



ENGENDERHEALTH
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ICRW
International Center for
Research On Women

Youth Reproductive Health in Nepal



Is Participation the Answer?

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Executive Summary

This report documents the processes and results of a project that scientifically tested the effectiveness of the participatory approach in defining and addressing the reproductive health concerns of adolescents. The project was conducted in Nepal between 1998 and 2003 and was undertaken jointly by EngenderHealth and the International Center for Research on Women (ICRW), in collaboration with Nepali partners. Although there is an extensive and growing literature on participatory research and design models for youth reproductive health (YRH), there have been no comprehensive evaluations conducted to date on the impact of a participatory process on youth reproductive health in developing country settings. The ICRW-EngenderHealth effort described here aimed to fill this gap through rigorous analysis and evaluation.

The project was set up with a quasi-experimental study design utilizing the participatory approach for research, intervention, monitoring, and evaluation at two study sites (one rural and one urban), together with more traditional reproductive health research and interventions at two control sites. An extensive needs assessment was conducted at the study sites using triangulated methodologies, followed by action planning with the community to design the program. At the control sites, a more limited needs assessment was conducted, and based on current knowledge and standard practice in the reproductive health field, a set of three interventions was implemented. These included: 1) adolescent-friendly services; 2) peer education and counseling; and 3) teacher training.

In contrast, youth and adult community members at the study sites identified a broader set of eight integrated interventions that addressed not only the specific sexual and reproductive health needs and concerns of young people, but also the broader social context that defines these needs and concerns. The interventions included: 1) adolescent-friendly services; 2) peer education and counseling; 3) an information and education campaign; 4) adult peer education; 5) youth clubs; 6) street theater on social norms; 7) efforts to improve livelihood opportunities; and 8) teacher education. The overall intervention period ranged from 12 to 24 months.

The evaluation reveals that with regard to outcomes of interest, the participatory approach did indeed yield more positive results. Although the effect is only marginally more positive in terms of basic indicators of youth reproductive health, it is substantially more positive in terms of the broader, more contextual factors that influence YRH, as well as capacity building, empowerment, and sustainability.

Our insights and recommendations are aimed at identifying the most strategic, targeted, and resource-effective lessons learned from the project experience, as follows:

1. Participation should be strategic, not all-encompassing.
2. Participation requires the custom-tailoring and adaptation of existing tools and mechanisms to local needs, rather than the creation or reinvention of new tools and mechanisms.

3. Participatory processes are time- and resource-intensive, but no more so than other programmatic inputs that yield positive, high-quality returns.
4. A quality needs assessment followed by a well-planned program design are the most critical components of effective programming on YRH.
5. Experience from this project indicates that a minimum “basket” of YRH interventions must include:
 - An intervention that improves the provision of information and services to young people.
 - An intervention that develops human and/or social capital among youth.
 - An intervention that mobilizes youth and community members to change norms, attitudes, and social systems.
6. When implemented through participatory processes, interventions focused on youth development and social norms and systems have the potential to yield both community buy-in and sustainable results at minimal costs.

1. Introduction

As youth¹ reproductive health (YRH) becomes a program priority in developing country settings, it has become increasingly clear that traditional programmatic approaches are limited in their capacity to fully address young people's sexual behavior, their reproductive health needs, and the normative and institutional conditions that define those behaviors and needs. In recent years, participatory research and programming techniques have been advocated as potentially more effective approaches because they involve the beneficiaries themselves in defining key issues, in identifying and prioritizing service needs and gaps, and in program design and implementation. However, there is little documentation of the extent to which participatory methodologies yield improved results in developing country settings. Little is known about the success or failure of participatory strategies in affecting reproductive health behavior and outcomes for young people, or the reasons as to why certain outcomes occur.

The program and research effort described in this report attempted to fill this gap in knowledge and contribute to the advancement of more creative, relevant, and effective YRH programs. This report documents the processes and results of a project that scientifically tested the effectiveness of the participatory approach in defining and addressing adolescent reproductive health concerns. The project was conducted at two study and two control sites in Nepal between 1998 and 2003. It was undertaken jointly by EngenderHealth, a service delivery organization, and the International Center for Research on Women (ICRW), a research organization, with support from the Andrew W. Mellon Foundation. This effort was made possible because of effective collaboration with a number of Nepali partners, namely the BP Memorial Health Foundation, New ERA, SAMANTA, Sarwanam Manch, the Nepal Red Cross, the Family Planning Association of Nepal, the Group for Technical Assistance, and World Education.

This report covers the essential elements of the project, from design to evaluation. It provides information about the conceptual framework that guided the project and the study design that was used to test the effectiveness of specific participatory approaches. The report also includes detailed descriptions of and lessons learned from the various phases of the project, including needs assessment, action planning, implementation, and monitoring and evaluation. Most importantly, it provides findings from the evaluation and an overall assessment of how effective a participatory approach can be in improving adolescent reproductive health within communities. Finally, the report provides recommendations for researchers, programmers, and policymakers to consider when developing or implementing projects that use participatory strategies to address reproductive health issues.

2. Background and Rationale

Two primary factors motivated the design and implementation of this project. First, Nepal provides a setting in which youth reproductive health needs are especially acute: despite a large population of youth with chronically poor outcomes on a number of reproductive health

¹ This report uses adolescents, youth, young people, and young women and men interchangeably to refer to the group between 15–24 years of age.

indicators, this issue has received very limited programmatic and policy attention. Second, despite the conventional wisdom that participatory approaches may be especially appropriate for implementing successful adolescent reproductive health programs, there are no programs anywhere in the developing world through which this proposition has been scientifically tested, proven, and documented. This project aimed to fill both these gaps. The goal of the project teams was to improve YRH for specific targeted communities in Nepal, while at the same time testing the validity of the proposition that participatory approaches are especially effective in accomplishing such a task.

Adolescent Reproductive Health in Nepal

Nepal presents an important setting for addressing youth reproductive health needs because one-third of the country's population is aged 10–24 (Ministry of Health, New ERA, and ORC Macro 2002). Adolescents in Nepal often face severe poverty, limited access to education and health services, and restrictive cultural and sexual norms. Nepali women in particular continue to be disadvantaged with regard to measures of literacy, health, and well-being. Life expectancy is 53.5 years for women and 55 for men. Nepal has the highest illiteracy rates in South Asia, which include large gender-based differences. Only 19 percent of women aged 15 and over are literate, compared with 54 percent of men of the same age. Literacy rates and gender differences for younger age groups are only marginally better; 26 percent of boys and 51 percent of girls in the 10–19 age groups are illiterate (Bott 2003; Ministry of Health, New ERA, and ORC Macro 2002).

Marriage is nearly universal in Nepal, with girls marrying at an average age of 16. Thus, sexual debut for the vast majority of girls occurs during adolescence and within the context of marriage. Moreover, early marriage means that childbearing often occurs during adolescence, before reaching physical maturity, with adverse effects for both young mothers and their children. Demographic and Health Survey data indicate that 52 percent of girls have begun childbearing by the age of 20. Early childbearing is an important contributing factor to high maternal mortality; at 539 maternal deaths per 100,000 births, Nepal has the highest maternal mortality ratio in South Asia. Among those giving birth, only 59 percent of girls under age 20 reported receiving any antenatal care; 18 percent of the births were attended by trained personnel; and only 12 percent of deliveries took place in a health facility. Only 12 percent of married girls in the 15–19 age group reported using any method of contraception and of those, just over 9 percent reported using a modern method (Ministry of Health, New ERA, and ORC Macro 2002).

Although extensive research on young people's needs and behaviors in Nepal is rare, existing data indicate that young people do not have adequate access to appropriate information and services about sexual and reproductive health issues. Little sex education is provided in schools, and both sex and reproductive health are not topics openly discussed in families. Girls are in a particularly vulnerable position because they have less access to formal institutional structures (such as schools and health care systems) than do boys, and are unlikely to be incorporated into or receive accurate information through informal communication networks. Furthermore, the design and delivery of appropriate services for adolescents has been constrained by long-held traditional beliefs and ideologies. As a result of inadequate or ineffective services and

information, young people often experience negative reproductive health consequences, including unplanned pregnancies and HIV/AIDS.

Participatory Approaches and Adolescent Reproductive Health

Participatory approaches have been used in the field of development since the 1970s, when grassroots activists became increasingly aware of the ineffectiveness of externally imposed development programs and policies. Participatory processes were advocated as being more effective than traditional approaches because they involved beneficiaries in the design, implementation, and evaluation of programs. In the last several decades, sophisticated Participatory Learning and Action (PLA) tools have evolved with which to assess needs and implement, monitor, and evaluate programs. The range of development efforts addressed through this approach has also expanded from poverty reduction alone, to include programs in natural resource management, adult literacy, and conflict resolution and negotiation (Guijit and Shah 1998; Nelson and Wright 1997).

Programmatically, participatory approaches are seen as a way to empower communities and facilitate ownership of interventions. In terms of research, such approaches are understood to provide more accurate and relevant information for program design because they allow grassroots perspectives and priorities to emerge. Advocates argue that participatory methodologies involve interactive problem solving, rather than a one-way flow of information; in other words, they allow the expertise of community members rather than that of the researcher to dominate processes (Chambers 1994; Cornwall and Jewkes 1995; Holland and Blackburn 1998; Selener 1997).

Participatory approaches have increasingly been applied in the field of reproductive health since the mid-1990s, following the onset of the HIV epidemic and the realization that such approaches could help facilitate discussions of taboo and sensitive issues such as gender and sex (Cornwall and Welbourne 2000). In part because they often are based on visual and storytelling tools, PLA approaches are seen by many practitioners as especially appropriate for adolescent reproductive health programs. It has been argued that by using participatory approaches to involve youth, programs can ensure that: 1) research, intervention design, and implementation reflect the ideas, concerns, and colloquial language of young people; 2) planned interventions enable youth to meet their objectives and advocate on their own behalf; and 3) projects designed for youth provide them with experience to enhance their own critical thinking and increase their ability to make decisions that reflect healthy choices and behaviors.

At the same time, the use of participatory approaches for research and programming on adolescent reproductive health issues poses several challenges, many of which have not been clearly delineated or addressed. For example, substantive issues related to adolescent sexuality and reproductive health are highly sensitive and complex in most cultures, much more so than topics more traditionally addressed through participatory techniques (such as the improvement of water resources or agricultural systems). It is not clear how well tools based primarily on group activities and articulation through consensus can be adapted to respond to matters of privacy and confidentiality. Moreover, although not intended as such, the participatory approach in development work has been implemented through “rapid assessment” techniques, which typically

involve one, or at most a few, days of training and research activity (Chambers 1994, 1997). The limited evidence available thus far suggests that in working on sexual and reproductive health issues, particularly with young people, participatory processes may require longer timeframes and more intensive training for field staff (Forder 1999; Shah, Zambezi, and Simasiku 1999).

Although there is an extensive and growing literature on participatory research and design models in adolescent reproductive health, in developing country settings there have been no comprehensive evaluations conducted to date on the impact of a participatory process on youth reproductive health.

3. Project Design and Framework

The two central elements of the project design were the participatory approach to programming, and how it is relevant to improving YRH in Nepal. Within development programming in general, and reproductive health programming specifically, understanding of how the concepts of participation and youth reproductive health fit together tends to exist only at a broad, abstract level. At the practical, specific level, such a shared understanding is often lacking. Researchers and implementing agencies tend to operationalize these concepts in a number of different ways, resulting in varied conceptual interpretations depending on the orientation of those who design and frame specific programs. It is therefore important to define precisely how the current team conceptualized these two central elements when developing a framework for the project.

Conceptualization of Participation

For the purposes of this project, the team was interested in participation by not only youth, but also by a range of community members. Although the project focused on the needs of youth, the participatory efforts had a broader emphasis in terms of engaging the community as a whole. This focus was motivated by the conviction that the needs, actions, and options of youth are embedded in their contextual surroundings. The lives of youth everywhere are integrally connected to, and affected by, adults, which is especially the case in cultures with strong age-based hierarchies, such as Nepal. Thus, adult approval and buy-in is essential for achieving youth participation or behavioral change. Moreover, altering adult behavior and attitudes is equally, if not more, essential for achieving sustainable change with regard to the fundamental factors affecting young people's reproductive health. The project team therefore implemented the participatory approach with a broad perspective when considering the range of individuals and groups to be integrated into project activities.

Participation exists in various forms and at various levels, and can be thought of as a continuum, with mere representation at one end. A graphical presentation of such a continuum is presented below (Figure 3.1), with level 1 being the lowest form and level 5 the highest form of the participatory process. Even representation has various levels, ranging from tokenism, a situation in which someone is simply asked to be at the discussion table, to more meaningful representation through which someone can actually make a difference at the table. Moving along the continuum, participation can also be seen as a form of engagement, through which the participant has an opportunity to provide ongoing input and feedback and has some sense of

ownership over the task at hand. In this conceptualization, the fullest form of participation would be a partnership that involves substantial ownership and decisionmaking abilities by those participating.

Figure 3.1. Continuum of Participation

(Tokenism)		(Input/Feedback)		(Decisionmaking)
Representation ... ⇒		Engagement ... ⇒		Partnership
1	2	3	4	5

Within this framework, there are several important points to note:

1. One should expect that the nature of participation will evolve over the life of a project. Given the existing power structures, capabilities, and community setup, it is often not realistic to expect a full partnership with youth or a community at the very beginning of a project. Moreover, it may even be unrealistic to assume that a full partnership can be achieved in the two- to three-year lifespan granted to most projects. Thus, rather than aiming to move from level 1 to 5, the current project was designed to start at around level 2, with the hope of achieving something closer to level 4 by the end.
2. The project was conducted under the practical premise that the “highest level” of partnership cannot, and does not have to, be activated at every stage with every activity with everyone involved. An intensive level of interaction often requires resources, skills, and time, which neither the project team nor community members have in abundance. For example, although many PLA efforts encourage the involvement of youth and community members as researchers during the formative stage, the project team decided against including this aspect this for a number of reasons. The most important of these was the potential for violation of confidentiality and privacy if community members were to investigate sensitive issues related to the sexual and reproductive lives of their neighbors. However, community members were used as researchers during parts of the monitoring and endline evaluation processes, by which time several community members had acquired a good understanding of basic research techniques and ethics.
3. In order to facilitate and provide legitimacy for all participatory activities in the study communities, the project team began its work (even at the research stage) by setting up two community-based advisory groups. These were the Adolescent Coordination Team (ACT), consisting entirely of young people, and the Project Advisory Committee (PAC), consisting entirely of adults.
4. In light of the conceptualization presented here, meaningful participation requires specific strategies to ensure that disempowered groups have an active opportunity to engage in the project. It was clear to us that in the Nepali societies involved in this project, women, young people, members of specific ethnic or caste groups, and the poor are much less likely to be present in public spaces and to be automatically given an opportunity to interact or make decisions. The team therefore had to devise a number of tactful strategies to ensure that these groups had an adequate say in the project. At the same time, it was not deemed essential that

every subgroup be represented in every activity; rather, the engagement of key groups was ensured at strategic points.

5. If partnership is the ultimate goal, then both the community and the implementing agencies have something valuable to offer. It is important to note this point because many groups think of participation as turning over the project to the community, with the idea that “it is theirs, not ours.” This approach was actively rejected in the current project design. First, given that the entire effort was conceptualized in New York City and Washington, DC, and the implementing agencies controlled the resources, it would have been hypocritical to suggest that the project is entirely owned by the community. Second, in working with the Nepali communities to improve youth reproductive health, the project staff had a lot to offer in terms of expertise and experience. The authors believed that both the community members and the nongovernmental organizations (NGOs) being represented brought valuable assets to the table, and that the project benefited from combining these skills and resources, rather than relying entirely on what the community alone could offer.
6. Having the community act as a full partner meant that young people and adults had to take the project seriously, and be willing to make difficult decisions and choices. Again, in the view of the project organizers, this decisionmaking process did not belong solely to the community. As informed, active, skilled partners, they had an obligation to participate actively and to provide information and guidance from a repertoire of experience and knowledge. In many cases, the information and expertise provided facilitated more informed judgment and decisionmaking by the entire project team.

