, in Cooch Behar, AWWs and NGO workers seem to have a significant contribution in this.

Figure 5: SOURCES OF INFORMATION ON ANAEMIA

Source of Information on Anaemia



	11-14 yrs Malda	11-14 yrs Purulia	11-14 yrs Nadia	11-14 yrs Kolkata	11-14 yrs Jalpaiguri	11-14 yrs Cooch Behar
Others	0%	0%	2%	0%	6%	0%
Family Member	7%	1%	8%	8%	6%	0%
Teacher/Ponchayet Member	6%	1%	0%	0%	3%	0%
Friend	4%	4%	2%	12%	6%	3%
AWW	2%	7%	2%	8%	3%	76%
NGO Worker	0%	0%	2%	0%	6%	58%
Local Medicine Shop	0%	0%	0%	0%	0%	0%
RMP/Quack Doctor	0%	0%	0%	0%	0%	0%
ANM/Govt Doctor	2%	2%	8%	1%	0%	0%
Pvt Doctor	0%	0%	0%	0%	6%	0%

Table 96: SYMPTOMS OF ANAEMIA

Symptoms of Anaemia	Malda		Purulia		Nadia		Kolkata		Jalpaiguri		Cooch Behar	
	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18
Weakness	4%	27%	4%	9%	2%	10%	11%	29%	3%	12%	73%	89%
Tiredness/Feelings of imbalance	4%	26%	7%	21%	6%	10%	8%	19%	9%	12%	73%	87%
Vomiting tendency	2%	16%	7%	8%	0%	5%	4%	8%	0%	0%	61%	59%
Pale appearance	4%	14%	1%	7%	0%	0%	3%	8%	0%	0%	58%	62%
Breathing problem after any work	0%	10%	0%	4%	0%	2%	3%	5%	0%	6%	58%	62%
Headache	3%	15%	0%	7%	0%	0%	0%	5%	6%	3%	61%	65%
Black out	0%	10%	3%	13%	0%	0%	1%	5%	0%	0%	58%	59%
Feeling not to take food/rejection of food	4%	11%	1%	3%	0%	0%	3%	0%	3%	0%	58%	58%
Not Known	35%	10%	44%	35%	49%	33%	57%	43%	50%	39%	21%	10%
Others	0%	0%	0%	0%	0%	0%	0%	1%	3%	0%	58%	58%

Data regarding symptoms of anaemia shows that overall symptoms are unknown to the respondents across all the study districts except in Cooch Behar wherein large number of respondents have reported different kind of symptoms of anaemia. Weakness and tiredness with vomiting tendency is the chief symptom cited by the respondents at large. Respondents in the age group of 15 to 18 years in Malda and Kolkata districts have cited weakness and tiredness with feeling of imbalance as the common symptoms of anaemia. It may be interpreted from the above scenario that

awareness on anaemia among the respondents is pretty low. Aneswa clinics are supposed to make a significant contribution to the improvement of adolescent health in terms of spreading awareness and disseminating information related to adolescent health. Overall low knowledge on anaemia among the respondents across all the districts engenders scopes for Aneswa clinics to perform better. Other related Government programmes may focus on concentrating their effort in notching up the knowledge level of the adolescent girls on adolescent health related issues.

The table below depicts a considerable need to strengthen the sources of IFA tablets for the adolescent girls in the districts. Agnan Wari Workers seem to play a major role as source of IFA tablets in Cooch Behar district for the adolescent girls. In Kolkata, Nadia and Purulia district also they seem to have a moderate contribution in this. Another source of IFA tablets worth noticing is school in Purulia and Nadia districts. In Purilia about 40 percent of the respondents have cited school as source of IFA tablets for them. However, a glance at the sources across all the study districts deciphers large scope for strengthening the sources as overall a weak status of sources of IFA tablets is pretty evident. Role of Aneswa clinics may be considered and focused on improving the scenario.

Table 97: SOURCES TO RECEIVE IFA TABLETS

Sources to receive IFA tablets	Malda		Purulia		Nadia		Kolkata		Jalpaiguri		Cooch Behar	
	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18
Private doctor	1%	6%	0%	1%	0%	0%	0%	0%	3%	0%	0%	0%
Primary health centre/sub centres	0%	3%	1%	3%	13%	6%	4%	3%	16%	3%	3%	3%
RMP	1%	1%	0%	0%	0%	1%	3%	1%	0%	0%	0%	0%
Local medicine shop	0%	5%	0%	3%	0%	1%	1%	0%	0%	0%	0%	0%
School	13%	22%	38%	41%	30%	18%	3%	0%	3%	6%	0%	0%
AWW	4%	8%	26%	29%	21%	9%	33%	33%	3%	0%	85%	83%
Youth meeting	0%	0%	0%	0%	0%	0%	0%	7%	0%	0%	0%	0%
Industry	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Home	0%	2%	0%	1%	0%	2%	0%	3%	0%	0%	0%	0%
Village health mela	0%	0%	0%	3%	2%	0%	0%	0%	0%	0%	0%	0%
Others	0%	1%	3%	0%	0%	0%	7%	4%	0%	0%	0%	1%

