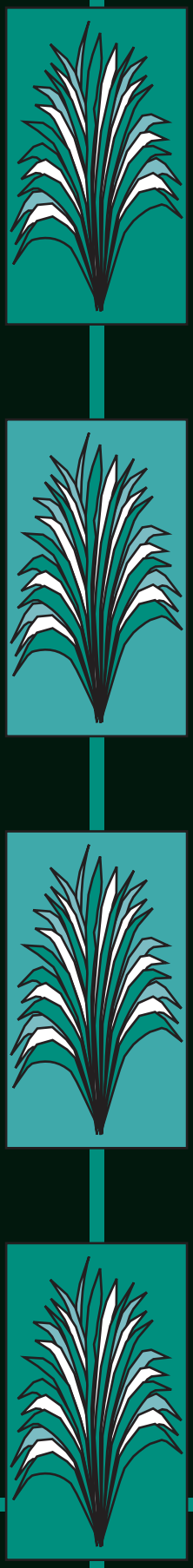

ACQUIRE Evaluation and Research Studies

Mobilizing Married Youth in Nepal to Improve Reproductive Health: The Reproductive Health for Married Adolescent Couples Project, Nepal, 2005-2007

E & R Study #12 ◆ August 2008

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Acknowledgments

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Acronyms and Abbreviations

ACQUIRE	Access, Quality, and Use in Reproductive Health (Project)
AIDS	acquired immune deficiency syndrome
DHS	Demographic and Health Survey
FGD	focus group discussion
HIV	human immunodeficiency virus
HMIS	health management information system
IEC	information, education, and communication
NDHS	Nepal Demographic and Health Survey
RHMACP	Reproductive Health for Married Adolescent Couples Project
STI	sexually transmitted infection
USAID	U.S. Agency for International Development
VDC	Village Development Committee

Executive Summary

Nepal has a large population of married adolescents with unmet needs for reproductive health information and services. Almost one-third of women aged 15–19 years are married, and more than two-fifths of women are already mothers or pregnant with their first child by 19 years of age, but access to family planning and maternal health services is extremely low. Among women under 20 years of age, only 22% of births were delivered by a skilled birth attendant, and more than one in four adolescent women in Nepal aged 15–19 dies of pregnancy-related causes. Only 9% of Nepalese adolescents have ever used a modern method of contraception (MOHP [Nepal], New ERA, and Macro International, 2007).

Marriage changes virtually everything in a young girl's life—where she lives, whom she associates with, and what happens to her body and her sexuality. For example, the misconception persists that once women are married, they are protected from unintended pregnancies, sexually transmitted infections (STIs), and HIV. However, women in Nepal generally marry men who are three years older and have already commenced sexual activity, and only 28% of women aged 15–24 have comprehensive knowledge about HIV transmission and prevention (MOHP [Nepal], New ERA, and Macro International, 2007). Orthodox cultural and gender norms, particularly in the southern *terai* region of the country, also frequently restrict women's access to education, as well as their mobility outside the family household, especially once they are married. More than half of Nepalese women have never been to school, and 46% are illiterate (MOHP [Nepal], New ERA, and Macro International, 2007). With little access to institutionalized structures (schools and health services) and reduced exposure to peers and the media, married adolescent women are extremely vulnerable to poor reproductive health outcomes.

Recognizing the acute needs of this population, the ACQUIRE Project, in association with CARE Nepal and with funding from the U.S. Agency for International Development (USAID), implemented a two-year pilot project in 2005—the Reproductive Health for Married Adolescent Couples Project (RHMACP) —within Parsa and Dhanusha, two *terai* districts of Nepal. The project utilized an ecological model[1] to improve health outcomes for married adolescents in the target districts. In close collaboration with District Public Health Offices, the RHMACP established a peer education network to disseminate reproductive health information to married couples; supported local health facilities to provide youth-friendly services; and fostered an enabling environment among parents, in-laws, and influential community members to increase married adolescents' access to, and use of, health services.

Project impact was significant at all levels of the intervention—individual, relationship, family, community, and health system. At the individual level, data collected from baseline and endline evaluations show improvements in key reproductive health indicators among married adolescents. At the relationship level, interventions encouraged communication and joint decision making by couples on reproductive health, as well as greater participation of husbands in maternal health services. Empowered by the training and support offered by the project, many peer educators developed into "champions" for youth behavior change and catalysts for broader community

[1] An ecological model is one that recognizes that interventions are needed at multiple levels—from individual to health system/policy levels—to bring about behavior change and improve health outcomes. See page 6 for a further description of the ecological model utilized by the project.

development. In particular, female peer educators served as powerful role models to promote adolescent women's access to essential health education and services.

At the family, community, and health system levels, interventions raised awareness of the needs and rights of married adolescents. Noticeable changes in attitudes among influential family and community members contributed to a more enabling environment for married adolescents' access to reproductive health information and services, while complementary improvements in capacity occurred at the health system level. Training for providers on youth-friendly services, together with the supply of essential medical equipment, increased the demand for health services and facilitated access to services by women and disadvantaged groups.

The leadership development training provided to 69 peer educators—one from each participating village—in the second year of the project was particularly successful in building a highly motivated and influential youth leadership. Following the training, peer educators established community-based development groups, conducted public hearings regarding health services, and identified and accessed government funds to complete health infrastructure projects at village level. The work of peer educators garnered widespread community approval, with health management committees and local government authorities inviting youth participation. Case stories of outstanding peer educators clearly reflect the transformative nature of RHMACP interventions as young people seized opportunities offered by the project to make positive changes in their lives and their communities.

Project impact was measured through baseline and endline surveys using household surveys structured after the Demographic and Health Surveys model. The sample size for both surveys was 960 individuals—480 for each sex and 480 for each district. In addition, at endline, 120 peer educators (60 from each district) out of the total 1,242 peer educators in the project village development committees were interviewed. Data on reproductive health indicators show that the percentage of married adolescents visiting government health facilities for services rose from 36% (n=463) in 2005 to 42% (n=472) in 2007 and that the percentage of female adolescents who made four or more antenatal care visits during their last pregnancy increased significantly, from 29% to 50%. The proportion of young married women who delivered with the help of a skilled birth attendant also rose from 24% to 31% over the two-year period, and the proportion of deliveries taking place at home fell from 75% to 67%. In addition, the percentage of married adolescents who discussed where to deliver with their spouse increased significantly from 24% to 40%.

Adolescents' awareness of two or more modern methods of contraception, as well as their knowledge of where to obtain contraceptives, was almost universal at endline. Further analysis revealed significant increases in knowledge of individual methods. For example, the proportion of female adolescents who were aware that condom use can prevent pregnancy rose from 65% to 93% (n=480). These findings indicate greater potential for informed choice of contraceptives, especially among young women. In addition, a strong change was recorded in couples' perceptions about who is responsible for deciding whether to use family planning. At endline, 65% of female adolescents and 79% of males considered that husband and wife together were responsible for family planning decisions, up significantly from 37% of women and 57% of men at baseline.

Use of contraception before first pregnancy, however, remained low (only 4.8% among female respondents [n=333] and 11.3% among male respondents [n=283]), and no delay in childbearing was recorded. Despite evidence at the endline that more than 97% of married adolescents perceived that postponing the first birth reduced health risks to the mother, the median age at first

birth remained at 17 years (n=265). Discussions with mothers-in-law further revealed the widespread belief that contraceptive use before first pregnancy causes infertility. All of these findings indicate that early proof of a woman's fertility remains a powerful social norm among many ethnic groups in the *terai.* Longer intervention timeframes with more intensive targeting of influential family and community members will be needed to affect cultural beliefs and behaviors that negatively impact youth reproductive health decision making and outcomes. Data, though, show a trend to postpone marriage and *gauna* (the local custom when a married girl moves into her husband's home following menarche, for consummation of the marriage). Median age at marriage rose from 14 to 16 years (a statistically significant increase), while median age at *gauna* rose from 15 to 16 years. The change in age at marriage indicates improved community awareness of the health needs of youth, which in turn sets the stage for increased impact on delayed childbearing if community engagement is maintained.

Married adolescents' knowledge of HIV and AIDS and its symptoms, modes of transmission, and preventive measures also increased significantly, but levels of awareness remained lower among female respondents than among males. At endline, approximately one-third of female adolescents (32%) (n=480) had heard of HIV and AIDS, compared with 86% of male adolescents (n=480); also, 6% of young women were aware of three ways to avoid becoming infected with HIV, compared with 35% of young men. However, data show that the proportions of female married adolescents who were aware of three HIV prevention measures more than doubled over the project period.

Of important note, the project was implemented during an extremely volatile political period in Nepal. For much of the project period, districts in the *terai* were the scenes of intense civil unrest and violence, including Parsa and Dhanusha, whose district capitals, Birgunj and Janakpur, represent major transit and trading centers between Nepal and India. General strikes, transportation and road blockades, and mass demonstrations were frequently called by political parties and armed groups in the region. Health facilities were shut down, sometimes for months. However, the highly politicized atmosphere in the two districts may have heightened participants' awareness of their power to bring about social change. The ecological model successfully accommodated an expanded project focus that embraced peer initiatives in community development, local governance, and citizens' rights—all of which strongly supported the core project goal of effective access to quality reproductive health services for all married adolescents.

In particular, the project encouraged debate on social and gender norms that impact adolescent health and personal development, including early marriage and the dowry system. Child marriage eradication committees were established by youth in 33 villages of Dhanusha, and a peer-led, district-level conference in Dhanusha was organized by the RHMACP to advocate for the abolition of these long-standing practices and to support compulsory education for all children. At this gathering, representatives from all political parties expressed their commitment to these issues—a considerable achievement in one of the most culturally conservative areas of Nepal.

To achieve major changes in individual behavior and social norms, and for systemic improvements in health provision, a two-year pilot intervention is extremely short. Results to date, however, indicate that the project's ecological model and multilevel implementation strategy is an effective and sustainable approach for improving the reproductive health of married adolescents in Nepal. In the endline survey, 71% of the peer educators (n=120) reported their willingness to continue their work after the project was phased out. Postintervention visits in December 2007 and January 2008—six months after project completion—confirmed that many peer educators were still performing key roles in their communities. Participants were active in local government, community development forums, health management committees, theater

groups, livelihood projects, and savings and credit societies, as well as working to maintain project activities and networks at local and district levels. With advocacy and funding support from government authorities, including health facilities, these institutions and individuals have strong potential to secure long-term benefits. The project model is recommended for expansion in the pilot districts and to other areas of Nepal. Experience from the intervention further suggests that the model would be applicable to health development and governance initiatives in diverse country settings.

Introduction

At High Risk: Adolescent Reproductive Health Globally

The world's population today includes 1.2 billion adolescents between the ages of 10 and 19 years, representing the largest adolescent cohort in history (UNFPA, 2003). Nearly 90% of these youth live in developing nations. Typically, adolescents have been considered a low-risk group for poor health, and their health care needs have generated less attention and fewer interventions. Yet in many resource-poor settings, adolescents are extremely vulnerable to adverse health outcomes.

Globally, an estimated 14 million adolescent women aged 15–19 years give birth annually, and their risk of dying from pregnancy-related causes is twice as high as that for women aged 20–29 (WHO, 2007). For every young woman who dies in childbirth, 30 to 50 others are left with an injury, disability, infection, or disease (WHO & UNFPA, 2006). Perinatal and infant mortality rates from early childbearing are also higher, and due to high levels of malnutrition—particularly nutritional anemia—preterm delivery and low birth weight are extremely high among adolescent women (WHO, 2007).

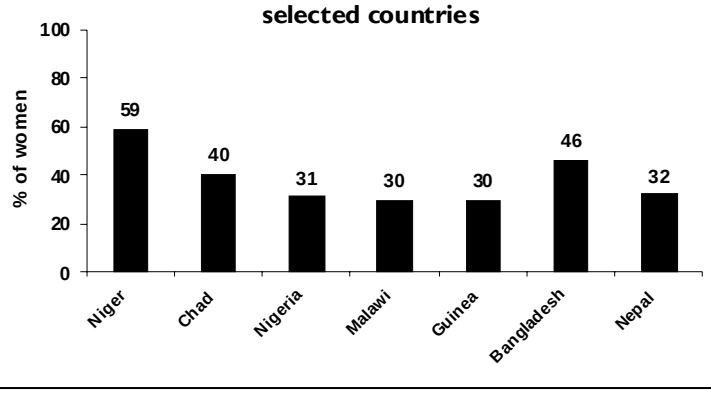
In addition, youth are at high risk of HIV and sexually transmitted infections (STIs). Young people aged 10–24 account for 60% of new cases of HIV infection globally each year, yet only a small percentage know that they are HIV-positive (UNFPA, 2003). Gender norms frequently encourage risky sexual behaviors among young men, and adolescent women are often pressured or forced into sex. In some societies, sexual intimidation and violence against young women is condoned and commonplace.

Compounding these health risks, adolescents are less likely to access essential counseling and care due to social norms and health system barriers. Young women especially have limited autonomy to make decisions about their own health care, depending instead on families, communities, and providers for approval to utilize services. In particular, lack of access to skilled attendance at birth, and delays in seeking care for maternal complications during pregnancy and obstetric emergencies, heighten the risk of maternal and fetal morbidity and mortality.

Married Adolescents: An Underserved Population

Up to three-fifths of adolescent women aged 15–19 in South Asia and Sub-Saharan Africa are married (Figure 1) (Measure DHS, 2008). Marriage commonly marks the point in a woman's life when childbearing becomes socially acceptable, and in some cultures, women face extreme pressure to demonstrate their fertility soon afterwards (Mathur, Greene, & Malhotra, 2003).

Figure 1: Percentage of adolescent women aged 15–19 who are currently married, selected countries



Early marriage is, therefore, a strong determinant of early childbearing, with its associated risks, and care during pregnancy often ranks low among family priorities.