In addition to the above key tenets, other elements were quickly identified that were important to the participatory process as the project developed. It is necessary to highlight these other aspects because, even though they may seem self-evident upon reflection, it is easy for most organizations to forget them when participatory work is first launched:

7. Participation is a political process that requires constant negotiation among participants, as well as nonparticipants. For example, in hierarchical societies such as the ones engaged with in Nepal, it is critical to ensure that the “gatekeepers” and community leaders are on board before anyone else is approached to participate; otherwise, the entire effort may be undermined. Constant management and negotiation is required to ensure that issues of hierarchy, status, protocol, and representation are considered in structuring project activities, meetings, advisory groups, and other activities. Similarly, ensuring balance and transparency in the allocation of tasks, authority, and resources is a constant challenge that must be skillfully handled at every turn.
8. Participating on an ongoing basis over a substantial period is a time-consuming burden for both youth and communities, which is one reason why one cannot expect full engagement by everyone all the time. It is also a major reason why during a three- to four-year project, one can expect the degree of participation to ebb and flow from very high to very low points.
9. During the course of the project, it became obvious that participation is not the same thing in rural and urban settings. Achieving and maintaining youth and community participation in

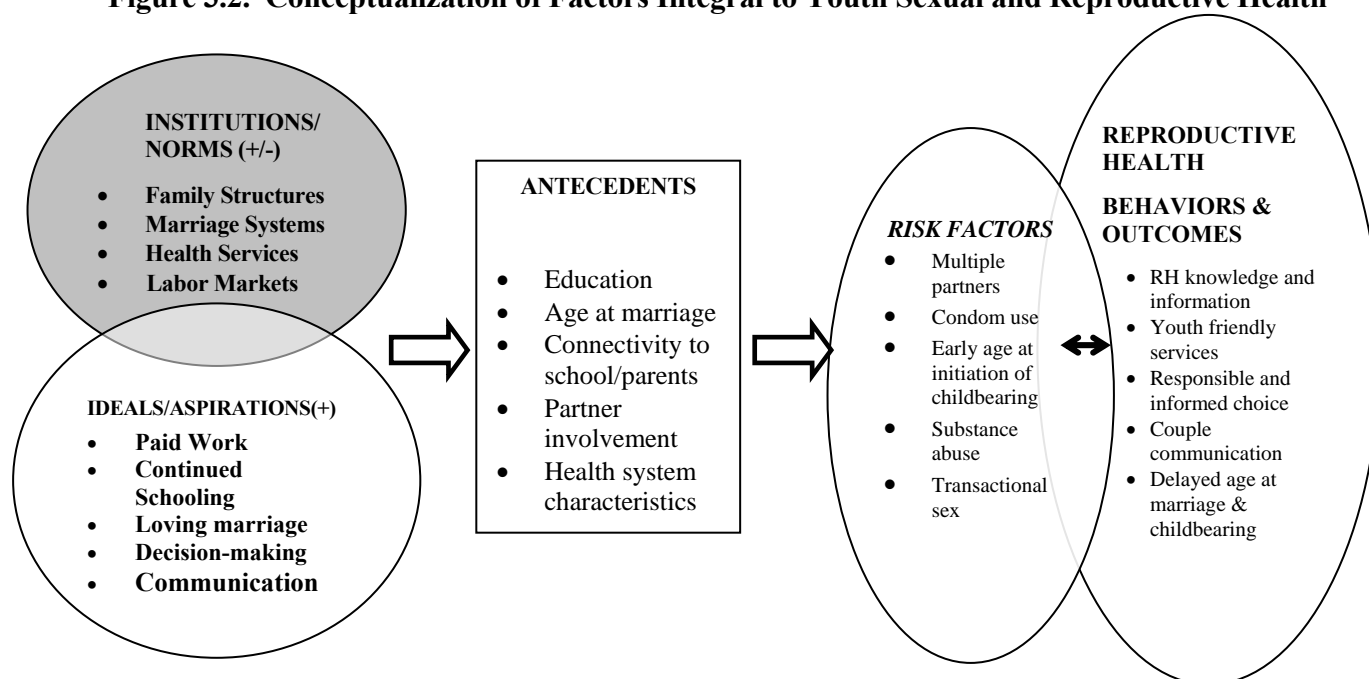
an urban area is a much more difficult and challenging task than it is in rural areas. There are several reasons for this difference. First, a sense of community is prevalent in rural areas, while in urban areas, the boundaries of “community” are more artificially designed, especially given the greater diversity of residents in urban areas. Urban residents are generally financially better off than rural populations and may not consider themselves in need of the benefits offered by NGO-initiated programs. Moreover, given the demands of urban life, they may have little time to invest in participatory processes. The time of urban youth and adults is also subjected to many more competing activities and demands than is the case for their rural counterparts, with the result that participatory activities may be a less attractive source of social expression or cohesion.

Conceptualization of Youth Reproductive Health

Equally critical to the project design was a comprehensive and holistic conceptualization of youth sexual and reproductive health. This conceptualization encompasses a wide range of concerns that not only affect young people’s health and well-being during their adolescent years, but which are often the foundation for events throughout adult lives. Good reproductive health outcomes therefore require knowledge, information, and services, as well as the ability to make responsible and informed decisions about partners, sexuality, marriage, contraception, and childbearing. During the key transitional years of adolescence, a number of life experiences—including schooling, relationships, friendships, work, and marriage—present the possibility for facilitating positive rather than negative practices and choices related to such matters. In this sense, attention to youth reproductive health requires more than a simple assessment of vulnerability and risk; it also requires an understanding of young people’s life views and aspirations, as well as the broader political, social, and economic contexts of their lives.

Figure 3.2 presents the essential elements of youth sexual and reproductive health as conceptualized in the current project in Nepal. The conceptualization focuses on important reproductive behaviors and outcomes of general interest in the field of YRH, including, but not limited to, access to knowledge and services. A number of risk factors (such as multiple partners and early marriage) are the “proximate determinants” of these outcomes. Equally importantly, however, is a range of social and economic “antecedents,” such as schooling, age at marriage, connectivity to parents, partner involvement, and health system characteristics, all of which impact both the risk factors and the ultimate outcomes associated with young people’s sexual and reproductive health. Even more fundamentally, outcomes, risk factors, and antecedents are shaped by young people’s ideals and aspirations and the broader social institutions and norms (such as marriage systems and gender roles) that define, shape, and constrain life options and experiences.

Figure 3.2. Conceptualization of Factors Integral to Youth Sexual and Reproductive Health



4. Study Design: Data and Methodology

Despite its hypothesized advantages, the success of a participatory approach in reaching young people in developing countries and improving their reproductive health has not been scientifically tested. The ICRW-EngenderHealth effort aimed to fill this gap through rigorous analysis and evaluation. Therefore, the project was set up with a quasi-experimental study design based on the participatory approach for research, intervention, monitoring, and evaluation at two study sites, together with more traditional reproductive health research and interventions at two control sites.

The study and control sites encompassed one rural and one urban area each. The two rural sites are located in the “Terai” area, in the districts of Nawalparasi and Kawasoti near the Nepali-Indian border. With approximately 200 households each, the two communities lie about 80 kilometers apart and were selected on the basis of having a secondary school, a range of health service providers, access to a main road and electricity, and the presence of at least one working NGO. As such, they represent the relatively more developed Nepali village. The two urban communities, consisting of approximately 300 households each, were drawn from middle class suburbs on the outskirts of Kathmandu.² Located about 20 kilometers apart from each other, the two suburbs selected met the basic criteria described above, along with having a more developed

² Communities in the urban area were defined as extended neighborhoods in a specific geographic area, in which shared facilities for schooling, commercial and social services, and a governance structure make up one ward within the larger municipality.

infrastructure and a wider range of options for such aspects as transportation, schooling, employment, health services, and leisure activities.

The study design for this project focused on collecting baseline and endline data for evaluation purposes, as well as process data on interventions and community perceptions for monitoring purposes. The baseline data also served as formative research and provided the basis for an initial needs assessment. Given the broad goal and multiple objectives inherent in a community-based, participatory approach to YRH, the evaluation design relied on a triangulation of research methodologies. Quantitative, qualitative, and participatory methods were employed to gather detailed information on the reproductive health knowledge and practices of young people from a range of perspectives, as well as rich data on the broader social and cultural context that shapes and defines the sexual and reproductive experiences of Nepali youth. Table 4.1 catalogues the different data sources, samples, and methodologies utilized as part of programmatic research in this project, while Table 4.2 shows the timeline for implementing the various phases of the project.

Table 4.1. Data Sources, Samples, and Methodologies

METHODOLOGY	PURPOSE AND RESEARCH TOOLS		
	Baseline and Formative Research	Endline	Monitoring and Process Documentation
Quantitative (study and control sites)	Household survey (N=965) Adolescent survey ages 14–21 (N=724) Adult survey ages 30+ (N=752) Service provider survey (N= 59)	Household survey (N=1003) Adolescent survey ages 14–25 (N=979) Adult survey ages 30+ (N=654) Service provider survey (N=62)	Facilitator reports on participation in intervention activities (N=231) Mystery client survey at midpoint and endpoint (N=48)
Qualitative (study and control sites)	Key informant interviews (N=3) In-depth interviews (N=14) Focus group discussions (N=10)	Focus group discussions (N=16)	Facilitator reports on intervention activities (same as above, N=231)
Participatory (study sites only)	Nine participatory activities with 4–5 groups each: ▪ Community mapping ▪ Mobility mapping ▪ Free listing and ranking ▪ Lifelines ▪ Body mapping ▪ Reproductive health problem trees ▪ RH service matrix	Five participatory activities with 20 groups each: ▪ Mobility mapping ▪ Lifelines ▪ Reproductive health problem trees ▪ RH service matrix ▪ Trend analysis	67 community group assessments at midpoint and endpoint

Table 4.2. Project Timeline

Phase 1	Setup and site selection	September to December 1998
Phase 2	Formative (baseline) research and needs assessment	January 1999 to March 2000
Phase 3	Action planning and program design	April to October 2000
Phase 4	Intervention implementation and monitoring	November 2000 to March 2003
Phase 5	Evaluation and analysis	April to November 2003

5. Needs Assessment

As a first step in program development, it was essential to ascertain specifically how issues of youth reproductive health were relevant in the communities of interest. Using triangulated methodologies to conduct baseline and formative research, data were collected and analyzed during the first 15 months of the project; this also formed the basis for a detailed and extensive needs assessment. The formative research was conducted from January 1999 to March 2000 and, as outlined in Table 4.1, covered adolescent, adult, service provider, and community perspectives on a number of issues, such as the relationship between household socioeconomic status and marriage practices, provider attitudes, gender norms, ethnic differentials, communications, aspirations, ideals, and perceived problems. The voices and priorities of community members were critical in shaping the range of issues covered, through both participatory tools and quantitative surveys.

Lack of In-depth Knowledge of Issues and Access to Services

The needs assessment confirmed that young people lack adequate knowledge and information regarding anatomy, physiology, reproductive processes, and sexuality. In contrast to the general perception in the field, however, the formative research conducted for this project shows that the news on adolescent reproductive health is not all bad. Young people know more about issues and facts related to sexual and reproductive health than is often realized, but at the same time, their knowledge on these matters is not very deep. For example, during the exercises on body maps and problem matrices, adolescents in the study area displayed considerable knowledge and awareness about the body, changes during puberty, menstruation, pregnancy, reproductive functions, and family planning methods and their use, even if they were misinformed about the details.

The lack of deep knowledge is especially apparent with regard to pregnancy and disease prevention. There is widespread awareness about reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), and nearly 90 percent of young people in urban and rural areas know about HIV/AIDS. Yet when youth were probed further, only 28 percent in rural areas and 64 percent in urban areas correctly named at least two modes of HIV/AIDS transmission. Similarly, more than 90 percent of respondents knew about modern contraceptive methods. However, when young women at the urban study site were probed further about contraceptives during a participatory activity, they were unaware of how these methods actually

worked or affected their bodies. These results confirm many other findings on adolescent reproductive health worldwide, and underscore that *young people in Nepal do not have enough accurate information* about sexual and anatomical issues to make good, informed reproductive health decisions.

The needs assessment also shows that services are not easily accessible to young people, in large part because providers often have judgmental attitudes towards adolescents who seek services. Provider reluctance, discomfort, and judgmental attitudes extend to not only unmarried youth, but also to married adolescents, a large proportion of whom are denied access to services. Providers report embarrassment in discussing topics of sexuality, discomfort with terminology, lack of appropriate knowledge on reproductive physiology, and lack of training in counseling young people. Providers also lack recognition of the special needs and constraints of married and unmarried girls; most feel that it is not essential to inform married adolescents on issues of physiology, sex, and pregnancy because they know about these topics already. Providers also do not approve of providing information on sex and sexuality to unmarried adolescents, especially girls.

At the study sites, where additional participatory methods were used, the formative research process yielded some exciting new findings that provided a more complex and comprehensive understanding of the context in which reproductive health interventions for young people must be designed and implemented.

Progressive Personal Ideals Contrast with Reality

Perhaps the most compelling aspect of the participatory experience was the extent to which it highlighted and reinforced the fact that rural and urban young people in Nepal dream about and aspire to a future as much as young people do anywhere in the western world. Adolescence is not just a period of “problems” and “risks,” but one in which Nepali youth think about their futures and dream about education, careers, modern comforts, friendships, loving marriages, and family life.

Both boys and girls are ambitious about educational attainment and the prospects of employment; they recognize that their own earnings are the best vehicles to a comfortable future.

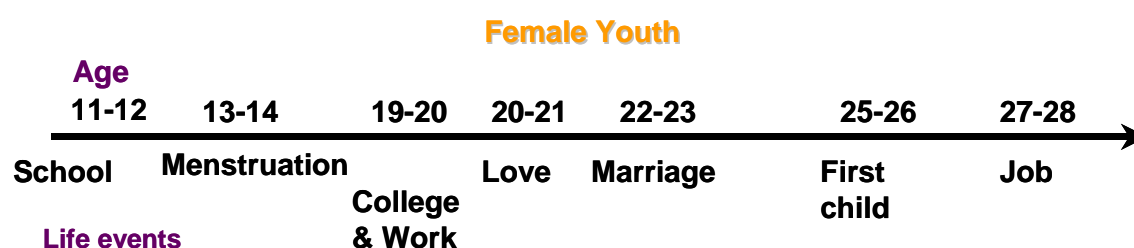
“...I want to be completely recognized through my own identity...I aspire to study hard and become a nurse in the future. That too a good nurse.” (Unmarried female youth, urban study site)

Although, arranged marriages are currently the norm (even more so in urban than in rural areas), during participatory activities young people were consumed with discussions of love and attraction for the opposite sex. Loving, late marriages are the ideal. Even within marriage, youth aspire to being part of loving relationships in which they have power, participation, and choices, especially with regard to the issue of having children.