Table 98: KNOWLEDGE ON HIV/ AIDS

Knowledge on HIV/AIDS	Malda		Purulia		Nadia		Kolkata		Jalpaiguri		Cooch Behar	
	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18
Percentage of Girls knew HIV is a virus	3%	12%	4%	15%	2%	9%	3%	9%	31%	21%	60%	65%
Percentage of Girls having complete information on HIV transmission	0%	1%	0%	0%	0%	0%	0%	0%	3%	9%	58%	56%
Percentage of Girls having complete information on HIV prevention	0%	1%	0%	0%	0%	0%	0%	0%	3%	6%	57%	57%
Percentage of Girls having complete information on relation of HIV and AIDS	0%	0%	0%	0%	0%	0%	0%	4%	0%	0%	58%	58%

The table above demonstrates the level of knowledge and awareness among the respondents on HIV/AIDS. Apart from Cooch Behar where with a moderate knowledge on the virus, all other districts suffer a considerable lack of information on HIV/AIDS, its routes of transmission and ways of prevention. Respondents in Jalpaiguri come next to Cooch Behar in terms of knowledge and awareness on the virus, which though, is far from satisfaction. Overall knowledge on HIV/AIDS among the respondents across all the study districts is drastically low which has enough scope for improvement and may be addressed immediately.

Table 99: GENDER STATUS, RIGHTS, BELIEFS & PRACTICES

Mobility and development	Malda		Purulia		Nadia		Kolkata		Jalpaiguri		Cooch Behar	
	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18
Percentage of girls believe girls should not move outside home without any companionship of their guardians	52%	44%	27%	24%	70%	70%	37%	56%	34%	45%	73%	73%
Percentage of girls believe girls should not have access to higher education than boys	25%	27%	23%	28%	70%	79%	34%	40%	59%	61%	73%	76%
Percentage of girls believe most important responsibilities of females are to prepare food for other members of her family	66%	69%	46%	53%	60%	73%	67%	84%	41%	39%	21%	16%
Percentage of girls believe decision should be taken by male members within family	50%	50%	32%	29%	43%	57%	60%	59%	22%	27%	3%	8%

The table clearly indicates that gender bias and disparity prevalent among the respondents of all the study districts. Nadia seems to be characterise gender bias more than other study districts as above 50 percent and sometimes above 70 percent of respondents either believe that they should not move outside home without guardians or they should have less access to education than males. About 57 percent of the respondents in the older age group of respondents here also believe that decision within family should be taken by male members of the family. CoochBehar also gives similar examples in believing that girls should not move outside along or that they should not have more access to education than males. A close look at the scenario in all the districts illustrates deeply ingrained gender bias in which females seem conditioned to accept male dominance and superiority. The table below delineates in depth status of reproductive health and rights of adolescent girls across all the six study districts from gender

perspective. What is striking is the response pattern of respondents from Jalpaiguri district. 100 percent of the respondents in the age group of 11 to 14 years believe that husband can beat his wife if she refuses intercourse. About 82 percent of the respondents in the other age group from Jalpaiguri are also of the same opinion. However, in Malda district about 76 percent of the respondents belonging to the age group of 15 to 18 years believe that female should decide when to conceive. In Kolkata the scenario is little moderate. However, about half of the respondents in the age group of 15 to 18 years accept physical violence from husband if wife refuses intercourse. In Nadia and Malda districts more than 70 percent of the respondents in the age group of 11 to 14 years and more than 50 percent of the respondents in the other age group believe that mothers should have all the responsibilities for childcare.