In many developing country settings, marriage brings radical change to an adolescent woman's life. Her marriage will often prescribe where she lives, with whom she is permitted to associate, and what happens to her sexually, physically, and emotionally. Pregnancy and motherhood commonly cut short an adolescent woman's education, thereby undermining personal development, economic prospects, employment opportunities, social networks, and overall well-being.

The misconception persists that once women are married, they are protected from unintended pregnancies, STIs, and HIV. In some societies, this belief is a central reason behind encouraging girls to marry at very young ages (Chowdhury, 2004). However, marriage often subjects women to early, unprotected sexual activity, and adolescent women usually marry older men who, because of their age, are at greater chance of having been infected with HIV (Bruce & Clark, 2004). Research in Sub-Saharan Africa has found that married adolescent women have higher rates of HIV than their unmarried, sexually active peers (Clark, 2004). A review of research on forced sexual relations among young married women in developing countries found that between 3% and 23% of women aged 15–24 had experienced nonconsensual sex with a current or former spouse and that women who marry in adolescence are more likely to experience sexual violence than are women who marry later (Population Council, 2004).

Research has also revealed that married adolescent women have more limited support systems and social networks, less freedom of mobility, and less exposure to information and media than do both their unmarried counterparts and older married women. They also have less schooling than unmarried girls, and less decision-making power in their households than older married women have (Haberland, Chong, & Bracken, 2004; Amin, Mahmud, & Huq, 2002; and Santhya et al., 2003). Restriction to their homes makes it difficult to reach married women alone, away from the pressure of family members such as husbands and mothers-in-law. As a consequence, married adolescent women are at a distinct disadvantage in accessing critical health information and services, even from their peers.

Young married men are also affected by the lack of health care services. A comprehensive report on men's reproductive health in 23 countries revealed a high unmet need for family planning services, HIV testing, and STI treatment (AGI, 2003). Some men infected with STIs reported that they tried to treat themselves or that they sought care from traditional healers because they were more affordable, more respectful, and less judgmental than are health care workers. Many married men expressed the desire to plan the timing of births or to not have any more children, but a significant proportion was not protected by a modern method of contraception. Educating men to practice safer sexual behaviors, coupled with an expanded scope of services available, can positively impact men, their partners, and their children.

Despite the urgent needs for reproductive health information and services for married adolescents, few programs to date exist for this population (Bruce, 2001). Most adolescent health interventions target unmarried adolescents. They often emphasize abstinence and rarely include discussion of antenatal and obstetric care or mother-to-child transmission of HIV. Programs are also commonly conducted in schools or youth centers, places not usually attended by married couples. In the absence of targeted interventions, married adolescents are frequently excluded by default.

Married Adolescents in Nepal

Nepal is an important setting for addressing youth reproductive health needs, with almost one-quarter of the country's population of 27.8 million (PRB, no date) between 10 and 19 years of age (MOHP [Nepal], New ERA, and Macro International, 2007). The country is extremely impoverished; in 2006, gross national income per capita was estimated at US$320, ranking Nepal 192nd out of the 209 listed countries in world development indicators (World Bank, no date). Levels of education and literacy are also low, especially among women. More than half (53.1%) of Nepalese women have never been to school, and 45.5% are illiterate. In comparison, 21.5% of men have no formal education, and 21.3% are illiterate (MOHP [Nepal], New ERA, and Macro International, 2007). Schools provide little education about sexual and reproductive health, and reproductive health issues are not openly discussed in families. Only 28% of women and 44% of men aged 15–24 have comprehensive knowledge about HIV transmission and prevention (MOHP [Nepal], New ERA, and Macro International, 2007). Adolescent women are particularly vulnerable. With limited access to institutionalized structures such as schools and health facilities, they often rely on informal communication networks for information.

Adolescent marriage and childbearing are major social and health issues. The most recent revision of the National Code of Nepal, 2062 (2006), sets the minimum age of marriage for both females and males at 18 years with parental consent and at 20 years without parental consent. However, early marriage and payment of dowries is still widely practiced, especially in the *terai* or Madhesh region of the country (Dhital, no date). In this tradition, parents arrange the marriages of children at an early age (as young as 5 years old), and girls are sent to their husband's home upon menarche to consummate the union. This transition is referred to as *gauna.* At *gauna* (if not before), the girls' parents are required to hand over the dowry price to the bridegroom's family. The dowry demanded can represent a heavy economic burden for the bride's family. As the dowry price is set according the education, qualifications, and social standing of the boy, marriage becomes more complicated and expensive as the girl gets older. Keeping an unmarried daughter at home, therefore, becomes a source of anxiety for parents, compelling them to arrange their daughters' marriages as soon as possible. The expense of the dowry, too, often undermines any chance that parents will pay the "double" expense of the girls' education. Upon reaching *gauna,* an adolescent girl can also face harsh discrimination, violence, and even death in her in-laws' household, if her parents are unable to pay a stipulated or sufficient dowry.

Nationally, the median age at first marriage among women aged 20–49 is 17.2 years; for men, it is 20.2. Almost one-third (32.2%) of women aged 15–19 are married. By age 18, 60% of Nepali women are married, and by age 20 this proportion rises to 78%. In the central *terai* subregion—the focus area for the current project—the median ages at first marriage are even lower, at 16.4 for women and 19 for men (MOHP [Nepal], New ERA, and Macro International, 2007).

Median age at first sexual intercourse among women is 17.2 years—identical to the median age at first marriage, suggesting that for the vast majority of women, sexual debut occurs during adolescence and at the time of first marriage. The median is 19.7 for men, two and one-half years older than among women in the same age-group, yet lower than the median age at first marriage. These data indicate that Nepalese men tend to marry later, but unlike Nepalese women, they frequently initiate sexual activity before marriage (MOHP [Nepal], New ERA, and Macro International, 2007).

Nepalese women often face extreme cultural and social pressure—intimately connected to gender perceptions of women and the dowry system—to demonstrate fertility soon after marriage. Median age at first birth is 19.9 years, and more than two-fifths (41%) of women are already mothers or

pregnant with their first child by age 19. Only 9% of women aged 15–19 have ever used any modern method of contraception. However, adolescents' access to skilled pregnancy and delivery care in Nepal is limited. Among women giving birth before age 20, only 51% received antenatal care from a skilled birth attendant, and only 22% of births delivered with the help of a skilled birth attendant. More than one in four female adolescents aged 15–19 (26.8%) die of pregnancy-related causes (MOHP [Nepal], New ERA, and Macro International, 2007).

Recognizing the acute social and health needs of married adolescents in Nepal, the ACQUIRE Project, in association with CARE Nepal and with funding from the U.S. Agency of International Development (USAID), implemented a two-year pilot project—the Reproductive Health for Married Adolescent Couples Project (RHMACP)—in 2005 in Parsa and Dhanusha, two central *terai* districts of Nepal. In close collaboration with the District Public Health Offices, the project established a peer education network to disseminate reproductive health information to married couples. The project also supported local health facilities to provide youth-friendly services and fostered an enabling environment among parents, in-laws, and influential community members to improve married adolescents' access to and use of health services.

Of immediate note, the project was undertaken during an extremely volatile political period in Nepal, particularly throughout the *terai*. A civil conflict led by Maoist groups opposing Nepal's constitutional monarchy has been going on since the mid-1990s (CIA, 2008). Early in 2005, the then Head of State, King Gyanendra, dissolved the parliament, declared a state of emergency, and imprisoned leaders of political parties. The King retained absolute power until April 2006, when mass protests forced him to allow the parliament to reconvene. A peace accord was subsequently negotiated between the government and the Maoists in November 2006 and an interim constitution promulgated, pending multiparty elections in April 2008.

For much of the project period, districts in the *terai* were the scene of intense political unrest and violence, including Parsa and Dhanusha, whose district capitals, Birgunj and Janakpur, represent major transit and trading centers between Nepal and India. Numerous general strikes, transportation and road blockades, and mass demonstrations—collectively known as *bandhs*—were called by political parties and armed groups. In 2007 alone, the United Nations Office for the Coordination of Humanitarian Affairs recorded that Parsa and Dhanusha were affected by between 61 and 119 days of *bandhs*/observed blockades (UNOCHA, 2008). RHMACP staff confirmed the heavy impact of these events. Various health facilities in the districts were shut down, sometimes for months, with medical personnel fleeing conflict areas. Essential health services were unavailable for lengthy periods of time, and project activities were disrupted. The *bandhs* also heavily affected the ability of project staff to travel to project sites to assist and monitor peer educators.

This final report presents the experience and impact of the intervention. It describes the project's conceptual framework, implementation strategy, and evaluation methodology, and details the results of the intervention, as assessed by changes in key reproductive health indicators from quantitative surveys and qualitative study methods (discussions and interviews) conducted among the target population at project start and completion. Case studies are also included to offer narratives on the intervention's impact on participants' lives. Finally, this report discusses key lessons learned and provides recommendations on future interventions to meet the needs of married adolescents throughout Nepal and in other developing country settings.

The Reproductive Health for Married Adolescent Couples Project (RHMACP)

Conceptual Framework

The project design for the RHMACP—developed by the ACQUIRE Project—employed an ecological model (Dahlberg & Krug, 2002). This model recognizes that health behaviors are influenced by multiple individual and societal factors, including age at marriage, partner involvement, family communication, and health system characteristics. To affect and sustain behavior change, comprehensive interventions are needed that not only engage individuals at risk of poor health outcomes, but also target family and community members who influence individual behavior, health care personnel and policy makers responsible for the provision of health services, and the social norms, beliefs, and systems that impact health practices within communities.

Interventions utilizing an ecological model, therefore, operate at multiple levels to improve the health outcomes of a target population:

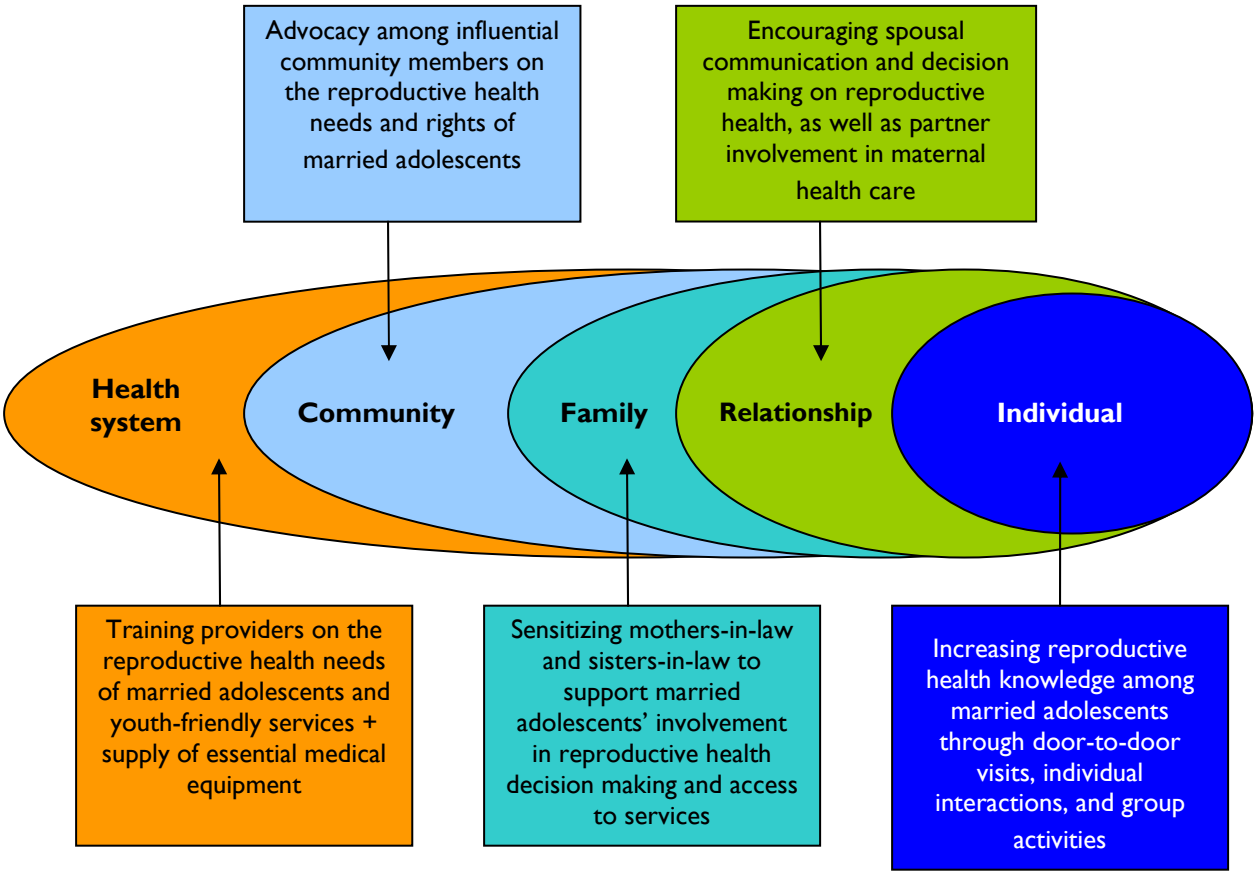
- *At the individual level* by strengthening expression, knowledge, and skills to adopt positive health attitudes and practices
- *At the relationship level* by improving interpersonal communication and decision making on health care, and by encouraging partner involvement
- *At the family level* by sensitizing family members about health risks and ways to support individuals to ensure their well-being
- *At the community level* by advocating for individual health needs and rights among influential community members, and by facilitating change toward organizational and social norms that protect individual health and safety
- *At the health system level* by enhancing the capacity of health care providers and facilities to deliver quality care, and by influencing health policies and procedures to expand access to essential services

The ecological model used by the RHMACP (Figure 2, page 6) reflects that the options and actions of young people in cultures such as Nepal (with strong, aged-based hierarchies) are integrally connected to, and affected by, adults. Thus, adult approval and buy-in underpin both youth participation in interventions and behavioral change. Young people need to be actively supported to make responsible decisions about partners, sexuality, marriage, contraception, and childbearing. The transitional years of adolescence present critical opportunities to encourage positive reproductive health choices. Moreover, influencing adult behavior and attitudes as well as community perceptions are equally, if not more, important for achieving and sustaining an impact on young people's reproductive health. Good health outcomes for married youth require sound knowledge and open communication on health issues within families and communities, as well as effective access to quality health services.