“In love marriage, the husband and wife discuss between themselves, and only give birth to children after both of them have a job. For this they use contraceptives. So, in love marriage, the birth of the first baby is delayed...” (Unmarried female youth, urban study site)

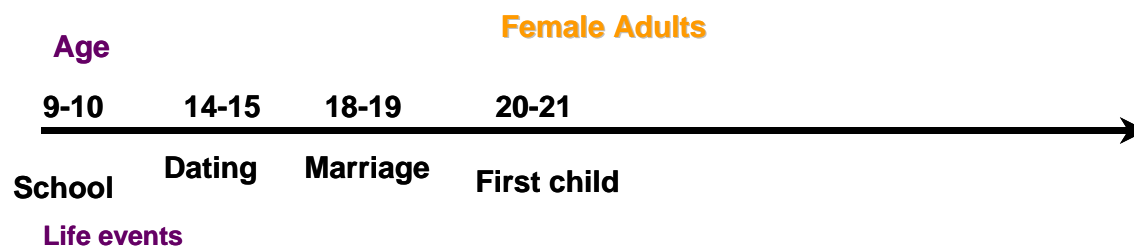
The contrast between the positive aspirations of girls and the less than rosy reality of their lives was perhaps most clearly illustrated by the results of a lifeline activity with urban adolescent girls and adult women. The girls were asked to chart the main events in the life of a typical girl in their community, from childhood to adulthood. The figure below represents the “lifeline” drawn by the adolescent girls. As stated above, the importance of schooling, work, love, and later marriages and childbearing are clearly represented here by the young women.

Figure 5.1. Key Life Events of Young Women in Urban Nepal, as Viewed by Female Youth



In contrast, when a group of adult women from the same community were asked to chart the key life events of young girls in their community, the resulting lifeline was starkly different from the one presented by younger women. The lifeline charted by adult women more closely reflects current statistics on the life transitions of young girls in Nepal (although even here, the age at first marriage and childbearing is more an ideal rather than reality). As such, it clearly exhibits the discordance between the girls’ expansive life goals and aspirations, and the restricted reality of their lives.

Figure 5.2. Key Life Events of Young Women in Urban Nepal, as Viewed by Female Adults

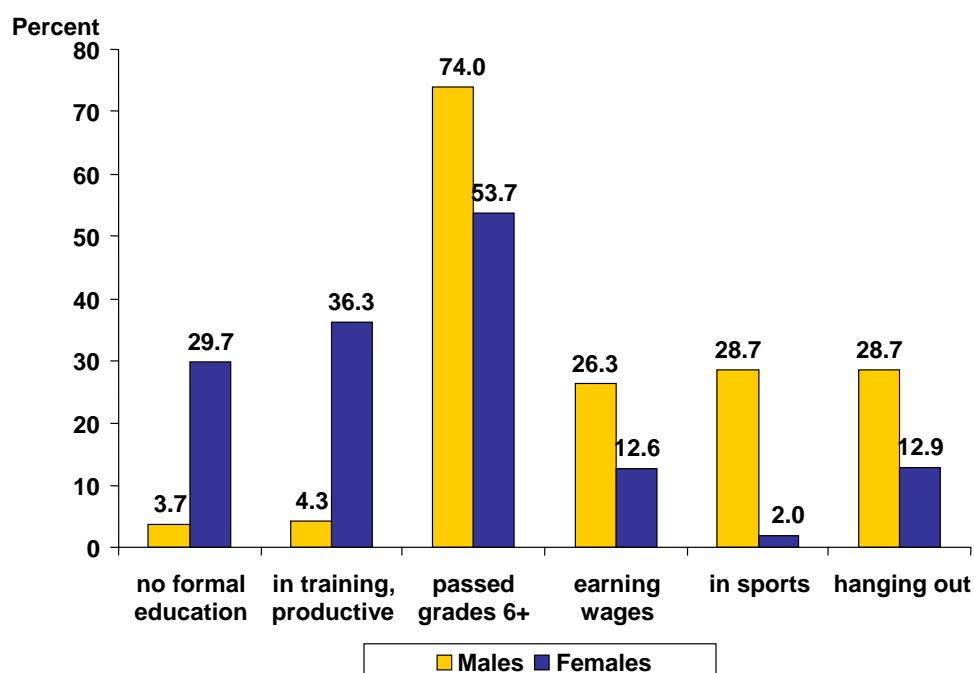


Gender as a Determinant of How Adolescence is Experienced

The data generated by this study make it apparent that one of the strongest internal barriers to the fulfillment of many positive aspirations for girls is the structure of gender inequality in

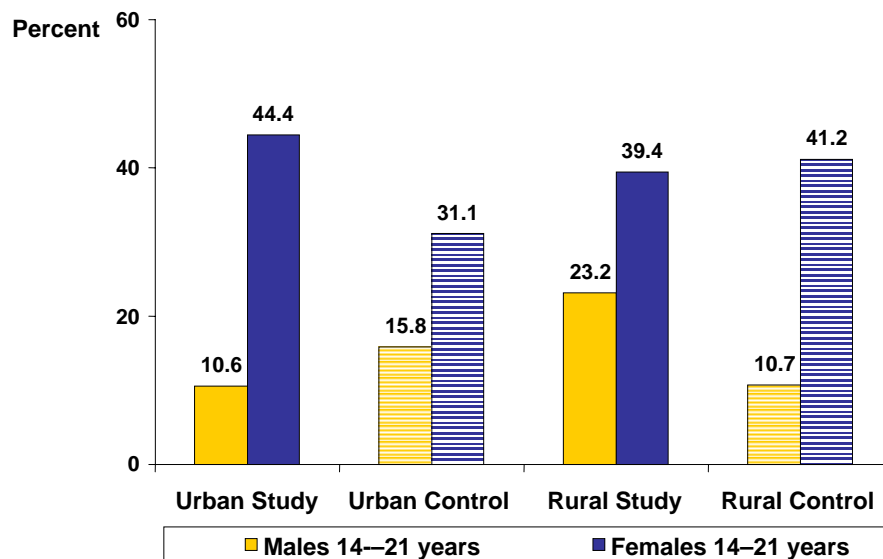
communities. Adolescence itself is constructed differently according to gender, with it being a more carefree and enjoyable life stage for boys than for girls. Both participatory and quantitative data indicate that despite modern ideas and aspirations, girls have limited options, resources, and decisionmaking power. Compared to boys, girls are disadvantaged with regard to access to schooling, wage employment, and sources for personal expenditures. Boys enjoy a wider range of social and leisure activities, more physical mobility, better access to sexual and reproductive health information, and greater social acceptability of premarital sexual activity.

Figure 5.3. Schooling, Employment, and Leisure Activities of Youth: Males and Females



However, the most critical gender difference in the construction of adolescence in both urban and rural Nepali communities is that the vast majority of girls marry during adolescence, while boys do not. As shown in Figure 5.4, a significant proportion of girls are married compared to boys, with a mean age at marriage for girls at 16.5 years at both the urban and rural sites. Girls also begin childbearing at very young ages; baseline data show that 83 percent of urban and 80 percent of rural married girls had already experienced at least one pregnancy at the time of the study. Contraceptive use immediately after marriage is almost negligible.

Figure 5.4. Proportions of Currently Married Youth: Males and Females Aged 14–21 Years



Marriage serves as a point of disjuncture between aspirations and realities for young girls; the social support for girls to aspire and dream is abruptly withdrawn at this point and they are expected to devote themselves to the responsibilities of family life. Thus, many girls find themselves initiating sexual activity and childbearing without much knowledge or understanding, and adjusting to family responsibilities without resources or decisionmaking power.

Adult Perspectives Mirror Those of Youth

Interestingly, the study found that parents also support the progressive aspirations of their children. Mothers in particular want a better life for their daughters compared to what they have had. In contrast to the dependence and limitations of their own experience, adult women emphasize the importance of education and economic independence for the next generation of young women. Parental expressions of ideal age at marriage are almost identical to those of young people, with a mean of 21 years for girls and 25 years for boys in the urban area, and 19 years for girls and 23.5 for boys in the rural area. There is also universal agreement among young people and parents that there should be a two-year gap between marriage and the initiation of childbearing.

“Girls here marry at the age of 17–18... after marriage they have physical contact as their husband wishes, which is a big event. There is a fear of how to sleep with the husband, how to do other activities. They want to cry... after marriage it is not easy in their homes.” (Adult woman, rural study site)

Also surprising and encouraging was the finding that parents are very supportive of sexual and reproductive health issues being taught in school (approximately 93 percent were in favor). Adult support for the availability of and access to family planning services for not just married, but also

unmarried, adolescents was also surprisingly strong (approximately 53 percent for boys and girls). Parental support for services to married adolescents is almost universal (above 98 percent).

Findings from formative research indicate that the realities of reproductive health in study communities are inconsistent, contradictory, and paradoxical. For example, young people are informed, but they are also misinformed; marriages and childbearing are early, but people would like them to be later; girls aspire to education and careers, but are usually married during adolescence. The realization and acknowledgement of these paradoxes is perhaps the most valuable insight for intervention design. Analysis of the data suggests that although individual aspirations for adolescents are highly positive, they have not as yet coalesced into social norms. What is socially acceptable, approved of, and expected is therefore more traditional and conservative than what is desired by a significant majority of community members.

Although doing so poses a great challenge, one of the greatest feats of intervention design would be to help communities reconcile these differences by shifting norms to match ideals. Thus, the most important lesson learned by the project coordinators from the needs assessment was that interventions and program activities must emphasize not just the specific sexual and reproductive health concerns of young people, but also the broader social context that indirectly impacts their reproductive health needs and decisions.

6. Action Planning

At the study sites, both the overall intervention design and the specific interventions were developed through participatory processes. Once the needs assessment was completed, project staff initiated a planning process with community members to identify, discuss, and prioritize interventions that would best address the needs identified. The action planning process was conducted over the course of several months and involved sharing and discussion of research findings with community members, creation of youth task forces to develop interventions, and the development of an intervention plan.

Sharing and discussion of findings

Project staff worked with the two project advisory groups in the study communities, the Adolescent Coordination Team (ACT), consisting entirely of youth, and the Project Advisory Committee (PAC), consisting entirely of adults, to facilitate the dissemination of findings to the rest of the community and to obtain feedback from a range of community members. Since the discoveries from the needs assessment process were extensive, the project team reviewed and summarized the research findings into specific themes in order to facilitate review by the ACT and PAC of results from the formative research. The findings were grouped under the themes of:

- Growing up
- Managing sexual feelings
- “Eves” teasing (sexual harassment faced by girls)
- Rape

- Prostitution
- RTIs, STDs, and HIV/AIDS
- Marriage
- Family planning
- Pregnancy, childbirth, abortion, and infertility

For each problem, the project team shared with the ACT and PAC the main concerns or problems of young people that were identified through formative research; causes and consequences; what young people were currently doing about it; and how young people would ideally like to address it. Members of the ACT and the PAC reviewed this information, identified key points to present to youth and adults in the community, and became the main conveyers of this information to neighbors and friends through role plays, diagrams, and pictures. Presentation and discussion on these issues was an extensive process that often required separate sessions with key groups (that is, adult women separately from adult men and young boys separately from young girls).

Creation of task forces

One of the most striking aspects of sharing results with the community was the degree to which the analysis of community members coincided with that of the project team in terms of the major areas to be addressed for improving adolescent reproductive health. In an analysis that was almost identical to the project team's needs assessment, the community members identified three broad areas as most relevant for intervention:

1. The need for more and better reproductive health information, counseling, and services.
2. The need for initiatives to address economic and personal development issues that affect the overall health status of youth.
3. The need for change in community norms and attitudes that influence adolescent health.

In order to address these areas, five task forces consisting of six to eight young people were created at each study site. Task forces included youth representatives who were male and female, married and unmarried, in school and out of school, and from different ethnic and socioeconomic groups. The first three task forces deliberated on, respectively, appropriate interventions for improving reproductive health information, counseling, and services. The project team was able to provide the task forces with substantial guidance and materials on these issues from existing models of YRH interventions. The remaining two task forces focused on interventions that could address economic and personal issues and community norms and attitudes. Since these two task forces were dealing with areas that are conventionally not addressed in YRH programs, their work was more difficult and required more deliberation and discussion of imaginative, novel, and experimental solutions.

Development of Interventions

The task forces identified a range of activities through which to address the needs and concerns highlighted by community members and further prioritized potential interventions based on the following criteria:

- Feasibility
- Sustainability
- Appeal to intervention target group(s)
- Acceptability to community
- Ability to reach intervention target group(s)
- Importance to youth
- Ability to promote principles of quality

Following completion of the activity plans, representatives from each of the task forces came together to develop an integrated intervention plan. At various stages during the development of specific interventions and the overall plan design, the task forces sought input, advice, and commitment from adult community members, as well as from key community resource groups such as teachers and service providers.

Challenges and Issues Related to the Action Planning Process

Project staff had to address several issues related to the action planning process, as follows:

1. The action planning process required substantial time and resources. In order for the process to be effective and concise, a significant amount of preliminary work needed to be completed by the project team. This included analyzing and synthesizing findings in order to ensure a timely and efficient review of the findings by the ACT, the PAC, and the task forces. Additionally, project staff had to spend a significant amount of time setting up structures (such as the task forces) before initiating the action planning process. The political nature of such structures with regard to ensuring adequate representation by various groups— as well as allowing the skills and leadership of talented youth to thrive—means that they require considerable time to establish.
2. In order to identify appropriate interventions, the action planning process required facilitation by experts in adolescent reproductive health programming who could incorporate lessons learned from other programs into activities suggested by task force members. Thus, in order to participate in the action planning process, project staff needed both training on participatory processes and significant on-the-job training in adolescent reproductive health programming.
3. Members of the task forces had no problems identifying activities that could address community needs for reproductive health information, counseling, and services. However, they had a hard time identifying appropriate activities through which to address social norms and economic and personal development; such an effort required more holistic and strategic thinking about possible solutions and activities. The project team therefore had to spend a considerable amount of time and energy sharing experiences of successful interventions so that task force members could conceptualize the type of activities through which to address social norms and economic activities appropriate for their community.

4. The action planning process—including data analysis, discussion of findings with community members, and fine-tuning of interventions—was continuous. Because of the amount of data collected through this process, a one-time discussion of findings with community members was not sufficient to obtain their perspectives on the study findings. Multiple phases were particularly necessary, since a continuous analysis of the data led to new and important insights into community needs, which were then incorporated into the ongoing interventions.
5. The action planning process took longer at the urban site than at the rural site. This can be attributed to the fact that urban community members perceived themselves to have less time and more competing priorities than did rural community members. Since they did not see themselves as part of a “community” in the same way as rural community members did, urban residents also did not see the need to be involved in a project that could benefit the community as a whole, but not necessarily themselves individually.

7. Interventions

Programmatic Approach: Study and Control Sites

Since a fundamental goal of the project was to test the impact of a participatory approach to improving youth reproductive health, different programming approaches were used at the control and the study sites. As noted above, interventions at the study sites were developed and implemented in collaboration with youth and adult community members and focused on both reproductive health and other issues, such as social norms and livelihoods. In contrast, a standard set of youth reproductive health interventions implemented at the control sites was based on current knowledge and standard practice in the reproductive health field. The interventions at the control sites focused only on improving access to and use of reproductive health information and services for young people. The overall intervention period ranged from 12 to 24 months, with the first set of interventions beginning in November 2000 and the last set ending in March 2003.

Although each intervention at the control sites was implemented separately, the interventions at the study sites were linked and coordinated. Furthermore, the entire process of implementation at the study sites was participatory and interactive, whereas at the control sites the interventions were largely run and coordinated by the implementing agencies. For example, interventions at the study sites evolved as the project progressed because community participants provided additional input on how the actual implementation was working and identified new areas they wanted to be addressed. Similarly, all trainings at the study sites were highly participatory and interactive in nature, while trainings at the control sites were more didactic. Table 7.1 shows the basic difference in the programmatic approach for the study versus the control sites.

