

ACQUIRING KNOWLEDGE

Applying Lessons Learned to Strengthen FP/RH Services

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Challenging Traditions and Changing Minds— Working with Young Married Couples in Nepal

Background

In Nepal, approximately one-quarter of the country's 27.8 million people are adolescents, and nearly 60% of girls are already married by age 18. Although the legal minimum age of marriage for both women and men is 18 years, in most rural areas of Nepal, cultural expectations carry more weight than national laws.

Families feel pressure to marry their daughters when they are young because the dowry they must pay increases with the girl's age. In a country where the gross national income is approximately US \$320, girls can become a huge financial burden the longer they remain unmarried.

Adolescent marriage and early pregnancy are major health risks in Nepal. After young women are married, they must prove their fertility by having a child as soon as possible. The median age at first birth is 19.9 years, with 41% of women already pregnant with their first child by age 19. In addition, ensuring safe childbirth is a challenge in Nepal, as access to skilled pregnancy and delivery care there is limited. As a result, only 22% of births to adolescent mothers were delivered by a skilled birth attendant. In Nepal, approximately one in four girls aged 15–19 die from pregnancy-related causes (MOHP Nepal, New Era, & Macro International Inc., 2007).

To address the reproductive health needs of married youth in Nepal, there is a need for normative change that will affect a range of behaviors, including those of adolescents, of their families, and of other influential people in their communities. But reaching Nepalese communities with behavior change messages is challenging, because literacy levels there are low, particularly for women: Women are less-educated overall than are men, and more than 50% of women have never



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attended school and are illiterate. Having little access to formal institutions and being unable to read, women often rely on informal communication networks for information.

Programmatic Approach

With funding from the U.S. Agency for International Development (USAID), The ACQUIRE Project, in partnership with EngenderHealth's Nepal Country Office and CARE Nepal, designed a project based on the social and cultural realities of adolescents in Nepal. The Reproductive Health for Married Adolescent Couples Project (RHMACP) built on existing communications networks to reach married adolescents. Local married adolescent couples were selected to be peer educators, to serve both as role models and as community outreach volunteers. At the same time, the RHMACP provided training and support to health care providers and local health care facilities, to ensure that



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quality youth-friendly services were available and accessible to married adolescents.

The RHMACP was implemented in Parsa and Dhanusha districts in the southeastern part of Nepal's *terai* region from 2005 to 2007. In this conservative area, very early marriage and dowry payment are both still widely practiced. During the project period, the districts were also the center of intense political unrest and heightened political awareness. While general strikes and road blockades impaired access to service delivery, the decentralized government structure and increased political awareness gave communities an opportunity to influence policies and programs to meet their health, education, and political needs.

In this environment, the goal of the RHMACP was to improve the health status of married adolescent couples by increasing their access to and use of reproductive health information and services. There were three project objectives:

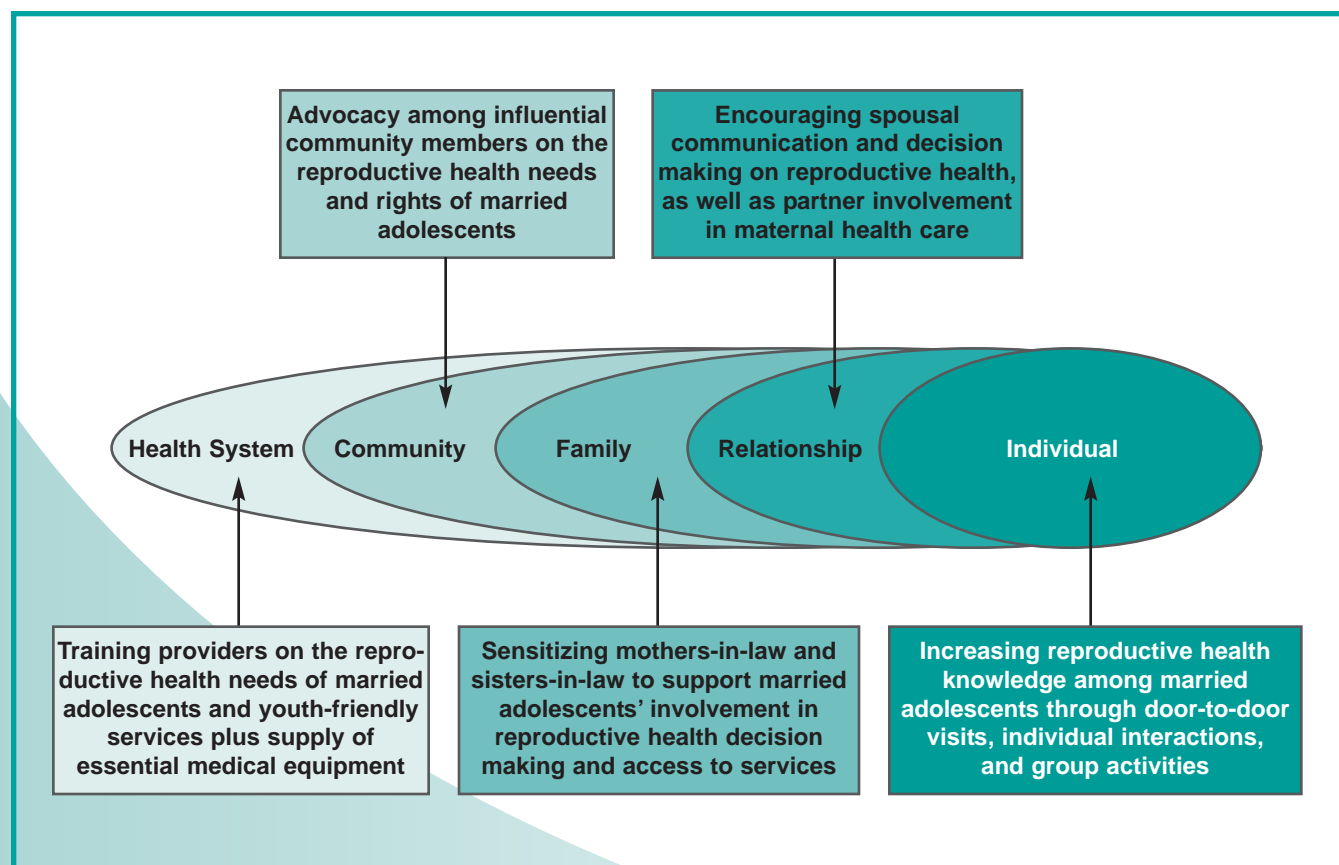
- Increase family planning, maternal health, and knowledge about HIV and sexually transmitted infections (STIs) among married adolescents

- Increase health service providers' knowledge about the reproductive health needs of married adolescents
- Increase community and family support for reproductive health decision making by married adolescent couples

Adolescents' decisions to marry or bear children are influenced by cultural and social traditions. Sustained behavior change for adolescents relies on a supportive and enabling environment from parents, health systems, and local institutions. To create this enabling environment, ACQUIRE used an ecological model to design a project that would influence health behaviors at multiple individual and societal levels (see Figure 1).

Interventions were implemented at five levels—the individual, relationship, family, community, and health system levels. The RHMACP model reflects the concept that good health outcomes for married adolescents require open communication, with the provision of correct information and with effective access for adolescent couples to quality health services.

Figure 1: The RHMACP Ecological Model



Among the interventions undertaken in each of these five areas were the following:

- **Health System: Making Local Health Services More “Youth Friendly”**—The RHMACP identified the most accessible facilities in the districts and trained a total of 359 health providers in youth-friendly¹ services and couples counseling. Facilities were then clearly marked with a sign indicating they were youth friendly. The ACQUIRE Project provided technical assistance to providers to ensure adequate quality and maintenance of youth-friendly services.
- **Community and Family: Training Peer Educators**—The project understood that advocacy among influential community members on the reproductive health needs and rights of married adolescents was critical to achieving success. After receiving community buy-in, the RHMACP trained male-female teams of youths (n=1,242) to disseminate accurate and timely information on family planning, HIV prevention, antenatal care, maternity issues, gender, and leadership. Communication between health care providers and peer educators was established, creating linkages between the community and the clinic. Once the peers and health providers were trained, they began sensitizing mothers-in-law and sisters-in-law to support married adolescents’ involvement in reproductive health and family planning decision making and their access to services.
- **Relationship and Individual: Helping Information Lead to Change**—The peer educators’ central responsibilities were to disseminate reproductive health information to married adolescents, especially young women with restricted social mobility, and to act as key actors and advocates within their communities to promote services for married adolescents. Encouraging spousal communication and decision making on reproductive health, as well as partner involvement in maternal health care, was a by-product of the peer education and youth-friendly clinic services.