Project Goals and Objectives

The goal of the RHMACP was to improve the reproductive health status of married adolescents in Parsa and Dhanusha districts—two districts of the central *terai* region of Nepal—by increasing their access to and use of reproductive health information and services. To achieve this goal, the project aimed to achieve the following three objectives:

Figure 2: The RHMACP Ecological Model



- Increase married adolescents' knowledge about family planning, maternal health, and HIV and STIs
- Increase health service providers' knowledge about the reproductive health needs of married adolescents (including information related to pregnancy, delivery and postnatal care, family planning, and HIV and STIs) so as to improve married adolescents' access to quality health services
- Increase community and family support for reproductive health decision making by married adolescent couples, especially related to family planning and pregnancy, delivery, and postnatal care

Project Area

The RHMACP covered 69 out of the 183 village development committees (VDCs) [2] of Parsa and Dhanusha. Three VDCs were selected from each of the 23 *ilakas*[3] across both districts. Based on population estimates for the two districts for 2005–2006 (763,000 in Dhanusha and 568,000 in Parsa), the population in the 69 project VDCs was estimated to be approximately 502,000 (MOHP,

[2] VDCs in rural areas and municipalities in town areas comprise the lower tier of the two-tier system of local government in Nepal. All VDCs are then divided into nine wards. Most VDCs are serviced by a sub-health post.

[3] The *ilaka* is a political unit consisting of a cluster of VDCs and municipalities with a health post. Dhanusha and Parsa districts have 14 and nine *ilakas* respectively.

2006). The project covered eight primary health care centers, 18 health posts, and 43 sub-health posts (see Figure 3, page 8).

Target Groups

Primary targets of the project were married women below the age of 20 years and their husbands. Secondary targets included service providers at government health facilities; influential community members; influential family members, such as mothers-in-law and sisters-in-law; and youth under 25 years of age.

Implementation Strategy

Consistent with the project's ecological model, the implementation strategy used three mutually reinforcing approaches to meet the project goal. The strategy was designed to improve service utilization among married adolescents by increasing both the demand for and the supply of quality health services for this population.

The three approaches, discussed in detail below, were as follows:

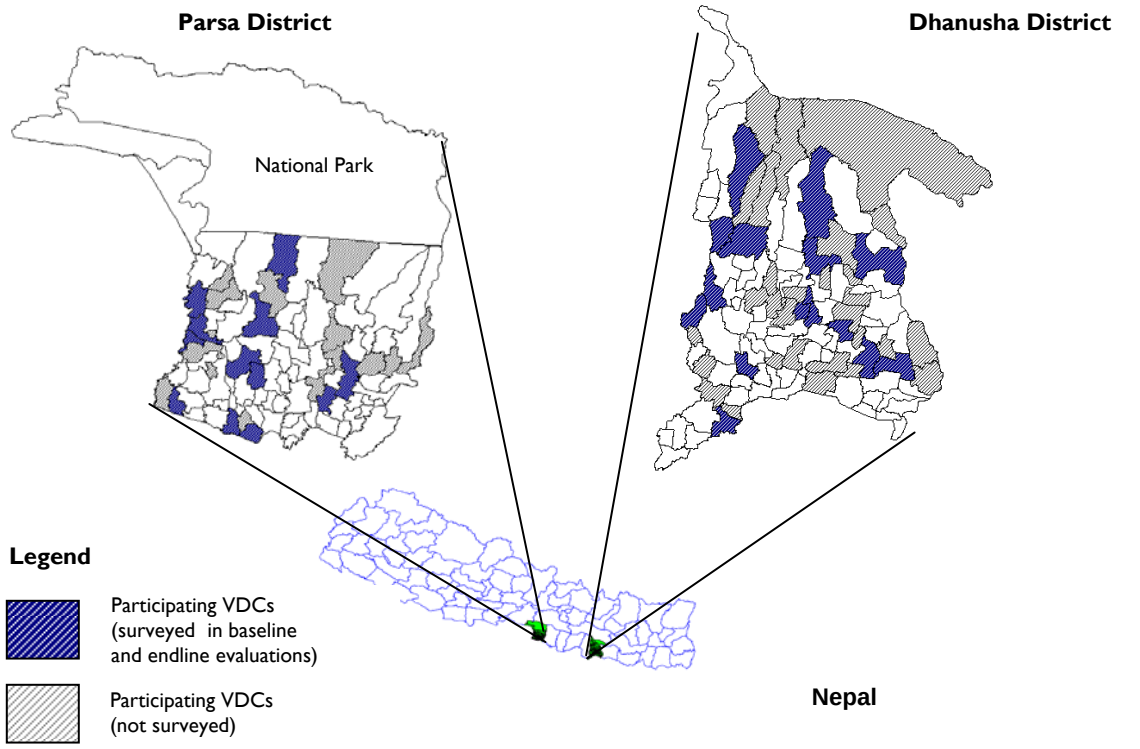
1. Educate married adolescents as peer educators to provide reproductive health information by organizing individual and group educational events
2. Create an enabling environment for married adolescents to access essential reproductive health information and services by working with influential family and community members to raise awareness of adolescent health needs and rights
3. Support local health facilities to provide youth-friendly services

At the district level, a project officer and a team of sexual and reproductive health facilitators were responsible for implementing project activities (see Appendix A for the project's management structure). In close collaboration with government health facilities, the sexual and reproductive health facilitators recruited, trained, and supervised peer educators at the VDC level. For the first year, eight facilitators were appointed, but this number was increased to 13 in the second year—eight in Dhanusha District and five in Parsa District—when project management identified the need for more intensive support at field level. Upon commencement of the RHMACP, project staff and District Public Health Officers participated in a training of trainers workshop to enhance their reproductive health knowledge and facilitation skills. Detailed project plans were also prepared. Throughout the project period, RHMACP staff worked closely with key health and administrative officials at all levels—district, *ilaka,* and VDC—to ensure local support and effective implementation. A second six-day training of trainers was held for SRHFs in September 2006.

Education and Activities for Married Adolescents

Acknowledging the importance of like-minded homogeneous groups in promoting behavioral change, a peer education approach was chosen. Two married youth from each ward of the 69 project VDCs—one male and one female—were trained and mobilized voluntarily to serve as community role models and "change agents."' The recruitment process sought to ensure representation from all ethnic groups, including *dalit* (lower caste) ethnicities and other marginalized groups.

Figure 3: Project districts with participating Village Development Committees (VDCs)



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. Peer educators also referred married adolescents to health services, distributed condoms and contraceptive pills, and ensured that condoms were restocked at designated community locations, such as shops. In addition, a special campaign called "Teen Saathi Abhiyan" (TSA) was organized, in which peer educators identified three close friends and met with them regularly to share the knowledge and skills they had gained through their training and community activities. TSA participants in turn supported peer educators in hosting events, and in some cases replaced peer educators who dropped out of the project.

Peer educator training

The training program for peer educators had four principal components over the project period (see Appendix B).

- *Basic training on reproductive health and dissemination skills (3 days).* Workshops were conducted at the VDC level with 18 participants per event. A total of 1,241 married youth participated.
- *Facilitation and communication skills training (2 days).* Workshops were again held at the VDC level, and 1,153 youth attended. Village health workers (VHWs) and maternal and child health workers (MCHWs) also participated, which increased the workers' individual capacity as well as their understanding of peer educators' roles and responsibilities.
- *Leadership development training (5 days).* One peer educator from each of the 69 project VDCs was trained in leadership skills. Major topics included coordination and networking skills, problem solving, social inclusion, community mobilization, good governance and transparency,

women's rights, and volunteerism. To facilitate ongoing peer education and community advocacy, participants were provided with a flex chart with reproductive health messages, a documentary on early marriage and the dowry system, the Local Government Act, 2055 (1999), and the Interim Constitution of the Government of Nepal.

- *Street drama performance arts training (7 days).* Twenty-five peer educators were trained to develop and perform street theater that incorporated messages on the reproductive health needs and rights of adolescents, on HIV and AIDS and STIs, on child marriage, and on dowry practices. The workshop was conducted with technical assistance from Mithila Natyakala Parishad, a celebrated drama collective that has performed in the *terai* for more than two decades. Following the training, participants established theater groups in both districts.

Activities for married adolescents

Peer educators conducted door-to-door visits to the homes of married adolescents in their wards to provide information and counseling on reproductive health and organized a variety of communal activities (such as group counseling and interaction sessions for married adolescents; pregnant mothers' gatherings at health facilities; advocacy workshops for influential family and community members on the reproductive health needs of married adolescents; wall painting; street theater; and community rallies). Activities implemented in VDCs were based upon local needs and priorities identified by peer educators during their community outreach work and were selected and planned in collaboration with health workers and sexual and reproductive health facilitators at monthly review/reflection meetings (see below). Table 1 lists communal events most frequently implemented at the local level over the project period.

Table 1. Communal events for married adolescents, by district

Description of activity	No. of events		
	Dhanusha	Parsa	Total
Wall painting with messages related to reproductive health and family planning, education, early marriage, dowry system	Many	Many	Many
Sensitization meeting with adolescents about gender issues and reproductive health rights and responsibilities	61	—	61
Sensitization meeting with newly married females on family planning and safe motherhood	42	8	50
Mass interaction program on reproductive health	36	11	47
Formation of child marriage eradication committee	33	—	33
Pregnant mothers' gathering at health facility to provide reproduc-tive health and family planning information and antenatal care services	16	12	28
Community rally on reproductive health and family planning, on HIV and AIDS, and/or against early marriage and dowry system	19	8	27
Street drama performances incorporating messages related to reproductive health and family planning, early marriage and dowry system, good governance, etc.	8	9	17
Social mapping to identify health and social issues in communities	—	10	10

Monthly review/reflection meetings with peer educators at the VDC level

Monthly meetings with peer educators were conducted at the VDC level to provide a forum where peer educators could share their feelings, experiences, problems, accomplishments, and lessons learned. The peer educators also updated their records of married adolescents in their localities and planned activities for the upcoming month. Sexual and reproductive health facilitators and in-

charges from local health posts facilitated these meetings. A total of 779 monthly meetings were held across the two districts from January 2006 until the end of the project period.

Creating an enabling environment

Given the deeply rooted social norms in the central *terai*, married adolescent couples may be discouraged by their families and communities from discussing reproductive health issues and may be prevented from accessing essential information and services. Therefore, fostering an enabling environment for married adolescents is vital to improve education and service utilization. To achieve this, the RHMACP implemented education and advocacy activities with influential family and community members to increase social support for reproductive health decision making among married couples. In addition, the RHMACP conducted community talk programs, street theater, wall painting, video shows, rallies, and outreach through radio, television, and newspapers.

Discussion groups with mothers-in-law and sisters-in-law

Traditionally, mothers-in-law and sisters-in-law are key reproductive health decision makers for newly married women. To raise awareness of the needs and rights of married adolescent couples, peer educators (along with project and health facility staff) led discussion sessions with these family members. Sessions focused on the serious health risks of early marriage and childbearing, the benefits of family planning to delay first pregnancies and space births, and the importance of using maternal health services. Over the project period, 168 discussion groups were conducted involving 4,037 participants.

Advocacy workshops with influential community members

The RHMACP carried out *ilaka*-level advocacy workshops with influential community members—including religious leaders, school teachers, and politicians—to promote the reproductive health needs and rights of married adolescent couples. These local stakeholders often play major roles in setting or enforcing social norms and can therefore influence families when making decisions that affect adolescent health. A total of 703 community members participated in 19 workshops. These workshops were a key platform in securing community support to establish and strengthen child marriage eradication committees in 33 VDCs of Dhanusha.

Sensitization workshops with female community health volunteers

The SRHFs together with local health facility staff also conducted one-day workshops for female community health volunteers to sensitize them to the reproductive health needs and rights of married adolescents. A total of 553 female community health volunteers participated. The workshops also fostered the working relationships between the health volunteers and the peer educators. In some communities, the two groups collaborated to make condoms more readily available by placing boxes of condoms in public areas, such as local shops.

Supporting local health services

The RHMACP carried out four types of major activities to strengthen youth-friendly services at local health facilities.

Training to health service providers

All staff in public-sector health facilities within the project VDCs were trained on the concepts, characteristics, delivery, and monitoring of youth-friendly services, using a curriculum developed by EngenderHealth. A total of 265 health workers participated. In addition, 117 providers were given two days of training on couples counseling (see Appendix B).

Provision of essential equipment to health facilities

The RHMACP supplied essential medical equipment, furniture, and curtains to 59 health facilities, through the District Public Health Offices, to improve the overall quality of services available and to enable youth-friendly services components to be integrated into service routines.

Technical support visits to health facilities

Project officers and sexual and reproductive health facilitators also made 327 technical support visits to health facilities to coordinate activities with peer educators, develop joint work plans, and monitor the availability and quality of youth-friendly reproductive health services, including staffing levels, condition of equipment, display of reproductive health information, facility layout, and availability of counseling space.

Ilaka-level meetings with health service providers

The project provided technical support to semiannual *ilaka*-level meetings of health service providers in both districts. These meetings were used to review targets and achievements in client utilization and to discuss ways to improve reproductive health indicators, including the provision of youth-friendly services.