Table 7.1. Difference in Programmatic Approach: Study versus Control Sites

Control Sites	Study Sites
<ul style="list-style-type: none"> ▪ Standard set of interventions ▪ Separate interventions ▪ No participant input ▪ Didactic training approach ▪ Program and training limited ▪ Focus on RH information and services 	<ul style="list-style-type: none"> ▪ Community-determined interventions ▪ Linked and coordinated Interventions ▪ Participant input in design and training ▪ Interactive program ▪ Participatory training approach ▪ Holistic programming

Specific Interventions: Study and Control Sites

As a result of the participatory process, not only was the process of implementation deeper and more thorough, but the number and range of interventions implemented at the study sites were much larger than at the control sites. Table 7.2 lists the specific interventions implemented at both the study and control sites.

Table 7.2. Specific Interventions Implemented: Study and Control Sites

Control Sites	Study Sites
<ol style="list-style-type: none"> 1. Adolescent-friendly services 2. Peer education and counseling 3. Teacher training 	<p><i>Direct Reproductive Health Programs</i></p> <ol style="list-style-type: none"> 1. Adolescent-friendly services 2. Peer education and counseling 3. Information and education <p><i>Indirect Reproductive Health Programs</i></p> <ol style="list-style-type: none"> 4. Adult education 5. Youth development 6. Social norms 7. Economic livelihoods 8. Teacher education

As illustrated in Table 7.2, three reproductive health-specific interventions were implemented at both the study and control sites, although the process of the implementation differed considerably. These included adolescent-friendly services, peer education and counseling, and teacher training programs.

Adolescent-Friendly Services

The purpose of the adolescent-friendly services program was to address attitudinal, logistical, and knowledge-related barriers among service providers that prevent young people from having adequate access to existing services. The main focus of the program was to provide training to services providers, including pharmacists, staff from the local health post, family community health volunteers (FCHVs), and other staff from local health organizations. The training covered orientation on reproductive health issues that affect young people, how to make services more youth friendly, and counseling skills. Additionally, based on input and requests, service providers at the study sites received training to improve their knowledge of family planning, maternal health, and issues related to STDs and HIV/AIDS. Providers at all sites also received technical assistance on marketing their services to youth.

Due to the participatory nature of the project at the study sites, an additional element of this program was the creation of a support network among providers. Study site providers met on a monthly basis with each other and with project staff to discuss issues they had faced in providing services to young people and strategies to address them. As a result of this support network, the providers created a strong referral system to address young people's reproductive health issues in the study communities.

Peer Education and Counseling

The peer education and counseling program aimed to build on existing youth communication networks in order to improve the exchange of accurate and useful information on sexual and reproductive health issues. At the control sites, the local implementing organization formed two peer educator groups (one male and one female at each site) based on its current program design for peer education programs. In contrast, peer educator groups at the two study sites were structured on the findings from the needs assessment process, which highlighted the different needs of younger adolescents rather than somewhat older, married youth. In this way, two mixed sex peer educator groups were created, one to address the needs and concerns of younger, unmarried adolescents and the other to meet the needs of older, married youth. At the control sites, all the activities implemented by the peer educators were predefined by the local organization implementing the program. In contrast, at the study sites the activities were designed and implemented by youth in the community, with the result that they changed and evolved as the project progressed.

Teacher Training

The teacher training program varied substantially depending on the site. At the two control sites, teachers from all the main schools were trained in adolescent reproductive health issues and were expected to hold specific sessions to provide information and education to youth who were both in and out of school. Out-of-school sessions were held on weekend mornings, when young people with other obligations could attend classes.

During the needs assessment and action planning processes, young people at the rural study site had identified teachers as an important source of information and education. Because involvement by teachers was actively desired by the youth in the community, an intervention in which where teachers played a key role in providing information, counseling, advocacy, and leadership for youth activities was planned in the rural area from the beginning of the project.

In contrast, during the planning discussions, young people at the urban study site were reluctant to have their teachers involved in the provision of information and education on sexual and reproductive health issues. For this reason, a teacher training and education program was not implemented immediately in the urban area. As the project progressed, however, it became clear that teachers in the community were a key constituency, and too influential and important in the lives of young people to be ignored in intervention activities. The exclusion of teachers was clearly creating a number of barriers to the implementation of activities; teachers began to view the project activities with suspicion, prohibit young people from attending project meetings, and were reluctant to provide facilities or cooperation when needed. The project staff therefore made an active effort to bring these issues to the attention of young people and to emphasize the political advantages of involving teachers in the interventions. As a result, teachers at the urban site were oriented on adolescent reproductive health issues and were frequently asked to serve as leaders and facilitators for many of the project activities.

Information, Education, and Communication (IEC)

The purpose of the IEC program was to increase young people's awareness and knowledge of reproductive health care issues and to fill existing information and service gaps. Several activities were implemented under this intervention, including: 1) monthly mobile seminars at which community and local experts facilitated discussions about reproductive health topics of interest to youth; 2) periodic community fairs that provided information to young people through games and contests; and 3) the development of detailed reproductive health publications for each of the study sites; in both cases, publications were written and designed by young people in the community. The rural publication covered the following issues: health seeking behavior, changes during adolescence, career development, consequences of early marriage and pregnancy, and parent and youth communication on adolescent reproductive health. In the urban area, the publication focused on managing sexual feelings and necessary life skills.

The remaining intervention activities focused on the broader personal and social development of youth and were implemented only at the study sites. These included programs on information, education, and communication; adult education; youth development; social norms; and economic livelihoods.

Adult Education

Results from the needs assessment process indicated that young people often go to older family members (such as mothers, sisters-in-law, and brothers) for reproductive health information. Since adults are an important source of information and support for young people, the youth task forces designed an intervention to encourage supportive and nonjudgmental attitudes among

adults regarding adolescent reproductive health issues. Additionally, this intervention sought to facilitate communication among youth and parents, as well as other significant adults.

At the rural study site, male and female adult groups were created for the adult peer educators training, but in the urban area only a female adult group was created since there was insufficient interest on the part of the male adults. Adults were trained in adolescent reproductive health issues, how to communicate with young people, and sharing information with other adults. The adults also created a support group that would meet on a monthly basis to discuss the issues and concerns on which young people need advice or input.

Youth Development

The needs assessment process indicated that youth, especially young girls, do not have healthy and safe spaces in which to interact and socialize with each other. The youth development program therefore aimed to support healthy recreational activities, personal development opportunities, and safe social spaces. The project team worked with existing youth clubs, or where these were lacking, helped community youth to establish male and female youth clubs. Largely through ownership and initiative from the youth themselves, these clubs provide a safe environment for social activities, including different sporting, cultural, and literary events. At both the rural and urban sites, the youth clubs created community libraries. In the rural area, the youth group took the initiative to obtain space from the local government at which to locate the library and raised matching funds to support it through staffing and materials. In the urban area, the library was housed in the school with support from the community members.

Social Norms

The purpose of the social norms program was to allow communities to discuss and identify solutions to help change social norms, especially those related to early marriage and childbearing, which clearly have a negative impact on youth reproductive health. As part of this program, community youth were trained in drama skills, including facilitation, scriptwriting, and production techniques. They implemented a set of serial dramas in community spaces that highlighted the negative impact of social norms and pressures that lead to early marriage, lack of schooling, childbearing immediately after marriage, exposure to and nondisclosure of HIV/AIDS, and substance abuse. In the rural area, for example, youth conducted plays at their school about children who do not regularly attend school and the consequences they face as a result and about respecting relationships with parents.

In total, five plays were conducted at the rural site and six at the urban site. The plays were popular with both youth and adult members of the communities. As the news about the plays spread, the young people involved in this activity were frequently invited by neighboring communities to conduct the plays. At both sites, youth involved in this program participated in an exchange visit to the other site to see the type of work that their counterparts were doing, to discuss lessons learned from their participation in the project and in the street theater program, and to obtain a better understanding of other types of communities in Nepal and the needs of youth in those communities.

Economic Livelihoods

The needs assessment elucidated strong understanding among adults and youth that many reproductive health problems result from a lack of resources and viable economic options. Thus, there was strong pressure from the community to emphasize livelihoods in the study's program design, and to make enabling youth to acquire skills to support their participation in livelihood activities the central purpose of the economic intervention.

At the urban study site, the intervention focused on providing youth with skills to access the current job market both in their community and the larger urban area. Project staff, in conjunction with youth, conducted a needs assessment to identify the skills that youth require to obtain employment; identified organizations in the community and in neighboring areas that may be interested in hiring youth and the type of skill sets they are looking for; and designed a training plan for youth to address existing skill gaps.

At the rural study site, the livelihoods intervention focused on helping youth to create or become part of savings and credit groups. The original plan was to establish savings and credits groups for both young men and young women, but it was soon discovered that young men in the rural area generally found better economic opportunities elsewhere or did not have sufficient time to participate in such an effort. Groups were therefore established only for young women. Since young girls have high mobility due to marriage, the savings and credit groups involved adult partnerships so that young participants had counterparts from their families participating in the group.

Management of Interventions

Since multiple interventions were implemented at multiple levels and with multiple partnerships, it was essential to establish a coordinating structure that allowed for effective progress, participation, and adjustments during the implementation stage. To this end, three tiers of coordination were established: the first involved EngenderHealth and ICRW; the second connected the implementing agencies in the United States and their in-country partners in Nepal; and the third linked communities and organizations in Nepal.

Coordination between EngenderHealth and ICRW

The EngenderHealth-ICRW collaboration focused on ensuring that the project's conceptual frameworks on participation and adolescent reproductive health were developed jointly, and that these frameworks closely guided each of the project phases. Both organizations had significant input in each phase of the project, including those that were not their primary responsibility. EngenderHealth worked closely with ICRW to develop the formative research, needs assessment, and evaluation and monitoring instruments, while ICRW worked closely with EngenderHealth to develop the intervention plan and provided ongoing input on the interventions.

Coordination between U.S.-based and Nepal-based organizations

Since there were five implementing organizations working simultaneously in the study communities, close coordination and management were required to ensure that the interventions were linked and did not simultaneously burden the communities. Representatives from all five organizations therefore met on a monthly basis in order to coordinate implementation schedules, share input and feedback from the community, and address any issues that were impeding progress on intervention activities. The five implementing organizations also provided monthly email updates to EngenderHealth project staff and requested technical assistance on an as-needed basis.

Coordination between Nepal-based Project Partners and Community Members

Given the range of interventions being implemented, the importance of community participation and ownership, and the presence of multiple implementing partners in the study communities, coordination between the Nepali-project partners and community members was arguably the most important level of project coordination. At this level, coordination involved meetings with the ACT and the PAC on a regular basis, monthly meetings between community members and representatives from the Nepal-based organizations that were providing assistance on each of the interventions, and systematic visits by project team members to monitor and facilitate activities and address bottlenecks and concerns.

Challenges and Issues Related to the Intervention Phase

Project staff faced several ongoing challenges during the intervention process, including:

1. Creating a project identity. The implementation of multiple intervention activities meant that many community members and in-country project staff identified themselves with the specific intervention(s) they were involved with, rather than with the project as a whole. This often led to community tensions, since some residents felt that certain interventions were more beneficial than others and that involvement in some interventions was more lucrative in terms of such aspects as expense reimbursements or the type of meals provided. Additionally, the lack of a project identity often led to the inadequate linkage of intervention activities. As a result, core project field staff had to spend a significant amount of time creating a project identity and ensuring that all intervention staff had the same policies regarding both benefits and communication with the community, the ACT, and the PAC.
2. Limited timeframe. Despite efforts to lengthen the intervention period as much as possible, the time period for implementing interventions was too short for several reasons. Key among these was the fact that coordination of activities was complicated and time consuming, and designing and ensuring that the interventions were sufficiently participatory required flexibility and time. Additionally, many of the interventions required materials (such as curricula) that did not exist or were not easily adaptable to the study sites, and therefore had to be developed and pretested before being implemented. Finally, linking interventions

required close coordination between project partners, a process that was also time consuming.

3. Ensuring participation. Participation continued to ebb and flow as community members strove to balance competing demands on their time. This pattern resulted in project staff spending significant amount of time trying to ensure adequate community participation in different interventions.
4. Youth-adult interactions. As young people gained experience and expertise by being involved in the interventions, they became more capable of implementing activities and more outspoken about their needs. In many cases, evidence of young people's capabilities was celebrated and appreciated by parents and other adults. At other times, however, this led to conflict in the community since in certain situations, adults considered youth initiative and outspokenness to be threatening and inappropriate. On occasion, project staff had to resolve differences of opinion among adults and young people. The intervention phase highlighted the importance of involving key adults in addressing issues related to adolescent reproductive health.

8. Monitoring

As was the case with the research and implementation phases, monitoring the project required innovation in creating a simple and streamlined process to support the work of the intervention and evaluation teams. Data collection during the monitoring phase served to track the process of participation and the progress of the intervention activities. Unlike most YRH projects with a limited number of interventions, the current effort was especially challenging because it required monitoring a set of eight intervention programs at each study site and three at each control site. Each of these interventions was distinct and fulfilled different needs, while at the same time being part of a larger approach. Moreover, in order to accomplish its mandate, each intervention program conducted several different types of activities, ranging from trainings to monthly meetings to community events. The monitoring process was further complicated by the frequency of multiple and varied activities at the study sites and the need for speedy report writing and data entry and processing with which to provide feedback to the intervention teams.

The research team worked very closely with the implementation teams to develop data collection tools that could capture the complexity of the participatory process and details of the intervention activities in an efficient manner. After a lengthy and iterative process, a set of data collection tools was developed and implemented that addressed the specific aspects of each intervention activity while at the same time eliciting information on a common set of variables across activities (see Table 4.1 for sample sizes and more information on the data collection methods). These tools included:

1. Monthly facilitator reports based on clear, common guidelines to document the processes of the interventions, areas that need strengthening, and the experiences of the participants.
2. Biannual group assessments with youth, adults, and service providers at the study and control sites in order to provide project leaders with feedback on community experiences with the

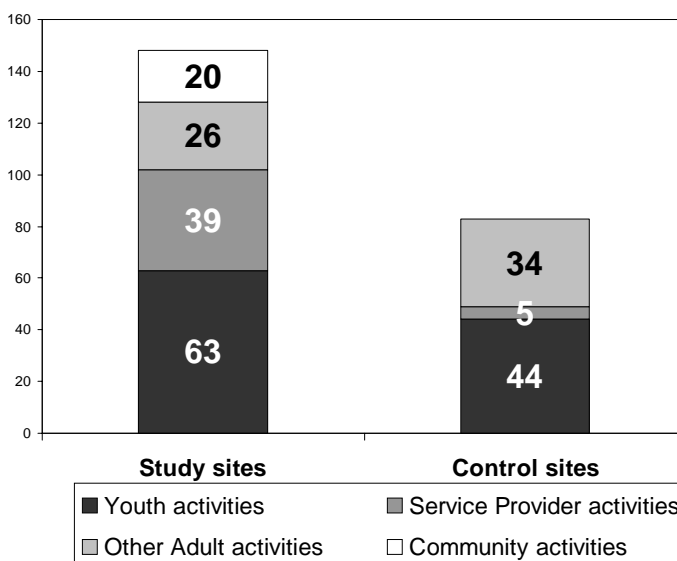
project, local perspectives on the issues addressed in the interventions, and the perceived impact of the project activities.