Table 100: Reproductive Health & Rights

Reproductive health and rights	Malda		Purulia		Nadia		Kolkata		Jalpaiguri		Cooch Behar	
	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18	11-14	15-18
Percentage of girls believe female have the responsibility not to conceive	0%	76%	14%	33%	0%	50%	36%	36%	25%	55%	0%	11%
Percentage of girls believe female should not negotiate condom use with her husband/mate	19%	37%	0%	38%	0%	30%	11%	21%	41%	34%	0%	0%
Percentage of girls believe male have right to beating his wife if she refuses in intercourse	0%	48%	0%	65%	0%	48%	20%	50%	100%	82%	27%	48%
Percentage of girls believe husband and wife should take joint decision about their child birth	0%	8%	0%	65%	0%	8%	8%	9%	25%	36%	0%	8%
Percentage of girls believe mothers should have all responsibility for childcare	79%	54%	25%	31%	70%	57%	48%	47%	28%	46%	36%	24%

The study also tried to assess the roles of various stakeholders in facilitating the implementation of the scheme. Findings demonstrate that on the one hand the stakeholders have a crucial role to play in the implementation of the scheme and on the other, their limited knowledge and awareness on different key areas act as barriers to the smooth implementation and oprationlisation of the scheme. Parents have the potential to nourish and guide girl child for their better nutritional and sexual health. However, their limited knowledge impedes achievement of expected results. Low level of awareness on the hazards of marriage at an early age fuels unstinted child marriage in the community. It entails major health complications among the adolescent girls who get married at early marriage. Stakeholders like Block Medical Officer of Health (BMOH), Auxiliary Nurse Midwives (ANMs) and Aneshwa clinic counsellors can play a vital role in creating awareness and dealing with sexual and reproductive health issues of the adolescent girls. But, their low level of involvement in the scheme and low skills of the Aneshwa Clinic Counsellor virtually make it difficult for the adolescent girls to access their required services. Experience with the Child Development Police Officer (CDPO) and ICDS supervisors is the same. Local administrative bodies like Panchayat members and Ward Commissioner have a key role to play in the implementation of the scheme in terms of protecting the girls and ensuring required service access. However, their low level of accountability acts as hurdles in the implementation of the scheme.

Table 101: ROLES OF VARIOUS STAKEHOLDERS

Stakeholders	Enablers	Barriers
Parents	• Has the capability to nourish and guide a girl child for her better nutritional and sexual health	• Knowledge on nutrition and sexual health is limited • Limited knowledge on proper age of marriage
BMOH, ANM, Aneshwa, Counsellor	• Has the potential to mitigate adolescent immediate health needs or to alert them on various health hazards	• Involvement with SABLA scheme is minimum • ANM's are not so focussed on adolescent health • Aneshwa counsellors are

Stakeholders	Enablers	Barriers
		not skilled in dealing with sexual problems
CDPO, Supervisors, ANM	• Have the capacity to facilitate the girls to be aware, educated and empowered regarding their health and problems.	• Not very clear about their role in SABLA • Limited knowledge and low level of motivation to work with sexual health issues
Panchayet Pradhan/ member, Ward counsellor	• They can protect girls, facilitate them on getting the necessary information for their life and enable them to reach the facilities available for them.	• Ownership to take responsibility on adolescents' health problems is less.
Quack doctor	• They can identify the health problems at early stage and can act as a referral	• Over confident about their treatment. • Limited knowledge to handle girls' health problems related to nutrition and sexuality.

Discussion regarding liking and disliking of the adolescent girls across the six study districts reveals that the respondents belonging to both the age groups are inclined to playing different games and watching TV. Among other things they enjoy are hanging around with friends, applying makeup or going to parlour, learning stitching work or making new friends.

The dislikes throw light on the existing practices in the society. From the disliking of the girls it may be inferred that beating of the girls by pulling their hair or abusing them are their common experiences of violence in their day to day life. That they do not like to join work before the completion of their education expresses their limited access to education. Their reluctance to marry by force also shows that forcing the girls to marry against their will is common practice in the society.

Table 102: LIKINGS AND DISLIKING OF ADOLESCENT GIRLS

Likes	Dislikes
Playing games and watching TV	If somebody beats grabbing hair
Hanging around with friends	If Parents quarrel with each other
Applying makeup or going to parlour	If someone hurls offensive words at us
Learning stitching work	If someone inside family abuses us
Teaching children at home	Getting engaged in work before completion of education
Making new friends	Being forced to marry

While conducting the Baseline study across six districts some issues related with challenges in Programme Implementation have come out from different stakeholders. The challenges are as follows:

- The in-school adolescent girls do not like to come to the Angan Wari Centres as operational time is overlapping to each other.
- The parents of the adolescent girls do not ascribe much importance to the activities of the Angan Wari Centres.
- Gap in supply of medicine (IFA) on time is quite common. It reduces trust among the beneficiaries
- The unmarried girls do not want come to centres and they do not want to discuss sexual and reproductive health issues openly.
- Usually ANMs discuss the issues of reproductive health in mothers' meet. Unmarried girls do not join these meetings. They do not have any access to ANM
- Girls from Muslim community do not like to discuss matters related to contraception practices.