Information, Education, and Communication Materials

The project published a variety of information, education, and communication (IEC) materials to facilitate dissemination of reproductive health information by project staff, peer educators, and health facilities. Materials included a poster-sized flex chart with reproductive health and family planning messages, a handheld flipchart with detailed reproductive health information for use in group discussions, and a reproductive health training manual. Other materials were produced for project publicity and advocacy at district, national, and international levels, including a video entitled "Waves of Change" that documented the experiences of several outstanding peer educators. Major publications are listed in Table 2 (page 12).

Table 2. List of major IEC materials

Publication	Languages	Purpose	Date of publication
Flex Chart (poster)	Maithali and Bhojpuri	Reproductive health and family planning messages	2006
Peer Educators' Voices (booklet)	Maithali and Bhojpuri	Stories, poems, articles, and experiences of peer educators, health workers, and project staff	2007
Reproductive health training manual	Nepali	Reproductive health issues and communication, facilitation, and leadership skills	2007
Flipchart	Nepali	Pictorial flipchart comprising detailed information on reproductive health to be used for group discussions	2007
Lifting the Veil	English	Photojournal with case stories of changes observed in the lives of married adolescent couples in the project area	2007
Waves of Change (video documentary)	English	Peer educator mobilization and its achievements	2007

Evaluation Methodology

Baseline and endline surveys

Baseline and endline evaluation surveys were carried out by New ERA, a specialist development research and training organization based in Nepal, to:

- Evaluate the needs of married adolescents in the project districts
- Modify activities to better target this population
- Assess the impact of intervention

The baseline survey was carried out in September 2005; the endline was conducted in October 2007. The surveys measured the extent to which project interventions affected knowledge, attitudes, behaviors and practices related to reproductive health among married adolescent women and their husbands, as well as changes in perceptions of adolescent reproductive health issues among influential people within households, members of the community, and service providers. Both quantitative and qualitative methods of data collection were performed. The endline study followed the same methodology as the baseline study and adapted the baseline tools as needed, so as to generate comparable data and ensure that indicators accurately measured change resulting from the intervention.

Quantitative data were collected using the Demographic and Health Surveys (DHS) model structured questionnaires, which were designed, pretested, and translated into Bhojpuri and Maithali (two languages widely spoken in Nepal). A 30-cluster sample of VDCs was generated from the 69 project VDCs. Baseline and endline surveys used the same clusters, with resampling of respondents from VDC household listings. The sample size for both surveys was 960 individuals—480 for each sex and 480 for each district. Male and female respondents were selected from alternate households, and an equal number of respondents (16 males and 16 females) were interviewed from each sample VDC. In addition, at the endline, 120 peer educators (60 from each district) out of the total 1,242 peer educators in the project VDCs were selected randomly and interviewed.

Qualitative data were collected principally through focus group discussions (FGDs), to further assess changes brought about by the project and to examine the broader social factors contributing to these changes. At baseline, a total of eight FGDs were conducted—four sessions among mothers-in-law and four among husbands of married adolescent women in the sample VDCs. Four sessions were conducted in Dhore and Bairiya Birta VDCs in Parsa District; the other four were held in

Sinurjoda and Nagrain VDCs of Dhanusha District. For the endline survey, 12 FGDs were conducted, six in Parsa and six in Dhanusha. Four sessions were conducted with married adolescent women, four with mothers-in-law, and four with husbands of married adolescent women in the sample VDCs. Each session had 8–10 participants. At endline, one FGD in each district was held with the project's sexual and reproductive health facilitators.

Case stories

Throughout the project period, case stories of peer educators and married adolescents involved in project activities were also collected, to understand more deeply the social and health-related impact of the project on the lives of participants, their families, and communities. The following case stories have been included with this report, in Appendix 4.

- *Lifting the Veil* tells the story of Sita Devi Shah, a peer educator for RHMACP in Thera VDC. Among her many efforts to improve the health and well-being of married youth in her village, she publicly challenged the "in-charge" of the local health post, who had refused to examine lower caste women with STI symptoms. Empowered through her training as a peer educator, Sita Devi has become a role model for her whole community.
- *Unprecedented Actions to Realize Youth-Friendly Services* highlights the extraordinary efforts of four peer educator couples to improve services at their local health facility for the benefit of the entire community. These four individuals are examples of the outstanding community work of the pairs of peer educators—one male and one female—who were invited to sit on the health management committees of 28 out of the 69 project VDCs.
- *A Tireless Advocate for Community Health* illustrates the importance of the project's comprehensive ecological model—how building an enabling environment among influential family and community members is a necessary foundation for improving individual health outcomes.
- *Where Health Education and Good Governance Connect* describes the significant advances in health and governance in Basbitti VDC, where a development forum established by an RHMACP peer educator is now recognized as one of the most active community-based organizations in Dhanusha district.
- *One Girl's Fight to Stop Child Marriage* demonstrates the powerful impact of the RHMACP on the lives of individual participants and how local advocacy campaigns established by the project are influencing communities to embrace change in social norms to protect the health and well-being of young people.

Service statistics for participating health care facilities in project VDCs

At the outset of the project, forms were developed to record peer educators' involvement in distributing condoms and oral contraceptives and in referring youth with STI symptoms to health facilities. However, given low levels of literacy among peer educators and the additional workload this entailed on top of their other volunteer duties, this monitoring system was not implemented. Instead, health workers were requested to collect these data for inclusion in the health management information system (HMIS). From 2005 onward, for the first time, the HMIS in the 69 project VDCs recorded services provided to clients under 20 years of age.

Project Impact

Project interventions proved to be landmarks at the individual, relationship, family, community, and health system levels in increasing awareness of the reproductive health needs and rights of married adolescents as well as the availability, quality, and use of local health services. Young people in many of the project VDCs effectively organized themselves to improve local health facilities and the provision of services for youth. They were also empowered to challenge social norms that impact their health and well-being, such as early marriage, the dowry system, and the restriction of married women within their households.

A two-year project period is an extremely short time to produce systemic change in health care provision in resource-poor settings and communal change in long-standing social norms and health behaviors. However, positive trends in reproductive health indicators for married adolescents in the project VDCs are evident, together with noticeable shifts in individual, family, and community perceptions and attitudes toward eliminating harmful practices and expanding married adolescents' access to reproductive health information and services.

Married youth who were trained during the RHMACP have also been at the forefront of campaigns that significantly improved local governance for the benefit of all community residents. The five stories of outstanding peer educators presented in this chapter clearly reflect the transformative nature of project interventions at both the individual and the societal levels. Empowered by the training and support of the RHMACP, many young people seized the chance to make positive changes in their lives. Many participants overcame substantial barriers and risks during implementation to become champions within their communities.

Married Adolescents' Reproductive Health Knowledge and Use of Health Services

Overall use of health services

The percentage of married adolescents visiting government health facilities for services rose from 36% in 2005 to 42% in 2007 (n=960). Higher proportions of respondents, especially young men, also reported receiving information on family planning/reproductive health services from health workers, from female community health volunteers and from their peers during the six months preceding the endline survey (Figure 4, page 16).

Family planning

Awareness of modern methods of contraception

The percentage of married adolescents who were aware of two or more modern methods of contraception was over 90% for both sexes in the 2005 baseline survey and was almost universal at the endline in 2007 (98% among young women and 99% among young men; n=480). Further analysis revealed significant increases in the knowledge of individual methods. At baseline, female sterilization and injectables were the most commonly cited methods among female adolescents, while female and male sterilization, condoms, and injectables were the most widely known methods among male adolescents. By the endline, there were significant increases in young women's knowledge of condoms, hormonal implants, oral contraceptives, male sterilization, and injectables and in male adolescents' awareness of oral contraceptives (which rose from only 4% to 84%)

(Table 3). The results indicate greater potential for informed choice of contraceptive methods, especially among young women.

Figure 4. Percentage of married young women and married young men who received information on family planning/health services in the six months prior to the baseline and endline surveys, by source

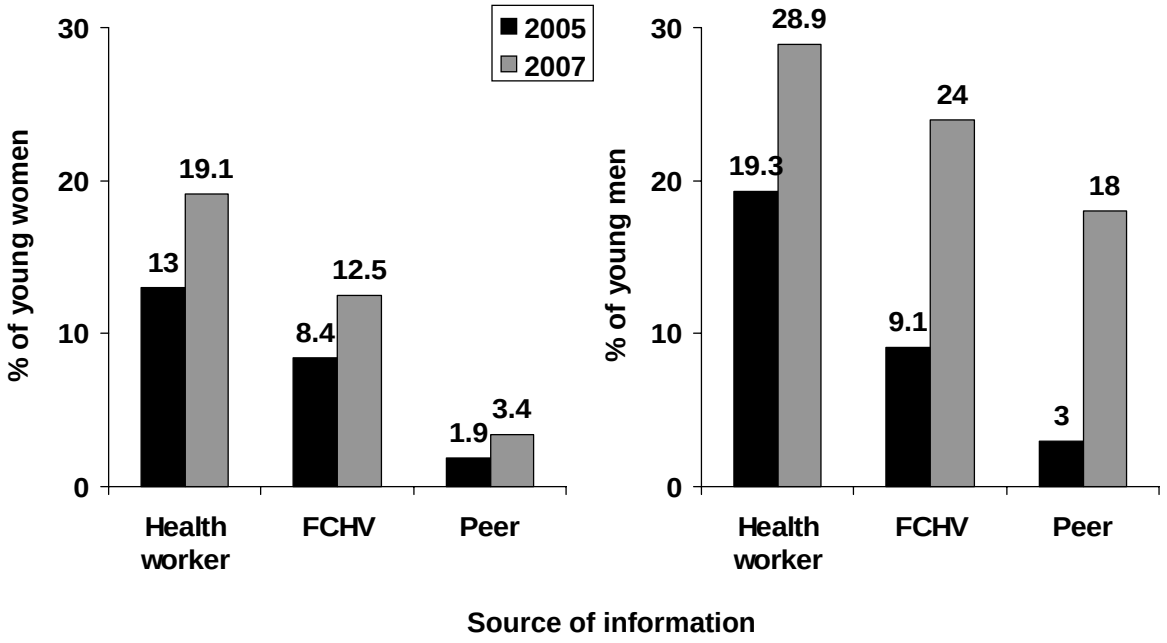


Table 3. Married adolescents' knowledge of modern methods of family planning

Method known	Females (%)		Males (%)	
	Baseline	Endline	Baseline	Endline
Injectables	85.4	94.7*	91.9	92.5
Oral contraceptives	74.2	84.1*	4.4	84.0*
Condom	70.0	94.7*	94.9	99.3*
Implants	51.5	68.9*	39.9	43.9
IUD	19.7	25.5	26.6	28.5
Foam/jelly	2.7	3.2	7.7	5.7
Female sterilization	94.3	96.2	98.6	98.2
Male sterilization	67.3	78.6*	83.7	88.5

* Difference between baseline and endline data is significant at p<.05.
Source: RHMACP Endline Evaluation, New ERA, March 2008

In addition, awareness that condom use can prevent pregnancy rose significantly, from 65% to 93%, among female adolescents, and increased from 90% to 98% among male adolescents. The percentage of young women who knew where to get contraceptives also rose, from 84% in 2005 to 98% in 2007, while awareness of sources among young men increased from 96% to near universal (99.8%) (n=980).

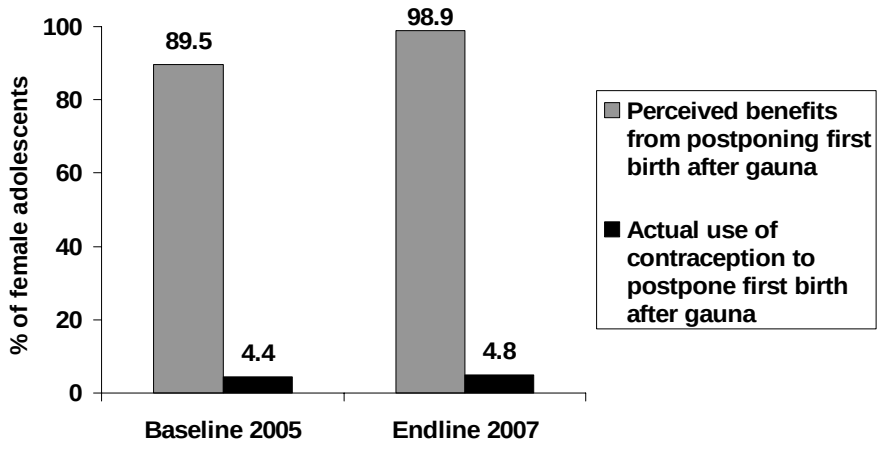
Perception of benefits in postponing first birth and decision making on family planning

Both baseline and endline survey results show that most married adolescents perceived benefits in postponing the birth of their first child after *gauna*. The percentage of female respondents who thought there were benefits to delaying childbearing increased from 90% to 99% (n=480); for male respondents, the figure rose from 93% to 96%. The vast majority of young women and men perceived that postponing the first birth reduced health risks to the mother. Strong change was also recorded in perceptions among couples 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 are responsible for family planning decisions, up significantly from 37% and 57%, respectively, at baseline.

Use of contraception before first pregnancy

In contrast to high levels of awareness of modern contraceptive methods and of the benefits of postponing childbearing, contraceptive use before the first pregnancy rose only slightly among female respondents over the project period, from 4.4% (n=294) to 4.8% (n=333), and did not change among male respondents (about 11% both at the beginning and at the end of the project period). Condoms were the most common family planning method used by both sexes. A large gap, therefore, was observed between adolescents' perceptions of the benefits of postponing the first birth and their contraceptive practice to delay pregnancy (Figure 5).