3. Mystery client surveys conducted on a biannual basis to assess provider-client interactions.

Tracking Intervention Activities

The intervention programs ran from November 2000 to March 2003, for a maximum duration of 24 months. As stated above, eight intervention programs (including youth-friendly services, adult peer education, and youth clubs were conducted at the study sites), while three intervention programs (on youth friendly services, peer education, and teacher training) were conducted at the control sites. A tally from the monitoring data shows that a total of 231 intervention activities were conducted at all four sites. As Figure 8.1 shows, a majority, or about two-thirds, of the activities was conducted at the study sites, while a smaller proportion, or one-third, was conducted at the two control sites. The largest proportion of intervention activities at both the study and control sites involved youth. Both the study and control sites also conducted a fair number of activities with adults, although at the control sites these were limited to teachers. Activities involving service providers were much more numerous at the study sites (compared to control sites) and community activities were conducted exclusively at study sites.

Figure 8.1. Number and Type of Intervention Activities: Study and Control Sites



Level of Participation

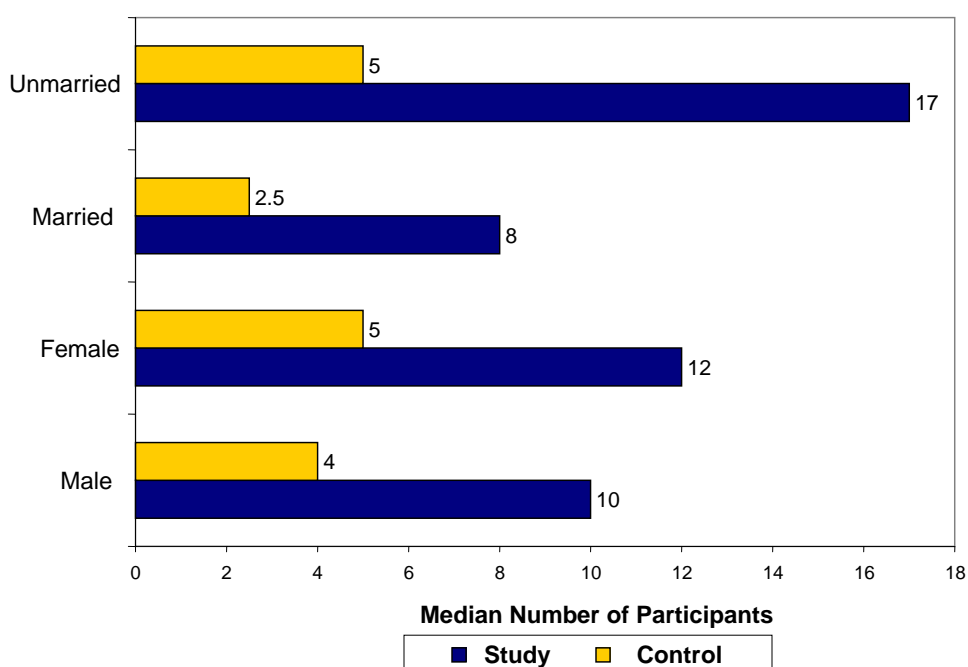
As would be expected, the level of participation in intervention activities was much higher at the study sites than at the control sites.³ Figure 8.2 shows the median numbers of participants per

³ Participation is defined here as organizing, coordinating, or having a meaningful role (such as receiving training or engaging in a discussion) in a specific activity. It does not include attendance as part of a large audience at a community event.

activity by selected characteristics of the participants (that is, gender and marital status). Median levels of participation in the study sites per activity were anywhere from two to five times higher than at the control sites. In part because of the lower levels of participation, the variation by participant characteristics is fairly minimal at the control sites. At the study sites, however, where participation was actively sought, young people participated more than adults, unmarried more than married youth, and females more than males. For the various activities conducted, the maximum number of participants ranged from 22 to 100.⁴

The monitoring data facilitated not only the tracking of outreach and coverage, but also made it possible to address gaps and problems on an ongoing basis. For example, with regard to the study sites, these data made it apparent that despite efforts to ensure inclusion, ethnically and socioeconomically disadvantaged groups were less likely to participate in project activities. Following advice from the community, project leaders adopted a strategy of conducting several activities separately according to ethnic group. Although this strategy was successful in providing an addition forum for the disadvantaged at the rural site, it was only marginally successful at the urban site, where demands for economic survival allowed the poor and disadvantaged little time to spare for programmatic initiatives. Similarly, lower levels of participation from adult men became apparent early on, prompting the need to devise a number of outreach efforts to involve this particular group. Again, because of competing obligations and lower levels of interest in program activities among adult men—especially in the urban area—only partial success was achieved.

Figure 8.2. Youth Participant Characteristics: Study and Control Sites



⁴ The maximum audience for community events ranged from 250 to 750.

The endline data show that overall, higher proportions of young people at the rural (89 percent) and urban (49 percent) study sites were aware of the youth reproductive health project, compared to the control sites (just over 50 percent in the rural area and 31 percent in the urban area). Furthermore, a higher proportion of young people participated in events at the rural study site (61 percent) than at the rural control site (38 percent). Youth participation in activities was slightly lower at the urban study site (34 percent) than at the urban control site (38 percent).

Quality of Participation

Monitoring data are critical in highlighting the process through which the intervention approach at the study sites changed the very nature of participation over time. As was anticipated, with the progression of time, community members acquired greater expertise, ownership, and direction with regard to project activities. There was clear evidence of movement along the participatory continuum, with the community members first becoming more engaged and, eventually, full partners in the intervention and even evaluation activities. Over the course of the project, the community members at the study sites gained greater input on and decisionmaking power over key project components and numerous signs of both youth and community empowerment became evident, as follows:

1. Valuable input and feedback. Compared to the control sites, information and feedback from the study sites were much richer and more valuable in modifying interventions on an ongoing basis. For example, community members at the study sites often alerted project organizers to the appropriate and inappropriate timing of different activities, as evidenced by suggestions to not organize youth activities during the school exam period. Similarly, community members participated in developing culturally acceptable solutions to problems, such as accepting rather than changing caste distinctions by conducting additional, separate activities for socially and economically disadvantaged groups.
2. Demand for accountability among youth and adults. Over time, community members and, in particular, young people, felt a strong enough sense of ownership over the project to demand accountability from the implementation team. The intervention activities were carried out during a period of major political upheavals in Nepal, including the massacre of the royal family and the rapid rise of a Maoist insurgency. When the implementation plans were disrupted due to curfews or restrictions on group activities, the communities at the study sites expressed impatience and regret with the delay, whereas those at the control sites were relatively complacent. At the study sites, community members were not willing to allow political instability to derail the project and demanded that the project teams find ways to quickly resume the interventions or work around the politically imposed restrictions.
3. Demand for authority and resources. An important sign of community empowerment and ownership at the study sites was the extent to which participants claimed authority and demanded financial resources over time. The project team was able to devolve authority since a number of structures (such as the ACT, PAC, and task forces) had been set up from the beginning to allow various interest groups in the community to acquire positions of authority, either on a rotating basis or through other representative mechanisms.

The demand for resources, however, was a more difficult issue, and one that was impossible to resolve satisfactorily throughout the life of the project. Certainly, the project team allocated resources for a range of activities in which community members had decisionmaking power. Yet despite recurring demands from the adolescent and adult coordination teams for access to financial resources that they could control, the project team did not devolve control over resources.

The project team was highly motivated to provide control of financial resources to community members, especially starting during the mid-period of intervention activities when both the need for and demands by community members for such devolution became more apparent. However, despite many lengthy discussions internally and with key community members, the project team was unable to devise a funding mechanism that was readily available and acceptable in the short term. Every option considered involved either substantial risk of the appearance of partiality, or ended up being a nominal rather than a real devolution of control. Ultimately, it became clear that the risk of creating bitter divisions and losing community support by implementing the wrong mechanism for financial devolution was much greater than the disappointment of not implementing the participatory process as fully as the team would have liked.

4. Youth capacity and initiative. Given the social structure, importance of age hierarchies, political instability, and levels of poverty, most young people in the Nepali communities involved in the project were disengaged and disenfranchised. At the study sites, the improvement in young people's capacity and initiative over the course of the project was remarkable. During this period, young people acquired and demonstrated skills and the ability to lead, organize, mobilize, articulate, innovate, and fundraise on both their own and their communities' behalf. By the end of the project, young people were leading many of the intervention activities, with the implementation team members acting only as facilitators.

Building a Social Space for Youth

- Youth club members at the rural study site initiated the idea of a shared community space that could be used by young people to carry out various intervention activities.
- The youth identified an old sub-health post building in their community and requested permission from the Village Development Community to conduct renovations.
- The youth raised a sum of Rs. 5000/6000 during the one of the festivals to initiate the renovations.
- The youth then leveraged their resources through donations, requests for additional financial support from the project, and pro bono labor from community members.
- The community space is currently being used as a meeting space and library for young men and women in the community.

5. Parental support and recognition of youth capabilities. Increases in youth capacity and leadership were notable throughout the communities, which in turn changed views of what

could be expected from young people. Most importantly, parents expressed a new-found recognition regarding the capabilities of their children:

Because of reproductive health education, youth are capable of taking care of their health...Youth have become competitive; their mental capacity has developed. They have become more energetic and confident. (Adult, rural study site).

Changes have come; for example, they (youth in the community) have understood a lot from this program. There has been an increase in their capacity to speak up. They participate well in the programs. (Adult, urban study site).

After participating in the street drama...it seemed that the confidence of the youths have boosted up. Even the unmarried girls doing the role play of the pregnant women had held everyone spellbound. (Adult, rural study site)

Parents at the control sites were also pleased with the involvement of their children in productive activities, but did not experience a similarly broadened view of their children's overall abilities. Moreover, whereas at the study sites the vast majority of adults felt that young people were capable of much more than they had ever imagined, parental approval and support of youth involvement at the control sites was limited to those adults whose children were actively engaged in the project.

6. Youth appreciation of adult involvement. Conversely, young people at the study sites also recognized the importance of adult involvement and buy-in for achieving their goals and desires. It became clear to most young people that they were able to participate in program activities—especially those involving more independence, time, or initiative—because of the legitimacy the program had acquired through participation by the adults in the community.

This program is also useful for the guardians. If they come to know about the program then they will also support their children in participating in the program. (Young man, rural study site.)

At the control sites, where no programs were specifically targeted to parents, young people felt and expressed the need for a program involving parents and guardians. The main motivation for this was the fact that a lack of parental support often became an obstacle to implementing lessons learned through the program.

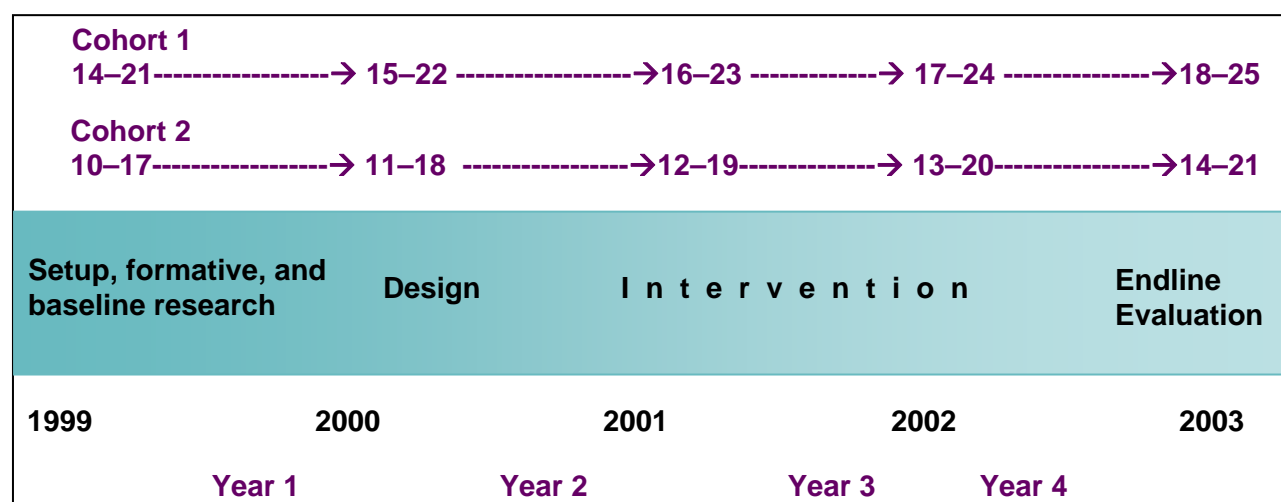
9. Evaluation and Findings

The final evaluation was carried out by comparing the status of youth reproductive health outcomes and determinants of interest at the end of the project to their status at the beginning of the project. As stated in the data and methodology section, triangulated methodologies—quantitative, qualitative, and participatory—were utilized at both baseline and endline to collect the relevant data. Since the impact of the participatory approach in improving youth sexual and reproductive health was being tested, the main comparison of interest was relative improvement in key variables of

interest at the study as opposed to the control sites. Improvements would be expected at both sets of sites since that both received interventions. However, if the central hypothesis proved true and the participatory approach was indeed more effective, then the relative improvements would be greater at the study sites.

The primary group of interest with regard to the impact of the interventions was youth aged 14–21. Figure 9.1 depicts this group as “Cohort 1” and shows its age progression in conjunction with the timeline of the project. While at baseline this age group was 14–21, in the four years it took to complete the formative research, design and implement the project, and conduct the endline evaluation, this cohort became older (aged 18–25).⁵ Clearly, YRH-related variables of interest with regard to this cohort were likely to have changed from baseline to endline simply because of the change in age. For example, 18–25 year-olds are much more likely to be sexually active or married than are 14–21 year-olds. However, to the extent that variables of interest may have changed at different rates at both study and control sites—even taking the age effects into account—the relative differences are of interest for evaluation purposes.

Figure 9.1. Project Timeline and Youth Cohorts



Since the intervention design being tested was community-based, the relative improvement of outcomes and determinants for “Cohort 1” was not the only point of interest. Also of interest was whether the shift in community environment due to the intervention would impact the experiences, attitudes, and outcomes of an emerging group of youth who were entering their critical adolescent years. This group, depicted as “Cohort 2” in figure 9.1, was aged 14–21 at the

⁵ It is important to note that although the progression of the age cohort 14–21 was followed over the time period of the interventions, since the intervention design was community-based, specific 14–21 year-olds were not tracked. Rather, the project teams were interested in the all the young people in this age cohort within the involved communities. Thus, to the extent that specific young people within this age group migrated in or out of the community at various times during the intervention period, they would have received different levels of exposure to the interventions.

time of the endline evaluation, but only 10–17 at the point of baseline and formative research.⁶ Thus, depending on the variable of interest, at times the results presented below compare the status of 14–21 year-olds at baseline with the status of 18–25 year-olds at endline, while at other times the comparison is made for the same age group (14–21) at both baseline and endline.

Due to the rich, extensive data collected for this study, the project organizers analyzed a large number of interesting, relevant variables measuring behavior, attitudes, norms, and conditions not only with regard to youth, but also adults, service providers, community members, and health facilities and infrastructure. Presented below are only some of the most central findings, with focus placed largely on how youth were impacted by the direct, indirect, and contextual determinants of their reproductive health. The results highlighted have been selected because they provide particularly interesting or good examples of the general trend and direction of overall findings.

In the results presented here, the fundamental comparisons are for the age groups 14–21 at baseline with the age groups 14–21 and 18–25 at endline, and for relative differences at the study as opposed to the control sites. Additionally, the key background variables that are likely to affect outcomes include age, socioeconomic status, sex, and rural-urban residence. In conducting multivariate regressions on each of the outcomes for which age and socioeconomic status were controlled, it became clear that in most cases these two variables did not influence the results in any substantial manner.⁷ Differences by sex and by rural-urban setting are often substantial and important, however.⁸ For ease of presentation, the results shown below are therefore bivariate that are differentiated by sex and rural-urban setting. The odds-ratios for the full regressions complementing the tables below are presented in Appendix A.