Recommendation:

The detailed district wise recommendations have been discussed in the detailed districtwise report . However, the table below marked with blue shade gives a glimpse of district wise overall recommendations with their immediate urgency and focus.

Table 103: Overall Recommendation

Recommendation	Districts					
	Malda	Nadia	Purulia	Cooch Behar	Jalpaiguri	Kolkata
Focus on coverage of ration card and birth certificates	■	■	■	■	■	■
Focus on prevention of early marriage	■	■	■	■		■
Missing cases						■
Focus on Child Labour	■	■	■			■
Focus on schoold drop out	■	■	■	■		■
Special focus on nutrition and anaemia	■					
Strengthening fucntionality of Aneswa clinics	■	■	■	■	■	
Sources of IFA tablets need strengthening	■				■	
Encouragement towards professional Engagements	■	■	■		■	■
Awareness on HIV/ AIDS	■	■	■	■	■	
Elimination on gender disparity	■	■	■	■	■	■
Hand Sanitation		■			■	
Nutrition and Anaemia		■	■		■	■
Menstrual Complications		■	■		■	■
Female Illiteracy			■	■	■	■
Skin disease				■		
Eye Care						■

Table 1: PERSONAL BACKGROUND (N=189) 22

Table 2 FAMILY BACKGROUND (N=189) 23

Table 3: GENERAL HEALTH(N=189) 24

Table 4: HEALTHY PRACTICES(N=189) 25

Table 5: KNOWLEDGE ON NUTRITION & ANAEMIA(N=189) 26

Table 6: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=189) 27

Table 7: KNOWLEDGE ON REASON FOR ANAEMIA(N=189) 28

Table 8: SYMPTOMS OF ANAEMIA(N=189) 29

Table 9: SOURCE TO RECEIVE IFA TABLETS(N=189) 29

Table 10: SYSTOMPS OF MENSTRUAL HEALTH(N=189) 30

Table 11: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=189) 31

Table 12: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=189) 32

Table 13: KNOWLEDGE ON HIV/AIDS(N=189) 33

Table 14: MISCONCEPTIONS REGARDING HIV/AIDS(N=189) 33

Table 15: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=189) 34

Table 16: REPRODUCTIVE HEALTH & RIGHTS(N=189) 35

Table 17: PERSONAL BACKGROUND (N=150) 40

Table 18: FAMILY BACKGROUND (N=150) 41

Table 19: GENERAL HEALTH(N=150) 42

Table 20: HEALTHY PRACTICES (N=150) 43

Table 21: KNOWLEDGE ON NUTRITION & ANAEMIA (N=150) 44

Table 22: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=150) 46

Table 23: KNOWLEDGE ON REASON FOR ANAEMIA (N=150) 47

Table 24: SYMPTOMS OF ANAEMIA(N=150) 48

Table 25: SOURCE TO RECEIVE IFA TABLETS(N=150) 49

Table 26: SYMPTOMS OF MENSTRUAL HEALTH(N=150) 50

Table 27: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=150) 51

Table 28: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=150) 51

Table 29: KNOWLEDGE ON HIV/AIDS (N=150) 52

Table 30: MISCONCEPTIONS REGARDING HIV/AIDS(N=150) 53

Table 31: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=150) 54

Table 32: REPRODUCTIVE HEALTH & RIGHTS(N=150) 54

Table 33: PERSONAL BACKGROUND (N=148) 59

Table 34: FAMILY BACKGROUND (N=148) 59

Table 35: GENERAL HEALTH(N=148) 61

Table 36: HEALTHY PRACTICES (N=148) 62

Table 37: KNOWLEDGE ON NUTRITION & ANAEMIA(N=148) 64

Table 38: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=148) 66

Table 39: KNOWLEDGE ON REASON FOR ANAEMIA(N=148) 67

Table 40: SYMPTOMS OF ANAEMIA(N=148) 68

Table 41: SOURCE TO RECEIVE IFA TABLETS(N=148) 69

Table 42: SYMPTOMS OF MENSTRUAL HEALTH(N=148) 70

Table 43: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=148) 71

Table 44: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=148) 71

Table 45: KNOWLEDGE ON HIV/AIDS(N=148) 72