Figure 5: Percentage of female married adolescents who perceived benefits from postponing the first birth and percentage who used contraceptives to postpone the first birth following *gauna*



When asked in 2005 their reasons for not using family planning before their first pregnancy, similar proportions of female and male respondents (76% [n=277] and 84% [n=240], respectively) reported that they wanted to have a child. However, in 2007, the percentage of female adolescents citing this reason declined to 70% (n=323), while the proportion of male respondents giving this answer increased to 92% (n=238). These findings appear to indicate a growing demand for contraception before first pregnancy among women, particularly among very young adolescents (those aged 16 and younger), but a corresponding decline among young men in support for delayed childbearing.

However, HMIS data from the 42 project VDCs in Dhanusha District show an increase in the total number of adolescents using family planning over the project period, from 996 individuals in 2004–2005 to 1,513 in 2006–2007, representing a 52% increase in the number of users over two years.

Maternal health

Knowledge of danger signs during pregnancy, delivery, and postpartum

Comprehensive knowledge of the danger signs for pregnancy, delivery, and the postpartum period was extremely low and showed little improvement over the duration of the project. For example, among the 480 respondents, only 0.2% of married adolescents were aware of all five danger signs for pregnancy, and 0.0% were aware of all five danger signs for delivery. However, this general assessment of respondents' knowledge concealed significant changes in awareness of individual danger signs among both female and male respondents. For example, 93% of female adolescents and 84% of male adolescents were aware that labor lasting more than eight hours without progress was a sign to seek immediate medical help (Table 4).

Table 4: Married adolescents' awareness of selected maternal danger signs, by sex

Emergency symptoms	Females (%)		Males (%)	
	Baseline	Endline	Baseline	Endline
Pregnancy				
Severe headache	17.4	25.2*	17.4	49.9*
Any amount of bleeding	21.6	36.2*	31.1	41.0*
Labor/delivery				
Long labor (lasting >8 hours without progress)	78.1	92.8*	75.2	84.4*
Postpartum				
Excessive bleeding	25.2	38.1*	31.2	45.5*
Severe headache	7.4	12.7*	8.6	23.2*

* Difference between baseline and endline data is significant at $p<.05$.

Peer educators' lack of knowledge of danger signs could have contributed to the low levels of awareness among married adolescents. For example, of the 120 peer educators interviewed in the endline survey, only 8% were aware of all five pregnancy danger signs, and 8% of respondents were aware of all five delivery danger signs. Increased availability of IEC materials, especially visual tools designed for audiences with little formal education, will be required to improve retention and dissemination of detailed clinical information such as danger signs.

Knowledge and use of antenatal care

The percentage of female married adolescents who were aware of the need for at least four antenatal care visits improved from 19% (n=463) to 28% (n=472), and the proportion making four or more antenatal care visits increased significantly, from 29% to 50% (Figure 6). The proportion of women attending antenatal care at least once during their last pregnancy also rose significantly, from 79% (n=240) to near universal coverage (98%) (n=269). Overall, the mean number of antenatal care visits increased from 2.7 to 3.7 visits. The following quote from a participant in a pregnant mothers' gathering offers further evidence of increased awareness about the importance of pregnancy care:

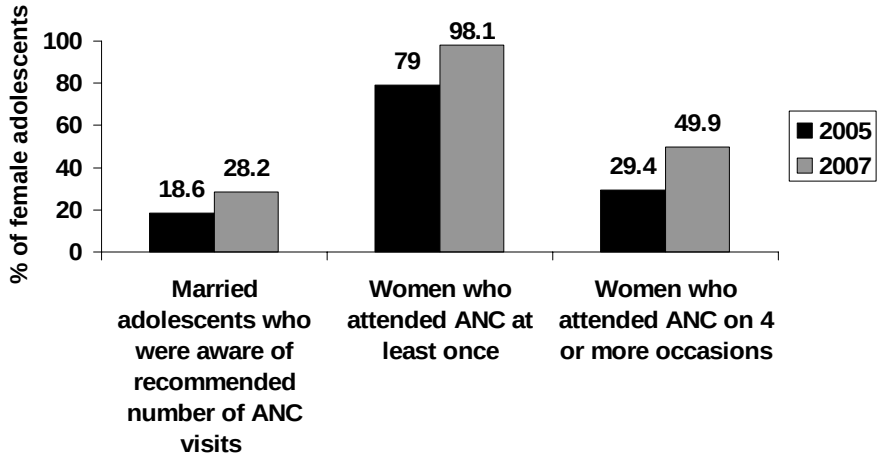
> *After participation in the pregnant mothers' gathering, we came to know that a pregnant woman needs nutritious food like green vegetables, milk, curd, and fruits, and [that] she should be prohibited from carrying heavy loads. She should also have at least four ANC visits during her pregnancy, irrespective of the*

complications she faces. During gatherings at the health facility, we were also provided with iron tablets and tetanus vaccination, and blood pressure measurement.

Birth planning and use of delivery and postnatal care

Birth planning by married adolescents and the use of skilled birth attendants increased. The proportion of couples who discussed where to deliver increased significantly, from 24% (n=463) to 40% (n=472), and the use of a skilled attendant (a doctor, nurse, or auxiliary nurse midwife) rose from 24% to 31% over the two-year period. The proportion of deliveries taking place at home fell from 75% to 67%. (The modest improvement in the use of skilled birth attendants must be placed in a regional context: The latest Demographic and Health Survey data indicate that only 15% of deliveries in the central *terai* are assisted by skilled birth attendants [MOHP {Nepal}, New ERA, and Macro International, 2007]). Use of postnatal care services also increased, from 20% (n=240) in 2005 to 30% (n=269) in 2007.

Figure 6: Female married adolescents' awareness and use of antenatal care



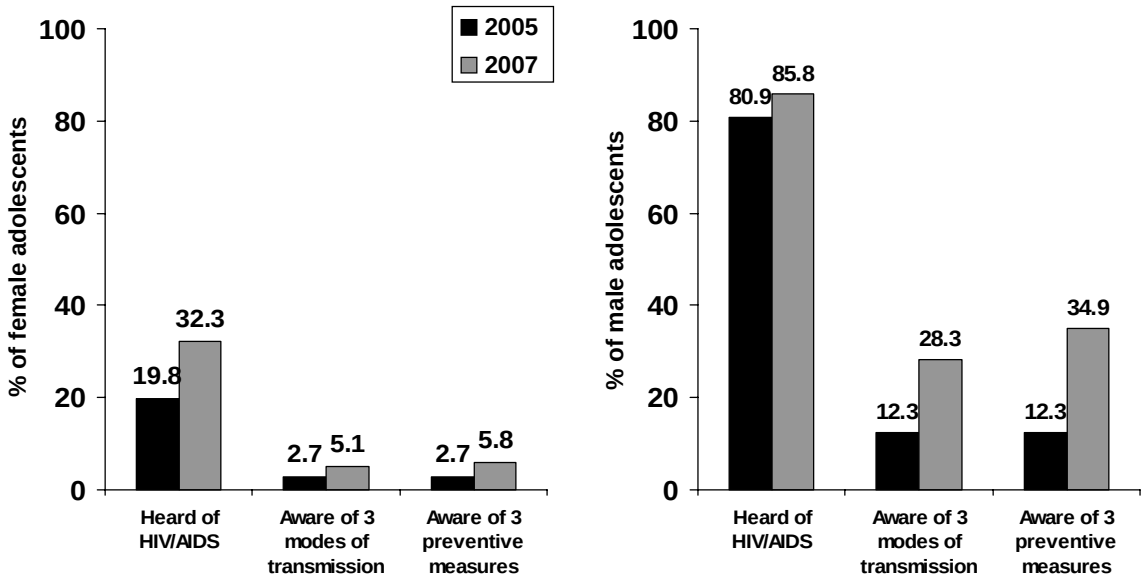
HMIS data for the project VDCs in both districts appear to confirm this trend. A two- to three-fold increase in the number of deliveries conducted by health workers was recorded in the project VDCs: from 1,146 deliveries in 2004–2005 to 2,872 deliveries in 2006–2007 in the 27 Parsa VDCs, and from 1,128 to 3,051 deliveries in the 42 Dhanusha VDCs.

Knowledge of HIV/AIDS and STIs

Overall, married adolescents' knowledge of HIV and AIDS, of its symptoms and modes of transmission, and of preventive measures increased significantly over the project period. Levels of awareness among female respondents started lower than and remained at a lower level than among male adolescents for all key indicators (n=960 and n=480 for each sex) (Figure 7). For example, at endline, approximately one-third of female adolescents (32%) had heard of HIV and AIDS, compared with 86% of male adolescents, and 6% of young women were aware of three ways to avoid becoming infected with HIV, compared with 35% of young men. However, the proportions of female married adolescents who were aware of three HIV prevention measures more than

doubled. Awareness that condom use prevents HIV transmission also increased dramatically over the two-year period, from zero to 41% of all adolescents, though at endline there was still a large gap in awareness between female respondents (12%) and males (70%).

Figure 7: Key indicators of HIV and AIDS knowledge among married adolescents, by sex



The proportion of married adolescents who were aware of STIs was unchanged over the project period (42% at baseline; 41% at endline). Once more, knowledge of the types and symptoms of STIs, as well as about prevention measures, was much lower among female adolescents than among male adolescents. Only 19 individuals (16 females and three males), or 2% out of the total of 960 respondents in 2007, reported STI symptoms in the preceding year.

Access to youth-friendly services

The trainings for health care providers on youth-friendly services proved effective in providers' awareness of the special needs of married adolescents. During the workshops, health providers identified several major reasons why married adolescents did not access services: poor staffing at health facilities; fear of judgment by providers; lack of confidentiality and privacy; and lack of awareness of services available.

> *I used to provide a wide range of health services in my sub-health post. But it is amazing to know in this YFS training that youth need services that should be free of bias and judgments. Youth have unique interests and needs, which we health workers should address so as to encourage them to utilize services in our health facility.*
>
> —participant in YFS training

Evidence from FGDs at endline indicate that providers had become more responsive toward married adolescents following the RHMACP interventions, that the quality and confidentiality of services had improved, and that services were now open to all ethnic groups and castes:

> *Now service providers give us complete information regarding family planning methods and encourage pregnant women to visit health facilities for an antenatal care check-up.*
>
> —focus group participant, married adolescent women, Dhanusha District

> *They [health providers] provide information about STI and HIV/AIDS and the counseling is kept confidential. So we do not hesitate to visit the health facility.*
>
> —focus group participant, husbands of married adolescent women, Parsa District

> *The attitude of health providers has improved. They give special attention to their clients, listen carefully, and provide complete information regarding health services.*
>
> —focus group participant, husbands of married adolescent women, Dhanusha District

Other participants remarked that peer educators had taken direct action to improve the performance of local health staff:

> *The quality of services has improved a lot in the last year. The sub-health post staff were irregular and not sincere in their duties. Peer educators, with support from other people, took action against them and locked their office. From that time on, we have been receiving good services.*
>
> —focus group participant, married adolescent women, Dhanusha district

In recognition of their outstanding community work, pairs of peer educators—one male and one female—have also been invited to sit on the health management committees of 28 out of the 69 project VDCs.

Changes in Married Adolescents' Attitudes about Reproductive Health and Gender

Recognizing that individuals' reproductive health and gender attitudes can strongly influence sexual behavior and family planning, the baseline and endline surveys examined the perceptions of married adolescents on these issues, including perceptions of the ideal age for *guana* and motherhood, a man's right to demand sex from his partner, a woman's right to insist upon condom use or to refuse sex, domestic violence, control of household finances, and a woman's right to access health care.

Perceptions of the ideal ages for gauna and motherhood

Significant changes were found in married adolescents' perceptions of the ideal ages for *gauna* and for motherhood (n=480 for each gender throughout this section). For example, the percentage of adolescents who thought that the ideal age at *gauna* for women was over 20 significantly increased over the two-year project period, from 6% to 34% (for female respondents) and from 9% to 28% (for male respondents). The proportions of adolescents who also considered the ideal age at *gauna* for men to be over 20 rose from 55% to 91% among female respondents and from 54% to 82%

among male respondents. Similarly, at endline, 83% of female respondents and 71% of male respondents believed that the ideal age of motherhood was over 20, up from 50% and 53%, respectively.

Figure 8: Percentage of adolescents who considered the ideal age at *gauna* for women to be over 20, by sex

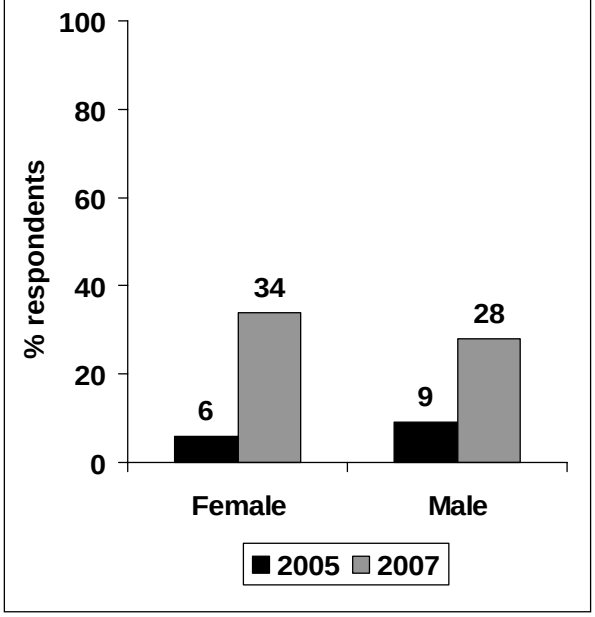
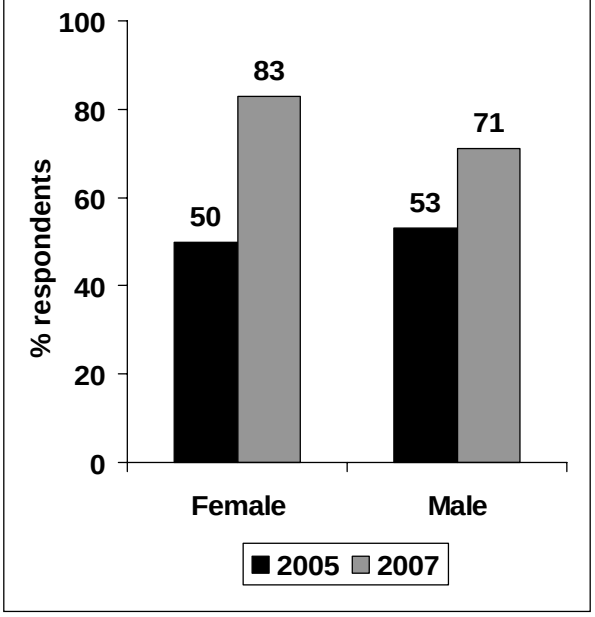


Figure 9: Percentage of adolescents who considered the ideal age of motherhood to be over 20, by sex



Gender Attitudes

Substantial changes were recorded in several key indicators for gender attitudes among married adolescents (Table 5). Notably, at the end of the project period, majorities of both male and female respondents considered that it was acceptable for women to insist upon condom use, and almost half of all respondents felt that a man does not have the right to decide when to have sex with his wife. In addition, more than half of male adolescents (55.7%) felt that a woman has a right to go to a health facility without her partner's permission. More than 80% of both female and male adolescents believed that it is not acceptable for a man to beat his partner.