Since the conceptual framework of youth reproductive health is broad, it is followed in the evaluation with regard to the presentation of outcomes. This set of findings is grouped into three conceptually different sections: 1) basic reproductive health outcomes, including STDs, RTIs, HIV/AIDS, premarital sex, contraceptive use, and service availability and access; 2) reproductive health outcomes especially relevant in the Nepali context, including entry to marriage and childbearing and care during pregnancy for married girls; and 3) broader normative and institutional factors that are critically relevant to YRH, including schooling and social spaces and young people's understanding and articulation of social norms and institutions as they relate to reproductive health and life outcomes. In addition, since building local capacity and laying a

⁶ Clearly, the two cohorts overlap somewhat. That is, the starting point for Cohort 2 at ages 10–17 includes some young people (14–17) who are also in Cohort 1, which consists of 14–21 year olds.

⁷ Age itself is an important determinant of a number of relevant outcomes. For example, older youth are more likely to be married, use contraception, and have reproductive health problems. However, the age structure at the study and control sites did not change substantially from baseline to endline. The mean age for both project and control sites at baseline was 17.5. At endline, the mean age for the 14–21 year-old sub-sample was 17.3 at the study sites and 17.5 at the control sites. Thus, age structure has little or no effect on the relative differences in the outcomes observed at study versus control sites, or baseline versus endline. In contrast, socioeconomic status of residents at all four sites improved in the endline compared to the baseline. Again, however, since the relative improvement in socioeconomic status in the study and control sites is comparable, this variable does not alter the relative differences in the outcomes observed at study versus control sites.

⁸ Differences by sex and rural-urban setting in general have an interactive effect rather than just an additive effect, which is why the results are differentiated by these two variables.

foundation for sustainability were also key goals of the project, these outcomes are reported as well.

Basic Reproductive Health Outcomes

Reproductive Health Problems: RTIs, STDs, and HIV/AIDS

In reviewing findings on knowledge and experience of reproductive health problems related to STDs and RTIs, it became evident that results are mixed, with the participatory approach having a more powerful impact in some cases than in others. Figure 9.2 shows that knowledge of STD symptoms (measured as the ability to identify pain/burning during urination and boils/sores on genitals) increased among rural males and that the increase was more substantial at the study than at the control site. Figure 9.3 shows that among rural females as well, knowledge of STD and RTI symptoms increased during the intervention period, but in this case the change was more substantial at the control than at the study site.

Figure 9.2. Knowledge of STD Symptoms: Rural Males

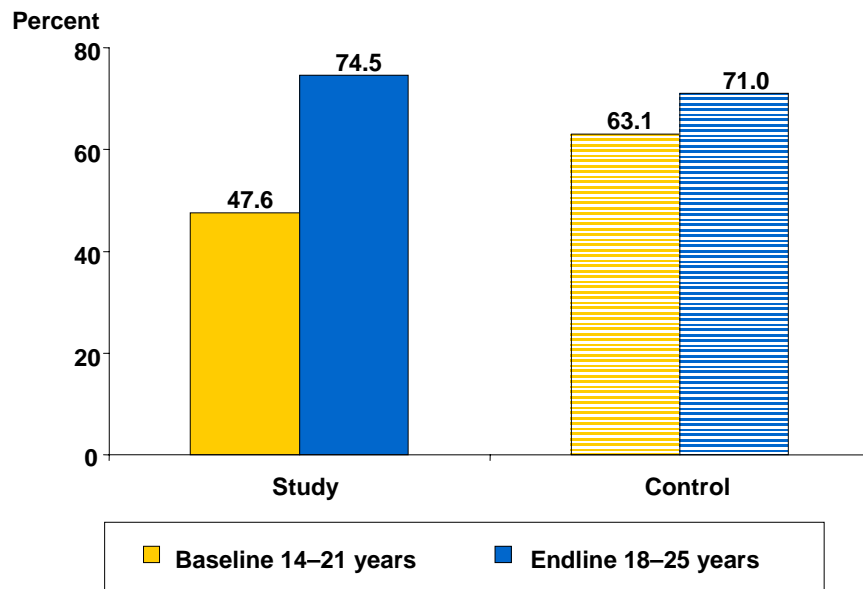
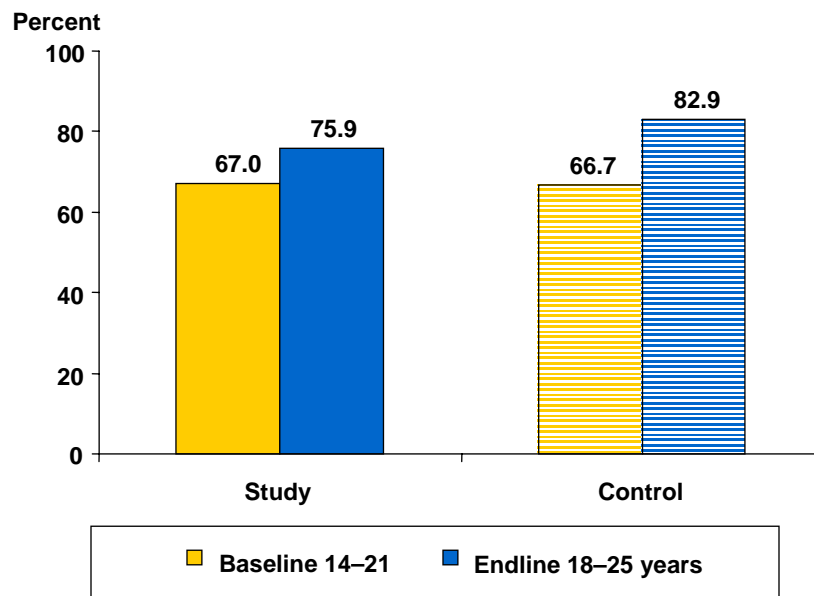
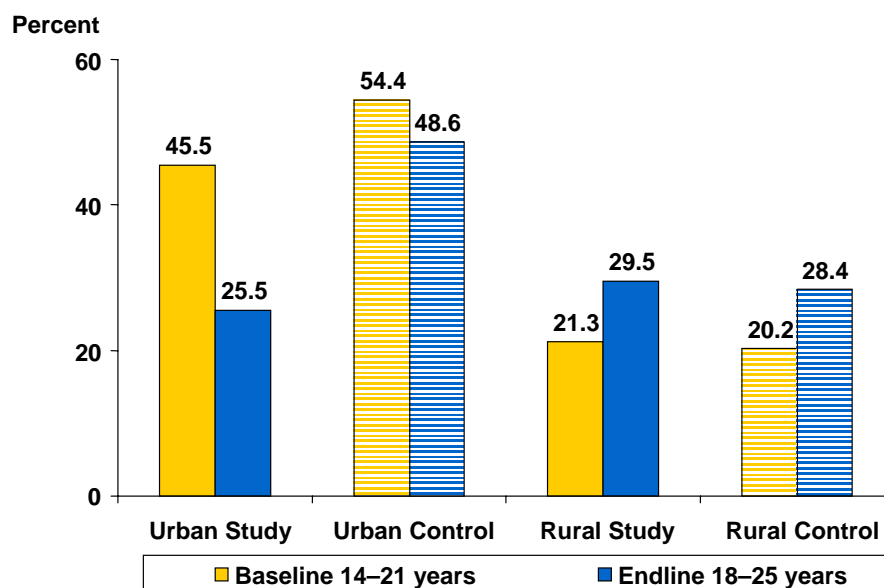


Figure 9.3. Knowledge of STD and RTI Symptoms: Rural Females



Moreover, in examining data on the experience of STDs and RTIs among young women, it became evident that females at the rural study site actually experienced an increase in the incidence of self-reported STD and RTI symptoms, and that there is no difference by study or control site. The increase may simply reflect the older age and sexual experience of the 18–25 year-old cohort at endline, or possibly the increased ability of these young women to recognize and identify STDs and RTI symptoms when they experience them. The results for the two urban groups, on the other hand, are more encouraging, since despite the increase in age and experience, young women at both sites showed a decrease in the experience of STD or RTI symptoms. Moreover, the decline was substantially greater at the study site than the control site.

Figure 9.4. Self-Reported Experience of STD and RTI Symptoms: Females



The results on knowledge of HIV/AIDS are also encouraging, but mixed in terms of the impact of the participatory approach. Baseline data showed that while general awareness of HIV was high in the project communities, more substantial knowledge regarding transmission and prevention was lacking. Figures 9.5 and 9.6 show that when compared to the baseline, substantially higher proportions of 14–21 year-olds were able to correctly identify at least two sources of HIV transmission at the endline. This is true for both males and females and across all sites, although knowledge among urban youth remained higher than for rural youth. However, the impact of the participatory approach was not universally greater than the traditional approach. Among urban males, the increase was substantially higher at the study as opposed to the control site, while at the rural site the opposite was true. Among females, on the other hand, there was little difference by study or control site in the urban area, but substantially better results emerged from the study site than the control site in the rural area.

Figure 9.5. Males who Correctly Identified at least Two Modes of HIV Transmission

Percent

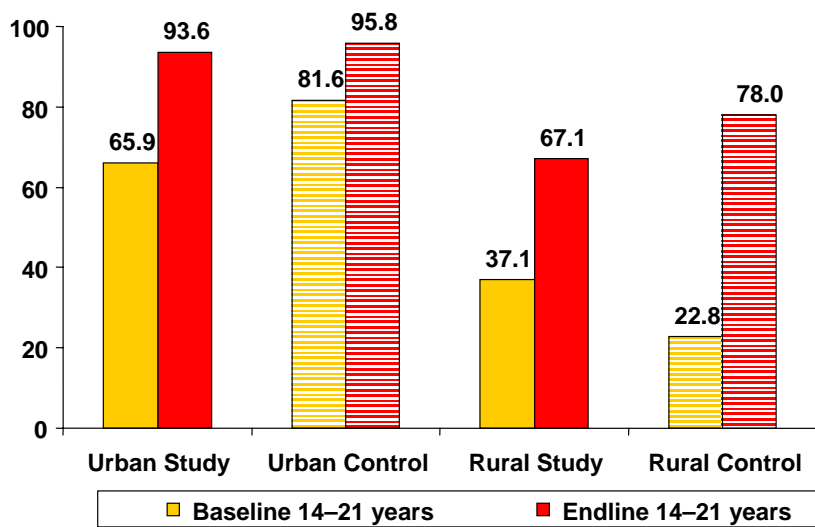
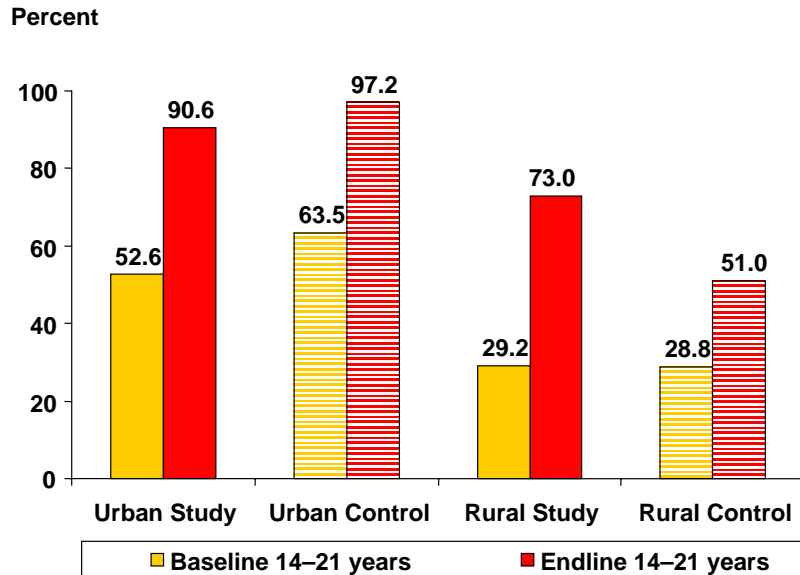


Figure 9.6. Females who Correctly Identified at least Two Modes of HIV Transmission



The participatory approach shows substantially better results for young people's ability to communicate with someone when faced with a reproductive health problem. Figures 9.7 and 9.8 show that while at the study sites there was an increase in the proportion of young males and females who have ever discussed their reproductive health problems with anyone, there was a decrease in this indicator at the control sites. The increase at the rural site was especially large among males (the proportion almost doubled), while among females, the most substantial positive change occurred at the urban site. Qualitative data indicate that at the rural study site in particular, young people felt that they could now discuss these problems with a range of family members, peers, and providers.

Figure 9.7. Ever Discussed Reproductive Health Problems with Anyone: Males

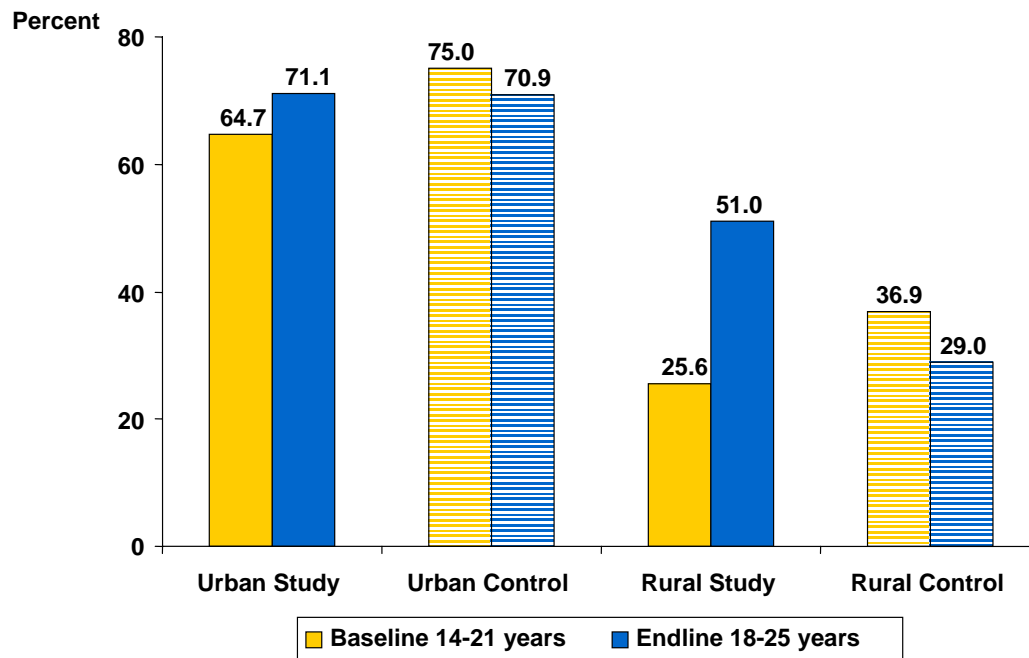
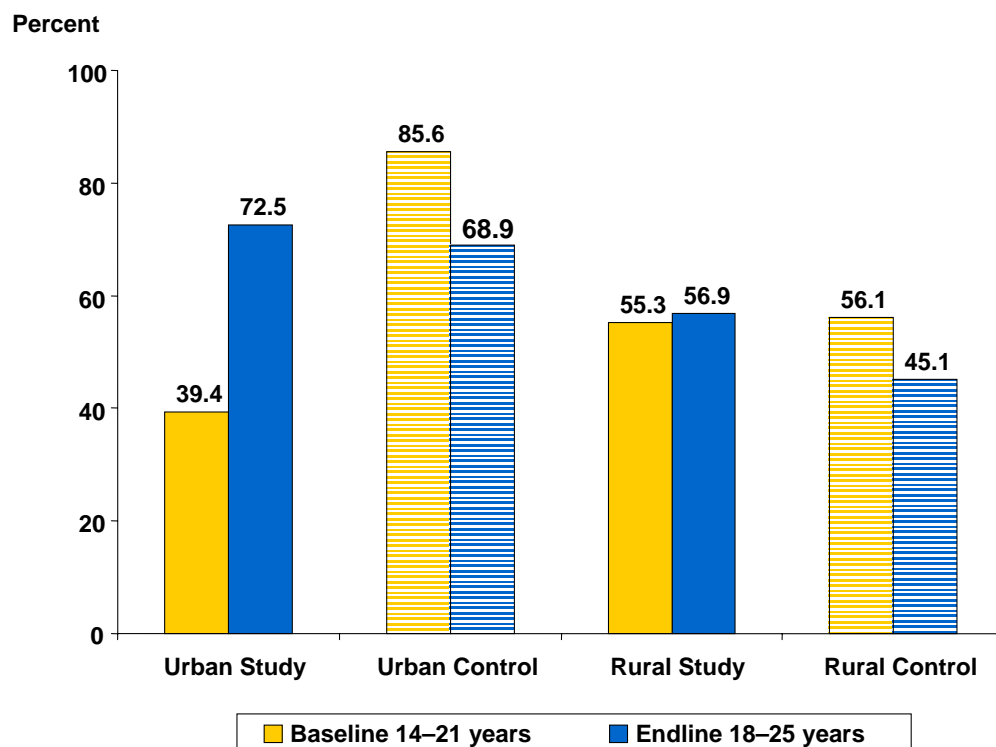