Table 46: MISCONCEPTIONS REGARDING HIV/AIDS(N=148) 73

Table 47: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=148) 74

Table 48: REPRODUCTIVE HEALTH & RIGHTS(N=148) 74

Table 49: PERSONAL BACKGROUND (N=104) 80

Table 50: FAMILY BACKGROUND (N=104) 81

Table 51: GENERAL HEALTH (N=104) 82

Table 52: HEALTHY PRACTICES (N=104) 83

Table 53: KNOWLEDGE ON NUTRITION & ANAEMIA(N=104) 84

Table 54: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=104) 85

Table 55: KNOWLEDGE ON REASON FOR ANAEMIA(N=104) 86

Table 56: SYMPTOMS OF ANAEMIA(N=104) 87

Table 57: SOURCE TO RECEIVE IFA TABLETS(N=104) 88

Table 58: KNOWLEDGE ON HIV/AIDS(N=104) 89

Table 59: MISCONCEPTIONS REGARDING HIV/AIDS(N=104) 89

Table 60: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=104) 90

Table 61: REPRODUCTIVE HEALTH & RIGHTS(N=104) 91

Table 62: PERSONAL BACKGROUND (N=65) 96

Table 63:FAMILY BACKGROUND (N=65) 97

Table 64: GENERAL HEALTH (N=65) 98

Table 65: HEALTHY PRACTICES(N=65) 99

Table 66:KNOWLEDGE ON NUTRITION & ANAEMIA(N=65) 100

Table 67: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS(N=65) 101

Table 68:KNOWLEDGE ON REASON FOR ANAEMIA(N=65) 102

Table 69:SYMPTOMS OF ANAEMIA(N=65) 103

Table 70:SOURCE TO RECEIVE IFA TABLETS(N=65) 104

Table 71:EXPERIENCE OF MENSTRUAL HEALTH(N=65) 105

Table 72: PERCENTAGE OF GIRLS EXPERIENCING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS(N=65) 106

Table 73: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS(N=65) 107

Table 74: KNOWLEDGE ON HIV/AIDS(N=65) 107

Table 75: MISCONCEPTIONS REGARDING HIV/AIDS(N=65) 108

Table 76: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS(N=65) 109

Table 77: REPRODUCTIVE HEALTH & RIGHTS (N=65) 110

Table 78: PERSONAL BACKGROUND (N=148) 114

Table 79: FAMILY BACKGROUND (N=148).. 115

Table 80: GENERAL HEALTH (N=148).. 117

Table 81: HEALTHY PRACTICES (N=148).. 118

Table 82: KNOWLEDGE ON NUTRITION & ANAEMIA (N=148) 120

Table 83: SOURCE OF INFORMATION ON ANAEMIA FOR ADOLESCENT GIRLS (N=148).......... 121

Table 84: KNOWLEDGE ON REASON FOR ANAEMIA (N=148) 121

Table 85: SYMPTOMS OF ANAEMIA (N=148)... 122

Table 86: SOURCE TO RECEIVE IFA TABLETS (N=148) 123

Table 87: EXPERIENCE OF MENSTRUAL HEALTH (N=148) 124

Table 88: PERCENTAGE OF GIRLS EXPERIECNING FOLLOWING PROBLEMS DURING MENSTRUATION IN LAST SIX MONTHS (N=148) 125

Table 89: PREFERRED SERVICE POINTS FOR TREATING MENSTRUAL PROBLEMS (N=148) .. 126

Table 90: KNOWLEDGE ON HIV/AIDS (N=148) 127

Table 91: MISCONCEPTIONS REGARDING HIV/AIDS (N=148)... 127

Table 92: MOBILITY & DEVELOPMENT OF ADOLESCENT GIRLS (N=148) 128

Table 93: REPRODUCTIVE HEALTH & RIGHTS (N=148)... 129

Table 94: KNOWLEDGE ON NUTRITION & ANAEMIA (11- 14 YRS)... 134

Table 95: KNOWLEDGE ON NUTRITION & ANAEMIA (15-18 YRS)... 134

Table 96: SYMPTOMS OF ANAEMIA 137

Table 97: SOURCES TO RECEIVE IFA TABLETS... 138

Table 98: KNOWLEDGE ON HIV/ AIDS.. 139

Table 99: GENDER STATUS, RIGHTS, BELIEFS & PRACTICES.. 140

Table 100: Reproductive Health & Rights 141

Table 101: ROLES OF VARIOUS STAKEHOLDERS 142

Table 102: LIKINGS AND DISLIKING OF ADOLESCENT GIRLS 144

Table 103: Overall Recommendation 145

IMAGE 1: MALDA DISTRICT MAP 21

IMAGE 2: NADIA DISTRICT MAP 39

IMAGE 3: PURULIA DISTRICT MAP 58

IMAGE 4: COOCH BEHAR DISTRICT MAP 79

IMAGE 5: JALPAIGURI DISTRICT MAP 95

IMAGE 6: KOLKATA DISTRICT MAP 114