¹ Activities for strengthening youth-friendly services included training staff at public-sector health facilities on the concepts, characteristics, delivery, and monitoring of health services geared toward youth, supplying essential medical equipment and supplies to health facilities, providing ongoing technical support to health facilities to coordinate activities with peer educators, and conducting periodic district-level meetings with health service providers to discuss ways to improve reproductive health indicators, including services directed to young married couples.



Members of anti-child marriage committee, organized by peer educators and active in organizing regional anti-child marriage forum

Results

A baseline survey was carried out in September 2005 and an endline survey was conducted in October 2007, each using both qualitative and quantitative methods. Although two years is a short time in which to change behavior, there is evidence that the attitudes of young people, community members, and providers shifted and that the quality of services for adolescents improved. Prior to the implementation of RHMACP, married adolescents often did not access reproductive health and family planning services, due to poor staffing at health facilities, fear of judgment by providers, lack of confidentiality and privacy, and lack of awareness of the services available.² The percentage of married adolescents visiting government health facilities for services rose from 36% in 2005 to 42% in 2007 (n=960). One client noted, “The attitude of health providers has improved. They give special attention to their clients, listen carefully, and provide complete information regarding health services.”

Strong changes were recorded in perceptions about who is responsible for deciding whether to use family planning. At endline, 65% of female adolescents and 79% of males considered that the husband and wife together were responsible for family planning decisions, up significantly from 37% and 57%, respectively, at baseline. Both women and men knew two or more contraceptive methods at baseline, but only 4% of males were aware of oral contraceptives. By the endline, the latter percentage had risen to 84%, due to peer educators’ visits, village health workers’ talks, and

² This information was revealed during peer educator and provider trainings.

clinic-based counseling. Although the use of family planning prior to a couple's first birth remained low, for cultural reasons, research showed that the age at marriage increased significantly in the two districts, from 14 to 16 years.

Door-to-door outreach and community meetings also raised knowledge and use of antenatal care. The proportion of women attending antenatal care at least once during their last pregnancy rose significantly, from 79% to 98%, and the proportion making four or more antenatal care visits increased as well, from 29% to 50%. Overall, the mean number of antenatal care visits rose from 2.7 to 3.7.

Peer educators' skills in communication, leadership, good governance, and women's rights were used to give married youth a voice in local government, community development forums, health management committees, and theater groups. For example, the peer educators facilitated meetings of anti-child marriage groups and helped to organize a regional forum on the subject. Child marriage eradication committees were established by youth in 33 villages, and a peer-led, district-level conference organized by the RHMACP advocated for the abolition of child marriage and the dowry system and supported compulsory education for all children. By the end of the project, community groups openly supported the government policy for the minimum age of marriage and instituted punitive measures for families not complying with the law—a considerable achievement in one of the most culturally conservative areas of Nepal.

Lessons Learned

Peer educators are respected and can influence behavior and social change when they are supported by and partnered with quality services. Involvement of key decision makers, such as mothers-in-law, sisters-in-law, health providers, and local politicians—from the beginning is critical to creating an enabling environment for married adolescents.

Even in one of the most conservative and highly politicized regions of Nepal, the RHMACP was effective in working at multiple levels to establish a supportive environment for meeting the reproductive health and family planning needs of married youth. Women began to take leadership roles in health advisory committees and in program development. In some cases, the peer

educators took action themselves, accessing government funds to improve facilities and playing a role on health post advisory committees to ensure that services improved.

Strong cultural and social barriers remain, but the incremental changes that were initiated show that more progress is possible. Building on these successes will help improve the environment even more to support delayed first birth and increase use of family planning and reproductive health services by newly married couples. Close collaboration between district health offices, local health facilities, and communities builds a sense of ownership and can overcome political conflict and disruption of services. In low-resource settings like Nepal, working with communities to build local capacity to address needed changes in health behaviors, policies, and services can improve married adolescents' access to quality reproductive health services.

Reference

Ministry of Health and Population (MOHP) Nepal, New Era, and Macro International Inc. 2007. *Nepal Demographic and Health Survey 2006*. Kathmandu and Calverton, MD, USA.

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