Table 5. Percentage of married adolescent respondents agreeing with selected gender attitude statements, by sex

Attitude	Females (%)		Males (%)	
	Baseline	Endline	Baseline	Endline
A man does not have the right to decide when to have sex with his wife.	37.6	52.3	26.9	42.5
It is acceptable for a woman to insist on condom use with her partner.	51.4	72.5	72.0	80.0
It is not acceptable for a man to beat his partner under certain circumstances.	82.7	87.9	69.4	82.2
A woman has the right to go to a health facility without her partner's permission.	38.5	30.9	42.2	55.7

Family and Community Support for Adolescent Reproductive Health

Age at marriage, age at *gauna*, and age at first birth for married adolescents

Analysis of endline results shows that the median age at marriage within the project VDCs increased significantly, from 14 to 16 years, and the median age at *gauna* rose from 15 to 16 years. Results indicate an increasing trend to postpone marriage and *gauna* in the project districts and to arrange marriage and *gauna* ceremonies at the same time. But there was no corresponding trend to delay childbearing. Median age at first birth remained at 17 years. The mean duration of the gap between *gauna* and the birth of the first child did, however, increase slightly (from 19 to 22 months) following project implementation. As described in the introduction, early proof of a woman's fertility is intimately connected with cultural and gender norms of ethnic groups in the *terai*, particularly the perceived adequacy of the dowry price paid by the bride's family. A two-year timeframe is extremely short to expect major changes in long-standing attitudes and behaviors.

Mothers-in-law: changes in reproductive health attitudes and behavior

Traditionally, mothers-in-law and sisters-in-law exercise decision-making power over daughters-in-law within Nepali households. Therefore, raising the awareness of these family members about the reproductive health needs and rights of married adolescent women was critical. Evidence from FGDs with mothers-in-law conducted at baseline and endline indicate significant changes in attitudes and health practices, particularly in attitudes toward early marriage and childbearing.

At baseline, participants in all groups agreed that early marriage and *gauna* ensured fertility. Participants commonly reported advantages of early marriage and *gauna*, such as having to pay less dowry, receiving a greater number of proposals, and stopping young people from engaging in illicit relationships. They also reported many strong disadvantages, particularly the dangers of early pregnancy to mother and child due to "immature age" and "inadequate physical development," which may lead to such complications as "burst uterus." One mother-in-law shared the story of a 14-year-old girl in her VDC who died during delivery. However, respondents still felt that the advantages of early marriage and childbirth outweighed the disadvantages and that individuals could not go beyond local culture or violate social norms over a short period of time.

> *If a woman does not conceive very soon after marriage, people will start thinking that she did not get enough dowry and that she might not be getting enough attention from her husband. In order to uphold the prestige of her paternal home, she must conceive as early as possible.*
>
> —mother-in-law (45 years old), Dhore VDC

Most mothers-in-law also believed that contraception would cause infertility or have other side effects, such as bleeding, weight loss, and weakness. All participants indicated that discussion and use of contraception by newly married couples is socially unacceptable. The mothers-in-law also reported that no woman is taken to a health facility for delivery under normal circumstances, only when serious complications arise and the delivery cannot take place at home. Indeed, in general, young married women are expected to stay inside their households and avoid contact with outsiders until they have given birth to 2–3 children, a critical hindrance to their access to essential reproductive health information and services.

At endline, many of the responses of mothers-in-law in both districts indicated significant changes in reproductive health attitudes and practices. For example:

- *It is appropriate for girls to get married only after the age of 20 years, because by that time they will have both mental and physical maturity. (Dhanusha)*

- *In mothers' meetings, we discuss about delaying marriage and* gauna *of our children. We have also made a rule to punish those who marry their daughters at an early age. (Parsa)*
- *Marriage after the age of 20 helps adolescents to get higher education and learn life skills that make them independent. (Dhanusha)*
- *An educated girl will get an educated boy to marry. This helps to run the family smoothly. (Dhanusha)*
- *First pregnancy after 20 years of age ensures safe delivery. (Parsa)*
- *Mothers-in-law should not force daughters-in-law to have their first pregnancy soon after marriage if the girl is less than 20 years of age. (Dhanusha)*
- *Now we accompany our daughters-in-law to the health facility and take good care of her during her pregnancy. (Parsa)*
- *A pregnant woman should be taken to the nearby health facility if any danger signs like excessive bleeding, high fever, and swelling of body are experienced during pregnancy and delivery. (Dhanusha and Parsa)*
- *Now we have no hesitation talking about family planning methods. (Parsa)*
- *Married adolescent couples now discuss family planning, birth spacing, and preparation for emergencies. (Parsa and Dhanusha)*

Responses also showed that achieving change in long-standing traditions will take time and sustained effort. For example, mothers-in-law in Parsa mentioned that having a child soon after *gauna* upgrades a woman's status in society, while respondents in both districts still believe that use of contraceptives to delay first pregnancy may lead to infertility. Delayed marriage and the use of family planning methods for birthspacing are now more accepted, but it is commonly felt that a woman should conceive soon after *gauna.* Significantly, in discussions with project staff, mothers-in-law related that recommendations from religious leaders were the main reasons for choosing to delay the marriages of their children. This strongly indicates that social perceptions on this critical issue are changing, which in turn sets the stage for delayed childbearing.

Advocacy campaign against child marriage and the dowry system

Recognizing that the reproductive health needs of married adolescents could not be effectively addressed without also addressing cultural practices, RHMACP peer educators established child marriage eradication committees in 33 VDCs of Dhanusha District, with support from local leaders and organizations. The committees conducted rallies to raise awareness of the issue and mobilize communities to stop child marriage and the dowry system.

To institutionalize these local efforts, the RHMACP, in collaboration with 22 organizations working in the district, organized a conference on child marriage and dowry system eradication in Janakpurdham from May 31 to June 1, 2007. Approximately 350 people participated in the conference, including representatives from all 33 child marriage eradication committees, political leaders, community-based organizations, international NGOs and donors (including USAID), and the media. Five young girls and boys who fought against pressure from their families to marry early, as well as two couples who married without taking or giving dowry, were honored during the conference. A rally and cultural program against early marriage and the dowry system were additional highlights of the gatherings.

Representatives from all political parties expressed their commitment to the issue. The conference concluded with the formation of a district-level network, the Early Marriage and Dowry System Eradication Federation and the announcement of the seven-point Janakpur Declaration (see page 25).

Seven-Point Janakpur Declaration against Early Marriage and the Dowry System

1. Individuals should socially boycott individuals and families practicing early marriage and taking/giving dowry.
2. The Government of Nepal should develop a new law indicating strict punishment against the practice of early marriage and the dowry system.
3. All political parties should explicitly mention commitment to this issue in their manifesto.
4. Education for children should be compulsory.
5. The issue of child marriage and dowry should be included in school curricula. Also, awareness on this issue must be created among adults through adult literacy activities.
6. The state should offer special rewards to individuals and families not taking/giving dowry.
7. Localities should comply with the state's provision for 33% compulsory participation of women in all sectors, and increase participation to 50%.

Peer Educators As Community Leaders: Advocacy and Action to Promote Health and Good Governance

Given the highly politicized atmosphere in the two districts, the original focus of RHMACP on improving the reproductive health of married adolescents broadened to include advocacy campaigns to secure citizens' rights by improving local governance and the performance of the health sector. Following the leadership development training, participating peer educators embraced opportunities to link their health initiatives for young people to the wider needs of their communities.

In many VDCs, peer educators formed community development forums, pressure groups, and committees that advocated successfully for transparency in the allocation of budget funds. Case stories from several villages revealed that government budget funds for major local infrastructure projects—including upgrades to health facilities—were identified by, and released to, peer-led community groups. These groups then planned and arranged construction.

In Janakpur, Dhanusha's district capital, peer educators also formed the Peer Educators' Society for Health and Good Governance (PESHGG), which hosted a district-level public forum in June 2007 on the availability and quality of local health services—the first event of its kind to promote good governance in the health sector. The forum was attended by more than 300 people, including health workers, DHPO representatives, political leaders, and the media. Responding to demands voiced at the gathering, providers committed to maintaining regular working hours and providing quality services, as per their ethical protocol. A representative of DPHO agreed to take immediate steps to fill vacant positions within health facilities.

Lessons Learned and Recommendations

Lessons learned and recommendations from the RHMACP are presented in three sections. The first section discusses the project experience related to the ecological model and multilevel implementation strategy. The second section assesses challenges encountered in operational logistics. The final section presents recommendations for scaling up the intervention within the pilot districts and to other areas of Nepal.

The Ecological Model and Multilevel Implementation Strategy

At the individual and relationship levels: Peer education

Project results indicate that the peer education approach improved married adolescents' reproductive health knowledge, communication, and use of services and increased awareness of the reproductive health needs and rights of young married couples. The work of peer educators garnered widespread community approval, with many examples of youth participation and leadership invited and accepted by local government authorities. The leadership development training—provided to 69 peer educators in the second year of the project—was particularly successful in building a highly motivated youth leadership. Following the training, peer educators established community-based development groups, conducted public hearings into health services, and accessed government funds to complete infrastructure projects at VDC level.

Endline data, as well as information collected during postintervention visits to 14 VDCs in December 2007 and January 2008, indicate the sustainability of the peer model. At endline, 71% of peer educators expressed their willingness to continue their work after the project ended. Postintervention visits confirmed that peer educators were still performing key roles in their communities—within local government, community development forums, health management committees, theater groups, livelihood projects, and savings and credit societies—as well as working to maintain project activities and networks at the VDC and district levels. In addition, the health facilities visited reported that:

- Married adolescents' use of antenatal and postnatal care services is increasing.
- Peer referral systems for STIs, skilled delivery attendance, and voluntary sterilization are active.
- Resupply of condom boxes at general stores by peer educators has continued.

Analysis of key indicators in the endline assessment, however, showed that reproductive health knowledge was significantly lower among female adolescents than among male respondents. Moreover, only 18% of female respondents reported knowing a peer educator or the services they offered, compared with 34% of male adolescents. These findings indicate that the intervention was more successful in reaching young married men and that young married women continued to have limited mobility outside of their homes.

According to orthodox social mores in the project areas, a young married woman is not supposed to have contact, let alone work, with any man other than her husband, but endline data show that the teams of two peer educators were frequently not married couples. Of the 120 peer educators interviewed, only 54% reported working with their spouse. As a consequence, the participation of some female peer educators may have been reduced, which in turn may have decreased the exposure of female adolescents to project activities. The high migration of men to areas outside of

the district for employment or to escape conflict areas and the preference of some VDCs to select only one peer educator from any one family (so as to spread the benefit of the project's training to a greater number of households) would have contributed to this situation. However, at the same time, it must be noted that some of RHMACP's champions *were female peer educators who were not partnered with their husbands,* and their achievements served as powerful examples of women's capacity to contribute to family and community well-being beyond the household. In many instances, they successfully challenged restrictive gender norms and acted as catalysts to overcome social isolation and empower young married women.

Recommendations

The peer education model was a successful approach for building a constituency of highly motivated youth leaders and for promoting behavior change among married adolescents. In particular, the leadership training provided to a selection of peer educators was a catalyst for their development as project "champions." It is recommended that these capacity-building workshops be made available to all peer educators during future interventions, with a strong focus on developing advocacy skills. More frequent refresher trainings and closer on-the-job supervision and mentoring would also benefit peer educators.

Strategies will also be required to support greater participation of female peer educators and adolescent women in project activities, including efforts to increase the proportion of married couples that are recruited and retained as peer educators—such as greater educational/training opportunities or economic incentives for participants. Additionally, the ideal age of peer educators needs to be examined. A high proportion of the most effective peer educators in the pilot intervention were in their mid-20s when they were recruited but had been married as adolescents. In many instances, these peer educators were found to be more experienced and, by virtue of their age, had greater influence among family and community members. The complex gender- and age-based norms that affect participation will need to be closely examined before activities are scaled up, to ensure the highest level of participation in and impact of future interventions.

At family and community levels: Creating an enabling environment

The project was effective in establishing a more supportive environment for meeting the reproductive health needs of young married couples. The highly politicized atmosphere in the two districts may also have heightened the awareness among participants of their power to bring about social change. The ecological model successfully accommodated an expanded project focus that embraced peer initiatives in community development, local governance, and citizens' rights—all of which strongly supported the core project goal of effective access to quality reproductive health services for all married adolescents. The formation of child marriage eradication committees in 33 VDCs in Dhanusha and the hosting of the district-level conference were significant achievements in one of most culturally conservative areas of Nepal. More gender-equitable attitudes, too, were recorded among married adolescents.