Figure 9.8. Ever Discussed Reproductive Health Problems with Anyone: Females



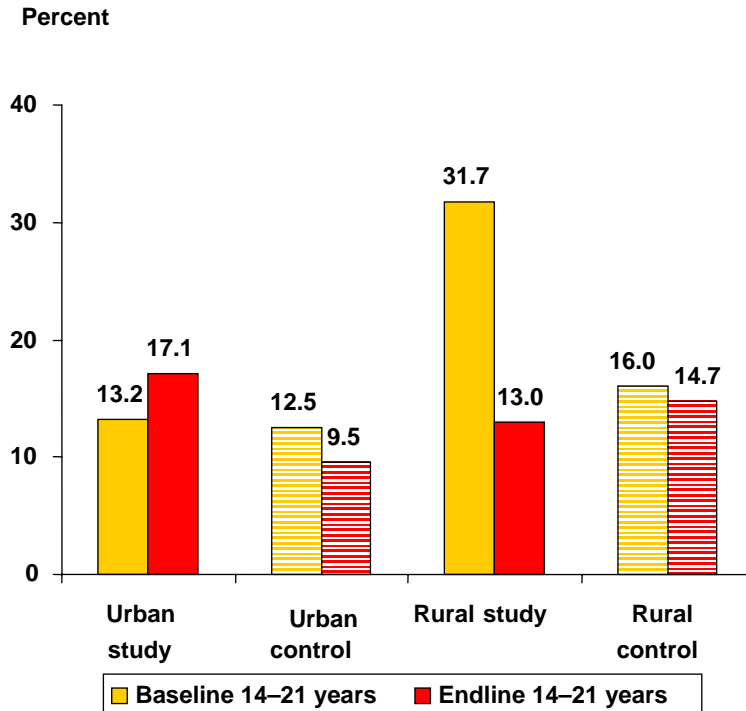
Premarital Sex and Sexuality

The findings with regard to premarital sex are complicated by the fact that quantitative data on premarital sex in South Asian settings is often suspect. For young girls and women, data are certainly unreliable because of massive underreporting, while it is difficult to tell the direction of reporting bias with regard to young boys and men.⁹ This report therefore does not include quantitative data on premarital sexuality for females (only one unmarried girl admitted to premarital sexual activity during the baseline and two in the endline research), and suggests caution in interpreting the results for males. The project does, however, include qualitative data, which provide a richer, more nuanced understanding of sexuality among young people in the selected Nepali communities, and possibly for Nepal more generally.

Figure 9.9 shows the change in premarital sexual activity for males 14–21 from the baseline and endline at all four sites. The two control sites show marginal, but insignificant, declines. The urban study site shows a small increase, while the rural study site shows a very large decline. However, since the proportion of young men who reported having had premarital sex in the rural study site was exceptionally large at the baseline, it is not clear whether the decline is real or the result of possible misreporting. The rural site does not present any specific characteristics that account for it being an outlier at baseline; it is possible that young men at this site overreported, or that young men at the other sites underreported.

TP⁹PT A number of surveys in South Asia show that the taboo against premarital sexual activity for girls is so strong that almost no unmarried girls admit to it in face-to-face interviews. It is possible to get more accurate estimates by using ACASI techniques (that is, self-reported computer interviews), but due to significant proportions of illiterate girls in the current project samples, this was not a feasible option. That premarital activity for unmarried girls is underreported is indicated by higher proportions (in the range of 10 percent in the rural sample) of married girls who admitted to premarital sex, and by information gleaned from qualitative data. The data on premarital sexual activity for married girls, however, does present the challenge of causality, since marriage may have been a result of premarital sexual activity.

Figure 9.9. Reported Experience of Premarital Sexual Activity: Males



Because of the issue of reliability, it is difficult to tell from the quantitative data—at either baseline or endline—the extent to which boys are actually having premarital sex. From the qualitative data, it is very clear that boys are interested in having sex. The data from participatory activities at the study sites are especially informative, since they indicate that boys are consumed and preoccupied with how to fulfill their sexual desires in a safe and pleasurable manner while still unmarried. Some boys are able to find the opportunity to have premarital sex with a girl their own age. Others explore possibilities of having sex with older women, or with girls who trade sex for money or gifts. At the same time, there is a lot of frustration among boys over not being able to fulfill their sexual desires and a lot of confusion about masturbation as an appropriate outlet. Boys are also worried about getting married just to be able to have sex, especially since they don't want the responsibilities that come with marriage. At baseline, boys talk about their preoccupation in abstract terms and use colloquial language:

At this stage he (young boy) is curious about sex and learning new things. He has lovology. This means interests in love affair, they go after girls and become Boka (behaving like a male goat). (Male youth, urban study site, baseline)

By the endline, boys at the study sites were still consumed by the need to fulfill sexual desires, but are less frustrated. They are also much more articulate and specific in discussing sexuality-related issues. Their terminology is more precise and focused on the aspect of sexuality being discussed, and they can openly discuss practical options for achieving sexual satisfaction. For example, in the baseline, masturbation was considered shameful and identified as a problem by urban young men, but was identified as a healthy means of fulfilling sexual desire in the endline.

They (boys) take masturbation as a process to maintain their sexual desire and they know that if they do it at limited manner it will do no harm... (Male youth, urban study site, endline)

Even though the quantitative data do not show girls reporting having sex, interesting discussion of premarital sex is evident in the qualitative and participatory data. In the baseline, girls discuss premarital sexual activity in several contexts:

- Having sex knowingly because of desire/curiosity.
- Having sex “unknowingly” or “knowingly” because of seduction or financial temptation and need.
- Fear of being forced into sex by boys who abuse drugs or alcohol.
- Being forced into sexual activity through rape or incest.

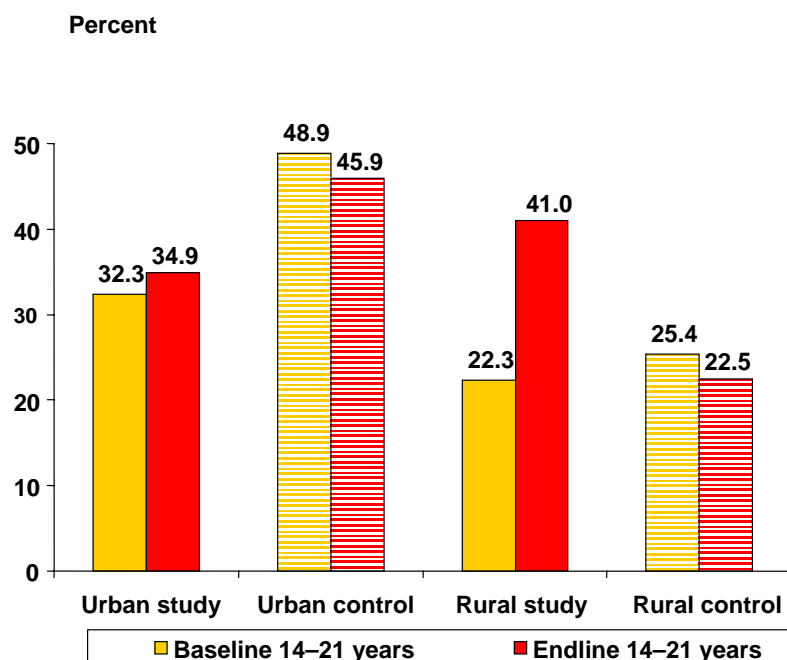
Even though it is very clear from the participatory baseline data that girls are having premarital sex for the above reasons, it is socially so taboo that in their discussions, girls always discuss the subject in negative terms, that is, in the context of being pulled into it, protecting themselves from it, or feeling shame when forced into it.

If a girl is returning from college, they will catch her and ask, ‘Will you let me do it right here or not?’ The girl will be able to do nothing. She had no choice but to do it. Now, if she will come back home and say that such and such boys did this to me, then her whole life will be destroyed. She will not be able to tell anybody else. She will be forced into having sex; she will be raped. (Adult female, urban study site, baseline)

Boys harass girls by making foul remarks in front of them. If they get a chance or if a girl is all by herself, these boys will not fall behind to even rape or physically abuse her. Due to the risk of being raped and getting a bad name girls are afraid to go out. (Female youth, urban study site, baseline)

The endline data show that at least at the rural study site, the intervention made a big difference in terms of the acceptability of girls discussing sexual issues with others. As figure 9.10 indicates, there were minor declines from baseline to endline at the two control sites in the proportion of females who report discussing sex with anyone. At the urban study site, there was a minor increase. However, at the rural study site, the proportion of females who report discussing sex with anyone almost doubled from baseline to endline.

Figure 9.10. Report Having Discussed Sex with Anyone: Females



That acceptability of girls talking about sex may also be increasing, albeit more slowly at the urban study site, is illustrated by the qualitative endline data.

We could not even talk about things related to RH with our friends. Now we can easily discuss about it with our friends. (Female youth, urban study site, endline)

Thus, although the data on the incidence of premarital sexuality is questionable, the richer, more reliable data on sexuality generally suggests that the participatory interventions improved the ability of young girls and boys to understand, deal with, and communicate about sexuality as part of the normal process of growing up.

Contraceptive Use

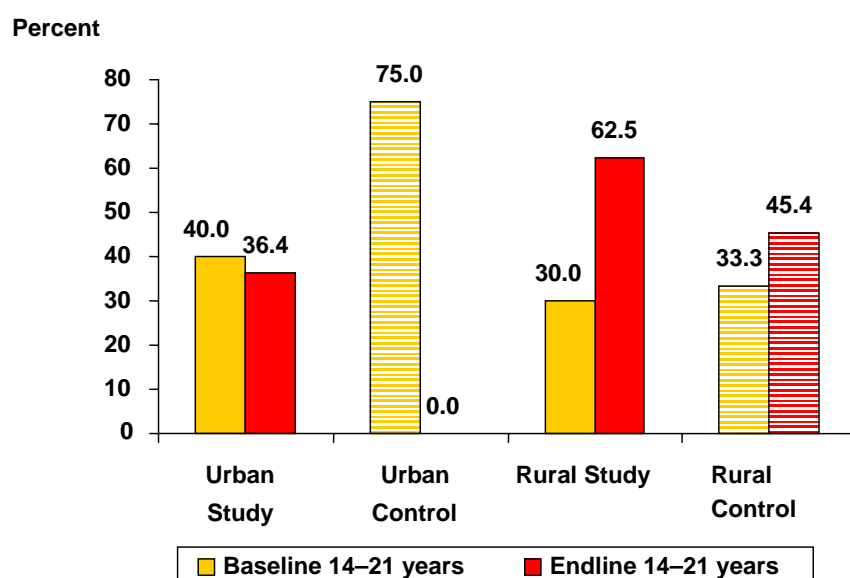
Results on contraceptive use are more mixed. The two most relevant subsamples for assessing contraceptive use in the Nepali context are young unmarried men who have had premarital sex and young married women, especially those in the early years of marriage.¹⁰ Figures 9.11 and 9.12 present results for both these subsamples at all four sites, but the findings do not show a consistent pattern. Among unmarried males, contraceptive use at first premarital sexual activity declined at both the urban sites and increased at both the rural sites. The participatory approach shows more positive results in the sense that there was a sharper increase at the rural study site, and a less steep decline at the urban study site. However, the fact that contraceptive use at the

¹⁰ The subsample of young women married less than two years is further restricted to only those who are currently sexually active; several young women in the study were not residing with their husbands due to migration or other reasons. Young married men were not included in this analysis because of extremely small sample sizes.

urban control site declined from 75 percent at baseline to zero at endline suggests that either the reporting was not be entirely reliable, or that some extreme cases possibly distorted the results at one or both points in time.

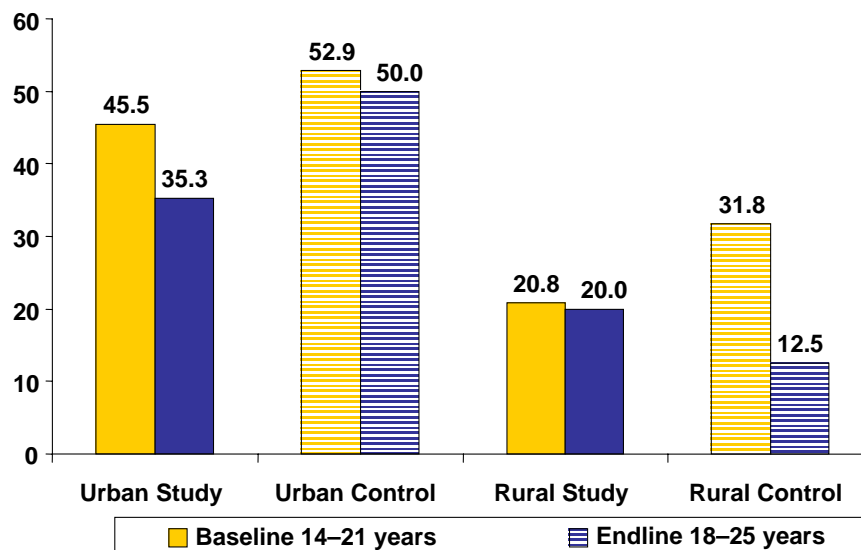
The results for current contraceptive use among young women married less than two years show a more universally disappointing picture. Based on needs assessment data showing young Nepali girls getting married early and having children right away, increasing contraceptive use immediately after marriage was one of the specific aims of the project. The numbers in figure 9.12 show that contrary to the project goal, contraceptive use early in marriage actually declined at all four sites. In the urban areas, the decline at the control site was minor, but there was a 10 percentage point drop at the study site, while in the rural areas the reverse was true: the decline at the study site was minor but an almost 20 percentage point drop occurred at the control site. Like the data on contraceptive use among unmarried men, it is not clear how much of a real pattern these results present, and how much is due to data distortions resulting from possible misreporting or outliers.¹¹

Figure 9.11. Contraceptive Use at First Premarital Sex



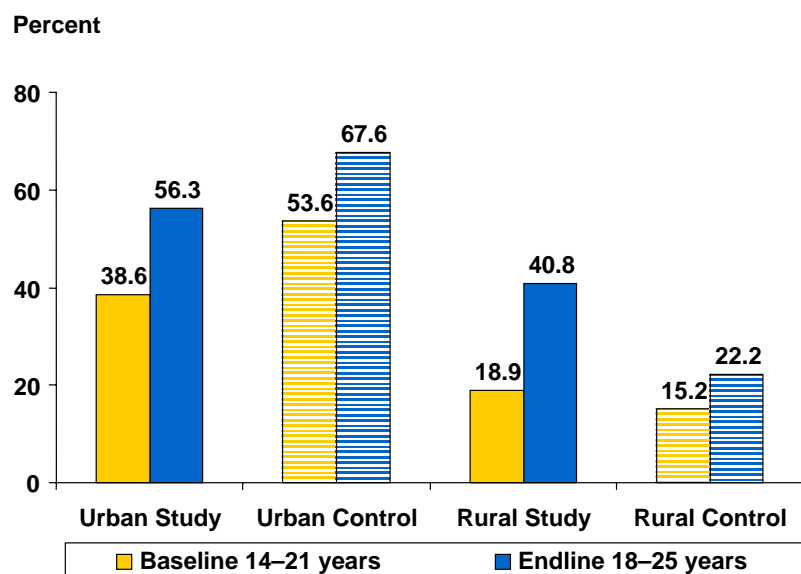
TP¹¹PT As data presented in other parts of this report show, the proportions of youth marrying have declined over time. With this in mind, the small sample size of young married women in the endline may also be a factor affecting results on contraceptive use.