However, data, case studies, and focus group discussions revealed that orthodox gender norms—that accord women low social status, limit their education, and severely restrict their mobility—were still widespread in project areas. The misconception that the use of contraceptives to delay a woman's first pregnancy would cause infertility was also commonly reported. A large gap persisted between perceptions among married adolescents about the benefits of postponing first birth and the actual use of contraceptives to delay first pregnancies. Over the implementation period, the median age at first birth remained the same, at 17 years, reflecting continued societal pressure for women to demonstrate their fertility soon after marriage.

Positively, marriage practices are changing: The median age at marriage increased from 14 to 16 years, and the median age at *gauna* rose from 15 to 16 years over the project period. Significantly, in discussions with project staff, mothers-in-law related that recommendations from religious leaders were the main reasons for choosing to delay the marriages of their children. This largely unanticipated outcome on age at marriage strongly indicates greater community awareness of the health needs of youth, which in turn sets the stage for increased impact on delayed childbearing in subsequent interventions.

Recommendations

To create an enabling environment for young married couples, influential members within families and communities need to be reached from the outset of interventions and engaged consistently throughout the implementation period. As part of strengthening engagement at family and community levels, key decision makers—such as mothers-in-law, fathers-in-law, and influential community members—should be trained on issues affecting the reproductive health of married adolescents, with a focus on teaching advocacy skills so that participants can influence their own peer groups.

Government authorities should be also engaged to support community-based organisations established by peer educators, such as village development forums, peer educator networks, theater groups, and child marriage eradication committees. These institutions, led by trained and motivated youth, represent invaluable local resources. VDC- and district-level offices, including health facilities, can directly assist in registration and advocacy for these organizations, as well as in providing them with financial resources, where available.

At the health system level: Strengthening capacity to provide youth-friendly services

Close collaboration with District Public Health Offices and local health facilities is an appropriate approach for promoting community ownership and sustainability of project interventions. However, the overwhelming number of priorities faced by health services in resource-poor environments poses major challenges to the integration of community-based reproductive health interventions into district health programs. Political unrest and violence during the project period also shut down various health facilities—sometimes for months—and medical personnel fled conflict areas. As a consequence, health services and most medical commodities were unavailable for lengthy periods during project implementation.

Most encouragingly, when facilities were operating, peer educators assumed strong leadership roles in promoting—and at times demanding—the adequate provision of youth-friendly services. Peer educators in various VDCs conducted public forums on health service delivery and quality, improved the fit-out of offices, and upgraded facilities, including overseeing major health infrastructure projects. Pairs of peer educators—one male and one female—were invited to sit on health management committees in 28 out of the 69 project VDCs, in recognition of their outstanding community work. With assistance from the RHMACP, facility staff in the project VDCs also started recording services provided to clients under 20 years of age for inclusion in the HMIS.

Recommendations

To streamline the uptake of project interventions into government health programs, clear integration plans need to be agreed to with local and national government officials prior to implementation. In addition, project staff should provide regular updates to government officials, to highlight progress and achievements of the intervention within local communities. In several VDCs, the relationships

between peer educators and the local health facility were extremely robust, with the names of the peer educators listed at the facilities. Prior to project expansion, these examples of effective collaboration should be examined for replication in other VDCs.

Project Logistics

Human resources

In the project's first phase (July 2005 to June 2006), eight sexual and reproductive health facilitators (SRHFs) were hired to cover the project area—five in Dhanusha District and three in Parsa District. Each SRHF was responsible for supervising, coordinating with, and reporting for 8–9 VDCs. SRHFs were provided with bicycles to use as their principal mode of transportation. However, given the implementation strategy to cover three VDCs in each *ilaka*, the areas of responsibility for individual SRHFs were broad and fragmented. The distances to be covered were large, and roads were poor. Staff travel in the districts was also severely curtailed by the volatile security situation.

Following the first-year project review, the number of sexual and reproductive health facilitators for the second year was increased to eight in Dhanusha District and five in Parsa District. However, facilitation and monitoring of peer educator activities at the local level was less than optimal over the project period. The knowledge and skills of the SRHFs were also reportedly insufficient to support all types of activities. Similarly, having one project officer for each district proved inadequate for effective advocacy for, and monitoring of, project activities. High staff turnover at the central, district, and community levels of project management also affected implementation. During the two-year period, personnel changes included the program officers for the EngenderHealth/Nepal team, focal persons with CARE Nepal, and the project officers for Parsa District.

Recommendations

For implementation of a scaled-up program, increased staffing at the district and local levels is required to enable consistent field supervision and on-the-job mentoring for sexual and reproductive health facilitators and peer educators. The following staffing structure is recommended to achieve optimal, cost-effective coverage of interventions:

- At the district level—one project officer for project advocacy, coordination, and technical back-stopping; one assistant project officer for monitoring, supervision, and documentation of local activities; and one office assistant for accounting and administration.
- At the local level—one sexual and reproductive health facilitator for every two VDCs is required, given the distances to be covered using bicycles as the principal means of transport.

IEC materials

Data showed very high levels of illiteracy among target populations. More than 80% of female adolescents in both the baseline and the endline surveys were illiterate, while the proportion of male respondents found to be illiterate were 40% at baseline and 48% at endline. However, educational support materials, such as the illustrated flipcharts to facilitate dissemination to participants with little formal education, were only published and distributed to peer educators in the second year of the project. Discussions with the project staff revealed that logistical problems and the volatile security situation delayed the finalization, printing, and distribution of these materials. The late supply of educational materials not only directly affected dissemination to married adolescents, but also impaired retention of reproductive health knowledge by peer educators from trainings, particularly technical and clinical information on contraception methods, symptoms and prevention of HIV and other STIs, and danger signs during pregnancy, delivery, and the postpartum period.

Recommendations

IEC materials for field use should be printed and distributed in the preparatory phase (the first 3–4 months) of a scaled-up intervention and ideally should be incorporated into the initial trainings for project staff, health workers, and peer educators. Most valuably, the corrected proofs for all IEC materials that were field-tested and produced in local languages during the second year of the pilot project are available for immediate reproduction upon the scale-up of the project.

Scaling up the pilot intervention

The ACQUIRE Project selected CARE Nepal as a project partner because the organization manages large health and community development projects throughout Nepal and displayed the capacity to integrate interventions for married adolescents into their programming. In collaboration with the Ministry of Health, CARE Nepal, and community-based NGOs, the potential for ACQUIRE to scale up the pilot intervention is high.

Recommendations

Two approaches are recommended to expand the RHMACP:

1. Scale-up of all project activities to the district level, in collaboration with the Ministry of Health and local NGOs
2. Or identification of best practices from the pilot intervention for integration within public-sector health programs in Nepal

As part of both approaches, government health workers and/or the staff of partner NGOs need to be trained to understand the special reproductive health needs of young married women and their partners, to advocate for young married couples among family and influential community members, and to expand the demand for and supply of youth-friendly health services.

Conclusion

Quantitative and qualitative data from the RHMACP in Dhanusha and Parsa districts of Nepal indicate that the project interventions increased reproductive health knowledge among married adolescents, promoted positive change in reproductive health attitudes and practices, and expanded young people's access to youth-friendly health services. Awareness of and support for the unique health needs of young married couples among their families, communities, and local health providers also increased. At a broader societal level, the project encouraged debate on social and gender norms, and a constituency of youth leaders trained during the project strongly embraced opportunities to improve the well-being of their communities, foster inclusion of disadvantaged groups, and empower young women.

Results to date from the two-year pilot intervention indicate that the ecological approach and multilevel implementation strategy utilized was successful for improving the reproductive health outcomes of married adolescents in the project districts. The project model is recommended for scale-up in the pilot districts and to other areas of Nepal. Experience from the intervention further suggests that the model would be applicable to health development and governance initiatives in diverse country settings.

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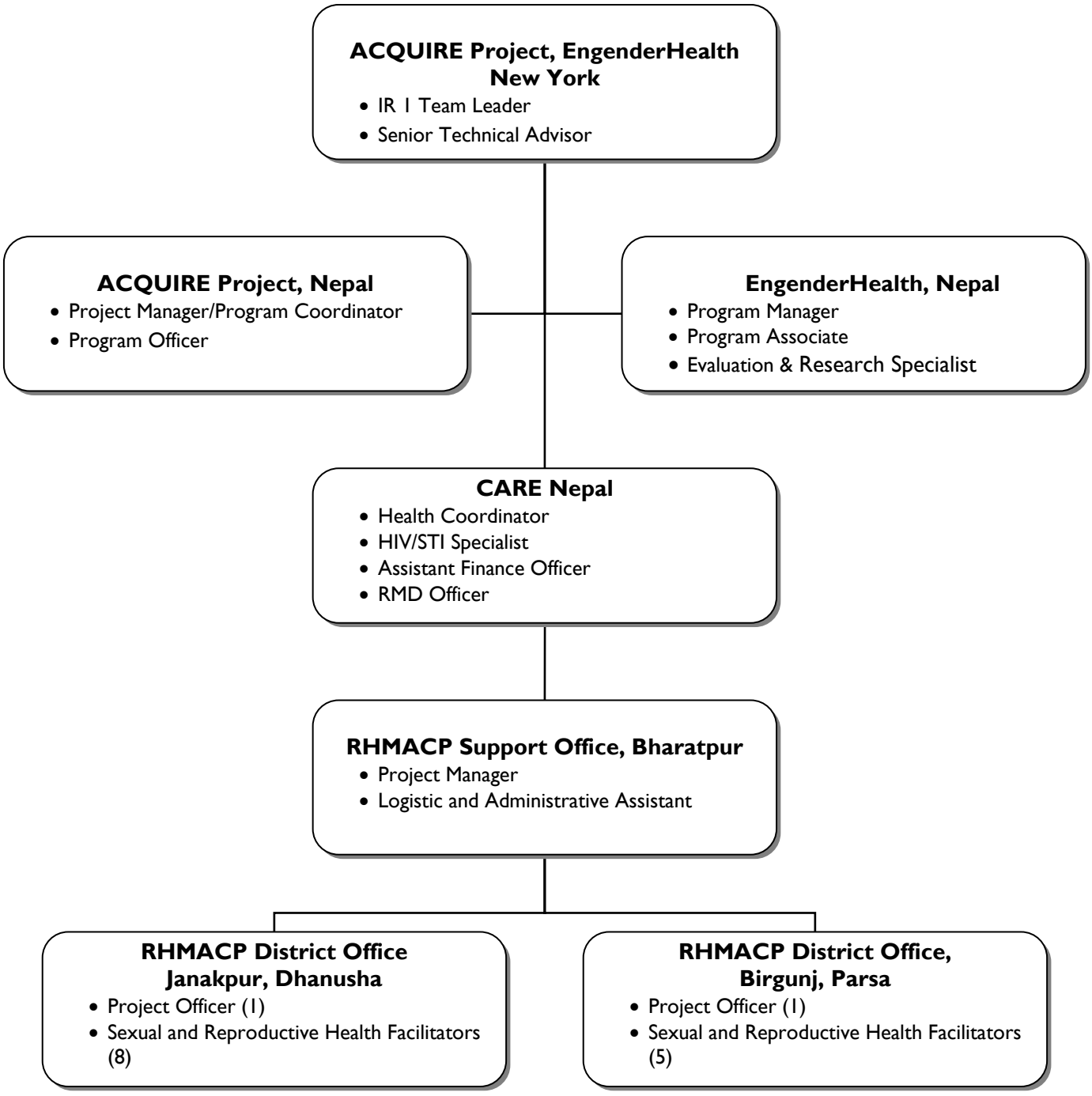
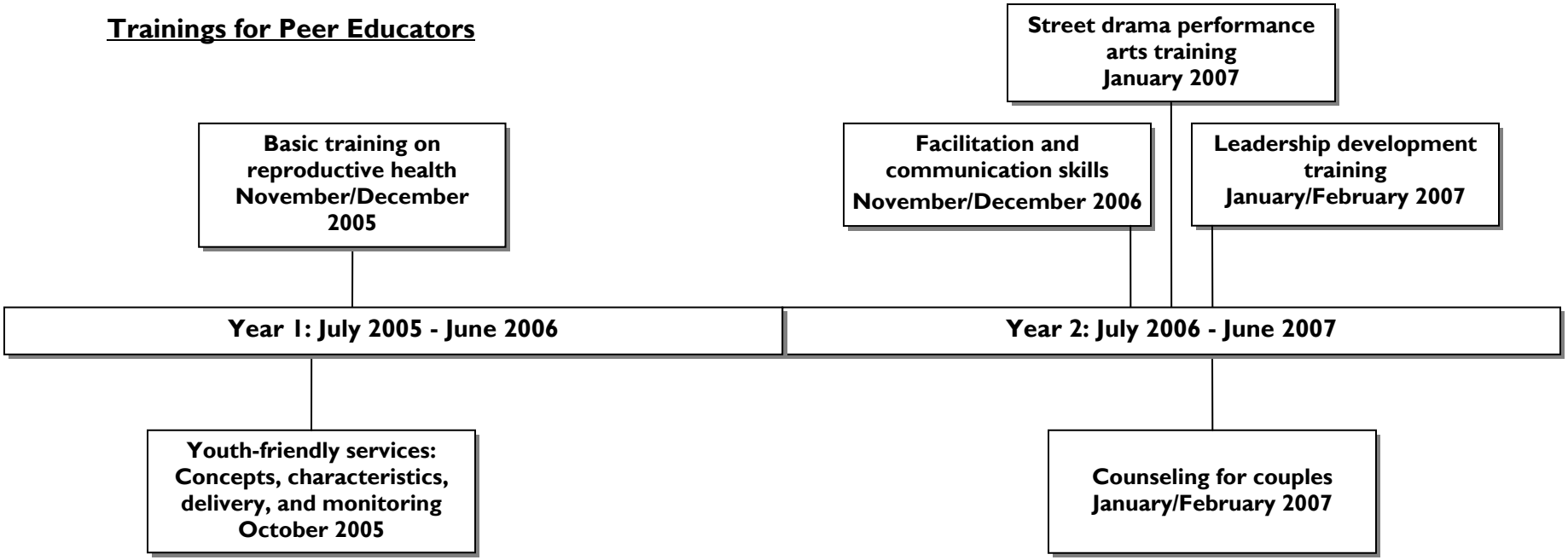
Appendix A:
Project Management Structure



Appendix B: RHMACP Timeline of Training for Peer Educators and Health Care Providers

Trainings for Peer Educators



Trainings for Staff of Public-Sector Health Care Facilities

Appendix C: Case Studies

Lifting the Veil

Until two years ago, Sita Devi Shah from Thera VDC was just like most women in her neighborhood and rarely left her home. When she did, she always kept her face covered with the veil of her sari. She was simply known as the 'shop keeper woman.' Now she is an active community leader, and her neighbors call her *Sita Didi*, a warm sign of respect.

It is unusual for young women in conservative Nepalese communities to go beyond the walls of the family compound, let alone to go door-to-door to counsel other married couples or host community gatherings on reproductive health.

However, after attending basic training with RHMACP, Sita hung the project's "flex" poster on the outside of her home, marking it as the residence of a peer educator, and immediately she began reaching out to her neighbors. The training she had received in communication skills gave her the confidence to hold monthly meetings in her home and to organize interaction groups for mothers-in-law, students, and other community members.

As Sita became known for her expertise, neighbors sought her guidance. When five women came to her and described symptoms of STIs, she referred them to the health post for examination. Shockingly, the health post in-charge refused to examine the women on account of their low caste. He sent them straight back to Sita, saying that she could examine the women herself. In response, Sita courageously stood up and challenged the in-charge to explain his actions at a public health forum in the village. After much grilling by those present, the in-charge agreed to see the women and has since improved his attitude. Following this incident, Sita received even more positive recognition, and a local nongovernmental organization hired her to teach literacy classes two hours every day.

She continues to works closely with her *teen saathi* (three close friends), accompanied one of them for family planning counseling, and stayed with her friend while she received her first Depo Provera injection. Every month, Sita holds meetings for mothers-in-law, and she reports that more women now accompany their daughters-in-law to antenatal care visits. The Health Management Committee in her VDC was so impressed with Sita's efforts that they awarded her a special shawl.

In February 2007, she was also chosen to take part in RHMACP's leadership development training, where she learned more about good governance, women's rights, and community advocacy. Upon returning from the workshop, she learned that a neighbor was arranging the marriage of his 13-year-old daughter, Sangita. Sita met with the family, convinced them to delay the marriage, and assisted the family to find resources to enable Sangita to continue her schooling. Sita believes that if girls were able to stay in school at no cost, it would reduce the pressure for early marriage. She actively advocates for free education for girls until grade 10.

Circumstances too have improved for Sita's own family. Her enthusiasm and success in her work sparked new energy in her husband, and he acquired a new and busy shop in Janakpur. Modestly, Sita says that she is a "good Hindu, but she is also open." Not only is her family proud of her accomplishments, but she has earned the respect of the entire village.

Unprecedented Actions to Realize Youth-Friendly Services

In the health post of Gamarhiya VDC in Parsa District, women had to endure examinations in a chair, on a narrow bench, or upon the floor—all embarrassing and uncomfortable positions with little or no privacy. That was until four peer educator couples took matters into their own hands.

From the time of their appointment, Jalandar and Anita Devi Thakur, Narish and Sunita Devi Ram, Sabindar Prasad and Shanti Devi Kusuwaha, and Parmananda P. and Teter Devi Kanu have actively promoted good reproductive health in Gamariya VDC, going door-to-door to reach out to other married couples, as well as hosting meetings and activities. Within a short time, the couples were well known in the village. In acknowledgement of their efforts, Jalandar and Sunita were invited to join the health management committee, and Sabindar Prasad was given an extra key to the sub health post for emergencies by the facility's in-charge, Mr Birenda Shah.

As part of the RHMACP, Mr Shah was also trained in youth-friendly service provision, and the sub health post was allocated an examination table and curtains. However, the peer educators felt that these additions were pointless, since the facility was so poorly maintained. Patient files were in disarray on the floor, and garbage lay behind the new curtain, filling the space that was intended to be the exam room. The walls were bare of any posters or information. Concerned, the couples approached the in-charge with suggestions for improvements, but they were not heard.

Staff of Gamariya SHP in the facility's refurbished examination room

Considering the condition of the facility to be an urgent issue, the couples took the unprecedented action of using Sabindar's emergency key to enter the health post without permission when the in-charge was away. Together, they cleaned and reorganized the facility. They threw out garbage, placed drugs and files into cabinets, cleared the examination room, put the exam table in the corner, and rehung the curtain to separate the room for privacy. When finished, they left a note on the in-charge's chair instructing him "to keep things in place after using them."

Not surprisingly, the in-charge was furious upon his return, saying that he had intended to make these changes himself. However, as visitors began complimenting the staff on the new look of the facility, he relented, and he accepted the couples' impulsive actions. Since then, Mr. Shah and the peer educators have collaborated successfully to access funding from the VDC for construction of toilets for the health post, an outreach program for marginalized remote communities, and a citizen charter—a chart for public display that details all health services and their costs. In addition, Mr. Shah asked the peer educators to submit a proposal to the Women's Development Office to continue their work when RHMACP ends.

Mr Shah now welcomes the involvement of the peer educators and believes that they deserve the support and respect of the community and the government. Due to their efforts, demand for outpatient services and for antenatal care at the health post has increased by 25% and 50%, respectively. And Sabindar Kusuwaha still has a key to the facility, although he and his partner peer educators no longer have to sneak into the facility to make changes.

A Tireless Advocate for Community Health

Determined. Confident. Tireless. These are just some of the qualities that residents of Dhore VDC recognize in Sunita Barnawal. She has become a leader and role model in her village.

Sunita has been a peer educator since the start of the RHMACP, and with her neighbor, Rakesh, has worked to provide essential reproductive health information to youth in her community and improve their access to health services. As part of her responsibilities, Sunita reached out to *teen saathi* (three close friends) to provide one-on-one counseling on reproductive health and family planning. Renu Ranju Devi, Momita Devi, and Premila Devi are Sunita's *teen saathi*. In the beginning, the women's husbands thought that Sunita was making trouble for them and refused to allow their wives to leave home to attend meetings.

But Sunita persevered. She continued to meet with the women in their homes and then invited their mothers-in-law to an orientation meeting. Following this meeting, the mothers-in-law became strong supporters for their daughters-in-law, and Momita and Premila were accompanied to the clinic to choose contraceptives. Renu, whose husband was working outside the country, will discuss family planning options with him upon his return. The mothers-in-law agreed that they had been afraid of family planning methods, but now they have more knowledge. They also advocated for their daughters-in-law to become part of a community savings and loans group led by Sunita. Momita, Renu, and Premila all now leave their homes to participate, and their mothers-in-law recognize the benefits for their families. The group raises funds for business loans and for emergencies, especially health-related emergencies, and Sunita has introduced discussion of reproductive health topics into the group's meetings.

Through her peer educator training, Sunita gained the knowledge, skills and confidence to discuss difficult reproductive health topics with women and with men. She described how women used to hide symptoms of STIs, but with her advice and encouragement they now go to health facilities for examination and treatment. Many husbands also come to her with questions about HIV and AIDS. Given that men often migrate to other areas for employment, accurate information to prevent HIV and STIs is critically needed. These issues are now more openly discussed.

To improve the availability and quality of local health services, Sunita also prominently lobbied for improvements to the sub-health post. Located inside the VDC office, the health post lacked space for proper or private examinations. To begin, Sunita conducted a meeting with students in which the need for youth-friendly health services was discussed. In turn, the students formed a VDC pressure group, which organized a mass community meeting with the leaders of the village to discuss upgrading the facility and improving the services provided. At this meeting, the building of a separate sub-health post was approved, along with the construction of an accessible road. Funds were allocated and construction commenced. Acknowledging her outstanding leadership and financial expertise, Sunita has been given the responsibility of monitoring all expenditures.

Although Sunita may never leave Parsa District, she says that her story is traveling around the world as an inspiration to other women. People now even come from other countries searching for her, and she is glad when they say good things about her role as a community leader.

One Girl's Fight to Stop Child Marriage

Indila Nayak is an engaging 16-year-old girl in Kurta VDC, Dhanusha District, who has courageously challenged her family and the tradition of early marriage in her community. With the support of RHMACP peer educator Pinky Shah, Indila delayed her marriage for three years and has now completed her School Leaving Certificate.

Indila loved school and was determined to graduate. However, when she was 13, her parents told her that they were about to accept a marriage proposal for her. In response, Indila entreated her family to put her dowry into an interest-bearing account until she was older. Her parents agreed. They allowed her to continue school and live at home, although they feared that she would be beaten and shunned by the community. Indila was happy and continued to work hard at school and at home. But only one year had passed before her parents approached her again, as they had the opportunity to marry off Indila and her older sister at the same time.

On this occasion, Indila needed help to convince her parents to continue delaying her marriage, and she sought the advice of Pinky Shah, the RHMACP peer educator in her local ward. Indila was inspired by Pinky's courage as she went door-to-door, talking to young couples about good reproductive health, family planning, and delaying their first birth. Indila also discovered that Pinky had the support of VDC leaders and other influential people in the community. She felt that her parents would listen to Pinky.

Indila Nayak (2nd from right) with other members of the CMEC of Kurta VDC

Pinky herself had been married at age 14 and, until she became a peer educator, had been a housewife who rarely left home. She believes that early marriage is a root cause of many health problems that women face in Nepal. Delaying childbearing is a challenge, but since the legal age for marriage is 18, Pinky has worked to convince her fellow villagers to obey the law. She agreed to help Indila and visited Indila's home shortly afterward, ostensibly in her role as a peer educator and not as a special advocate. During the discussion, she counseled Indila's parents that the legal age for marriage was designed to protect young girls from the dangers of early childbirth and to ensure they were able to complete their education. She noted that she had met Indila and had heard that she was an excellent student who aspired to be a nurse. Pinky pointed out that trained nurses were desperately needed and that the family would be doing a valuable community service by allowing Indila to finish school. Thankfully, Indila's parents agreed to postpone her marriage until she turned 18.

Encouraged by her own experience, Indila participated in a student meeting led by Pinky to discuss adolescent reproductive health, and she discovered, much to her surprise, that many other young people, including boys, thought that delaying marriage was critical. In response, the students formed a child marriage eradication committee. Since that first meeting, the committee has organized several rallies and speaking competitions and has created wall paintings with key campaign messages. The group also hosted a community workshop to gain the support of VDC leaders and local political parties. As a result, a Social Norms Monitoring Committee was established with the following tenets: upholding the law regarding minimum age of marriage; free education for girls until Grade 10; and the right of girls to complete Grade 8 before marriage.

Indila is pleased that she—and other girls like her—are no longer alone in this struggle, but have a collective voice. Although she accepts that her marriage is likely when she turns 18, she now will insist that her husband pay for her nursing education, and she will delay having children until she completes her studies. She believes that women's status will improve, and that better access to family planning will become a reality. From all indications in her story so far, Indila Nayak will be leading the way.

Where Health Education and Good Governance Connect

Shatrughan Thakur was once known as a "good-for-nothing guy," accused by friends and family of being lazy. However, since his appointment as a peer educator for the RHMACP in Basbitti VDC, Dhanusha District, he has worked diligently to improve the situation in his village.

After participating in basic training, Shatrughan Thakur and his wife, Misra Devi, visited newly married couples in their homes to discuss family planning, distributed condoms, and organized interaction meetings with mothers-in-law and other village groups. Misra Devi also accompanied her sister-in-law for antenatal care visits.

Recognized for his outreach efforts, Shatrughan was selected as the representative from his VDC to attend the project's leadership development training. There, he gained new insight into sexual and reproductive health issues, youth rights, and the critical need for the active participation of citizens in achieving open and accountable local government.

Having learned during the training how the VDC budget allocation worked, Shatrughan formed a VDC Forum to monitor the budget process and ensure its transparency. The forum consists of 51 community members representing all wards. Thirty-five of the members are women, *dalits* (people from low castes) are also included, and meetings double as an opportunity to discuss adolescent health. To begin, the forum analyzed expenses in the VDC budget for the 2006–2007 fiscal year and identified unspent monies earmarked for the construction of a perimeter wall and toilets for the health post. In response to the collective voice raised by the forum, the VDC released the funds, and the improvements were completed under the forum's management. In addition, the forum reinstalled irrigation pipes to make the water more equitably accessible to residents of the VDC, not the handful of wealthy farmers that the original layout benefited.

This signboard painted by Shatrughan reads:

- Work together with peer educators for an improved life.
- Get married at the legal age of 18 and 20.
- Two children is a gift we can afford.
- Good reproductive health leads to a good life.

The forum is now recognized as one of the most active community-based organizations in the district, and Shatrughan has become a respected leader in his village. Recently, he and Misra Devi organized a picnic for all health post staff, female community health volunteers, and peer educators for their VDC. Shatrughan has also led local rallies, painted public signboards to raise awareness of youth reproductive health rights, and advocated for community members to register for citizenship. Reflecting on his new status, Shatrughan remarked: "The only incentive I needed was training. I now have a responsibility to share my knowledge and mobilize others in my community."