Figure 9.12. Current Contraceptive Use: Youth Married Less than Two Years
Percent



However, actual contraceptive use is only one measure of the steps that young women may be taking to prevent early pregnancies. Data from this intervention indicate that although they were not more likely to be using contraception by the endline, married young women were more likely to take the first step and at least seek advice on family planning. Figure 9.13 shows that the proportion of young married women who have ever visited an organization for family planning advice has increased at all four sites. Since the 18–25 year-old cohort was being considered at the endline, this result may be either an age or an intervention effect, or both. However, at the study sites in both rural and urban areas, there was a more substantial increase in the proportions of young women who were likely to have sought family planning advice, suggesting that the participatory approach did have a positive impact.

Figure 9.13. Ever Visited an Organization for Family Planning Advice: Married Females

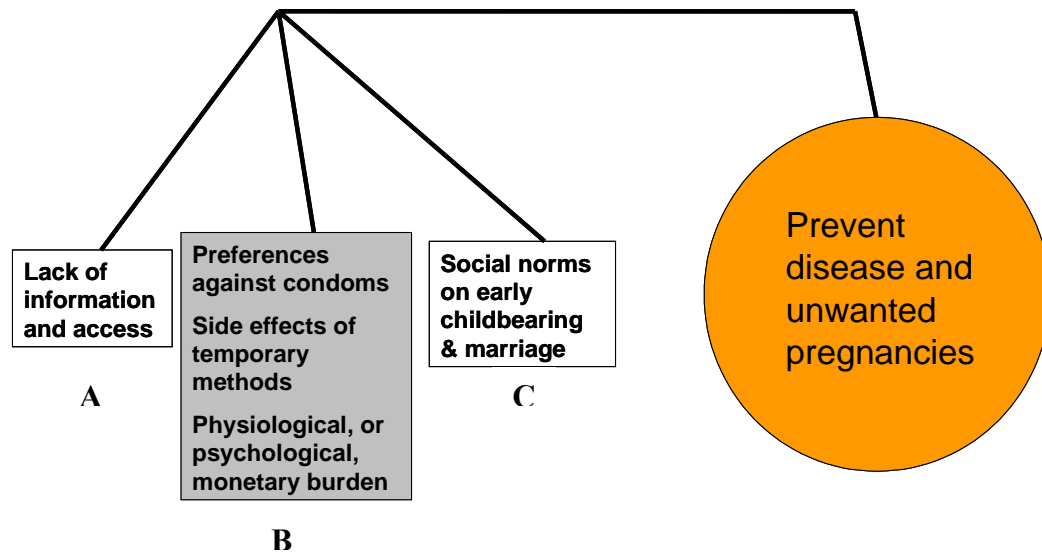


Findings based on the qualitative and participatory data from the study sites help to explain some of the ambiguity in the results on contraceptive use. These data suggest that young people are very interested in protecting themselves from unwanted pregnancies, as well as from STDs. During the intervention period, young people at study and control sites received better information on specific contraceptive options and where to access family planning. The interventions at the study site also targeted social norms regarding early childbearing, hoping to help young people counter social pressure and fulfill personal goals of later childbearing. However, like most other YRH programs, the interventions did not address a key, critical factor that prevents young people from using contraception: real or perceived negative experiences with specific contraceptives, especially hormonal methods for women and condoms for men.

Figure 9.14 pictorially depicts the authors' interpretation of the qualitative data as a balance between the costs, or negative factors, that prevent the use of contraception (left side) and the benefits, or positive factors, that motivate the use of contraception (right side). In any setting, the positive motivation for using contraception is the desire to prevent disease and unwanted pregnancies, although the degree of this motivation tends to vary among individuals and across locations.¹² In Nepal, the three most critical barriers to contraceptive use among young people are lack of information and access, social norms that encourage early childbearing, and personal preferences and experiences with contraceptives. In order for a young person to actually use contraception, the balance of the situation would have to tip to the right of Figure 9.14, that is, positive motivations would have to outweigh the negative factors that prevent contraceptive use.

TP¹²PT For example, some cultures or some individuals may be more accepting, or "willing to live with" an unwanted pregnancy, whereas in other cultures or for other individuals, this would be completely unacceptable. Even the same culture or individual can be more or less motivated to prevent an unwanted pregnancy depending on the situation (as in the case of unwanted pregnancies in a premarital or extramarital compared to a marital relationship).

Figure 9.14. Tipping the Scale of Family Planning



The needs assessment at baseline provided a good sense of the need to strengthen positive motivations and address negative factors A and C; thus, the intervention design targeted only these. Hindrance B did not come to light at this stage, possibly because young people consider the specific physiological, psychological, and financial implications of using specific contraceptives only when the motivation to use contraception is strong and structural barriers (such as social norms and lack of access) are removed. For these reasons, it was only when the intervention removed these structural barriers (hindrances A and C) that young people began to articulate hindrance B. While this specific information is absent in the baseline data, in the endline data for the study site, young men and women placed a great deal of emphasis on their preferences, anxieties, fears, and negative experiences with specific contraceptive options. As is true in many other settings, men state very clearly that they do not like condoms, which is an important barrier to condom use.

If a person takes a bath by covering their body with a plastic there is not use of taking bath. Similarly, if a person has sex using a condom and does not get sexual satisfaction, what is the value of having sex? (Adult male, urban study site, endline)

Women discuss the side effects that they experience in using temporary contraceptive methods. While modern hormonal contraceptive methods are available at the project sites, the lack of method choice, along with limited counseling regarding side effects and bodily changes, fosters negative attitudes toward contraceptives such as injectables or the pill. For young women, the negative consequences of contraceptives are not just a trivial inconvenience. Aside from causing pain, discomfort, and long-term health problems, inadequate contraceptives also impact daily

workload, accountability to in-laws for completing housework, and sexual relations with husbands.

The oral pills and Depo-Provera have more side effects. The others have normal effects...it causes profuse bleeding, weight loss, and dizziness...weakness, headaches, inability to have sex... (Female youth, urban study site, endline)

The emergence of this information serves as an important lesson for YRH programs. In an attempt to increase contraceptive use among youth, most YRH programs adopt an intervention portfolio that aims to improve motivation and access, for example through interventions such as IEC and youth-friendly services. In an effort to implement a participatory approach, the current project went beyond this standard portfolio to address social norms. However, the mixed nature of the results suggest that even this step may not be enough to tip the balance toward more widespread use of family planning. YRH programs therefore also need to address the very real, personal psychological and physiological concerns that young people have regarding contraceptives. These concerns may present the most “proximate” barrier to contraceptive use among youth.

Service Availability and Access

As a result of the interventions, the availability of and access to services increased at both the control and study sites. However, project findings indicate that both the system in which the providers function and young people’s understanding of how to best use the options available to them improved more substantially at the study sites. Additionally, data from the study site underscore the importance of peers and social networks as critical sources of service provision for young people.

The peer education program at the control sites targeted only young people, and emphasized increased knowledge on specific reproductive health themes, including modern family planning, STDs, and HIV/AIDS. In contrast, peer education programs at the study sites targeted both younger and older youth (through separate efforts) and adults. It also evolved from the needs assessment process, which highlighted the extent to which the issue of services for *youth* reproductive health is essentially different from such services for other age groups.

In particular, cultural and social networks (including friends as well as brothers, sisters, sisters-in-law, aunts, and others) are especially critical for information sharing and counseling among young people. The study site peer education programs therefore aimed not only to inform and educate key “peers,” but also to tap into and strengthen social networks that could effectively serve as a source for service provision. For example, counseling training and thematic knowledge were important elements of the program. Overall, in several of the intervention efforts, special emphasis was given to building the capacity of existing community providers and strengthening social networks in order to provide young people with accurate information, appropriate counseling, and timely referrals.

The evaluation reveals that at both the study and control sites, young people’s reliance on peers for information and counseling is paramount. However, by the endline at the study sites, it

became clear that there is not just a preference for friends, but also for “peer educators” or “experienced friends” who have taken part in reproductive health training; this group essentially fills a service provision role. The importance of peers who are well informed and trained cannot be overstated. Young men and women repeatedly stated that for the most part, their reproductive health needs are social rather than medical, and include such aspects as tensions around early marriage and sexual desires. As such, these problems do not have medical solutions but require social support systems that can provide empathy, understanding, counseling, support, and referrals.

Where do you go regarding problem about restriction in love marriage? We don't go to the sub-health post, hospitals, FCHVs because they cannot solve our problem. We can talk with friends and peer educators, they can help in case of severe problems and if we cannot live apart after falling in love. (Male youth, urban study site, endline)

The adolescent boys go to the peer educators to talk about reproductive health. This is because they feel comfortable talking to them and thus can speak freely. They are trained, so there is no fear of their secrets spreading around....if the unmarried boys find it difficult to ask for condoms themselves, they ask the peer educators to get it for them. (Male youth, urban study site)

In fact at the endline stage, boys at the study sites listed the following as a pathway for service use:

**Consult friends -> Self-treatment -> Hide or ignore problem -> Seek professional care
(if persistent)**

In addition to a lack of well-informed peers, judgmental attitudes among service providers and their lack of in-depth information on reproductive health issues were highlighted as key barriers to young people's access to reproductive health information and services. The evaluation results indicate that options for professionally trained service providers who can serve young people have improved at both the study and the control sites. As noted above, young people tend to seek care from these providers only when they have clear physiological or medical symptoms.

At all the sites, pharmacists are the providers of choice for young men. There is evidence that pharmacists at the study sites are viewed as qualified and experienced and as able to give accurate information and counseling in a private setting. (It was not clear if the same perception had emerged at the two control sites.) Among young women, trained health volunteers, government health posts or clinics, and pharmacies were identified as reliable channels through which to address reproductive health issues. It also became clear at all the sites that married youth are most likely to seek care from government or private institutions within or near their community.

An important element of the improvements in service providers at the study sites is greater awareness among both youth and adults about the qualifications, availability, and professional demeanor of the service providers with regard to YRH. For example, endline data showed that

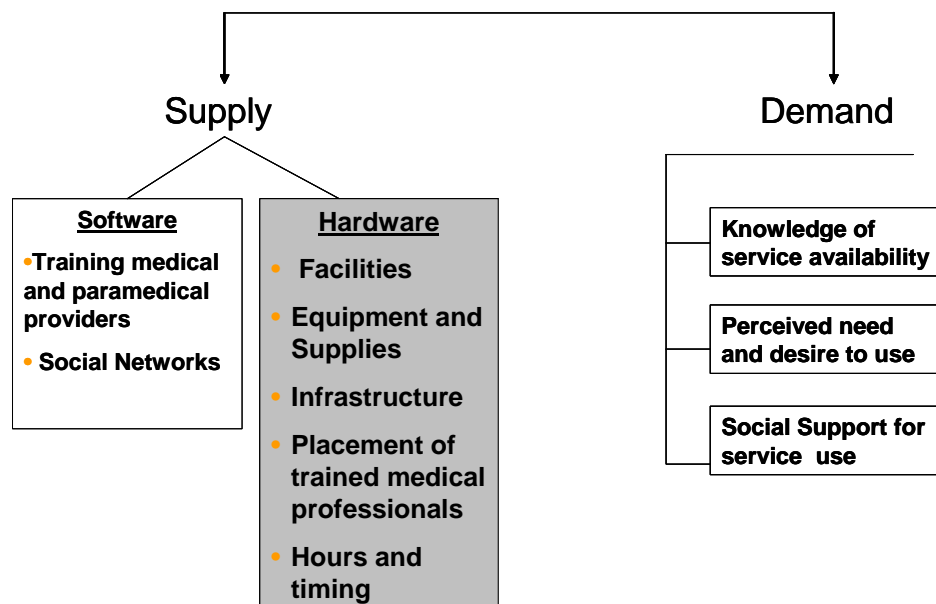
youth at the study sites are aware that providers in their communities have been trained by the program, and many who had accessed services were pleased with the quality of interaction with the provider.

Earlier, the service provider used to give a very bad response if anyone went for counseling, hence I feared and felt embarrassed to go...but now with the help of the program, the service providers show cordial behavior and maintain confidentiality. Due to this the adolescents as well as the adults have started to go for health and counseling services. (Youth, rural study site)

Although options have improved at all the sites, youth awareness of service provider options is greater at the study sites. This finding reflects the more integrated and participatory nature of the program design at these sites

At the same time, it is important to note that although professional service provision for youth reproductive health concerns improved in the project communities, and what social networks could accomplish expanded, there were important limitations as well. Figure 9.15 depicts the feedback on this issue from the study communities based on qualitative baseline and endline data. The figure depicts the service provision needs articulated by community members in terms of “supply” and “demand” factors. The supply side factors can be divided into “software” needs such as training, skills, and better use of social networks, and “hardware” needs such as better buildings and infrastructure, a larger number of trained professionals, and more supplies and equipment.

Figure 9.15. Community Needs for Better YRH Services



These three sets of needs were identified during needs assessment from the baseline data. Given the tools and resources available during the project, interventions focused on the demand issues and the software side of supply issues. As is true for most YRH programs, the project was unequipped to address the hardware side of the supply issues. At none of the four sites was the project able to address issues such as staffing at the government health posts or the absence of basic equipment and supplies. Indeed, project leaders found that during the endline process, the study communities again articulated hardware-related issues as a continuing need, even though a dent had been made in the scope of the software and demand-related issues.

The [health] institutions within the community do not have modern equipment and advanced technology for providing good health services. (Male youth, rural study site, endline)

There is a point worth noting with regard to youth reproductive health programs in general: the current portfolio of interventions available to most programs can achieve positive results if they are implemented appropriately. However, the portfolio has limitations and cannot modify certain basic barriers to achieving an adequate and appropriate health care provision system within resource-poor communities.

Contextually Relevant Reproductive Health Outcomes in Nepal

Marriage and Childbearing

For the majority of young girls in Nepal, the experience of sexuality and reproductive health occurs within rather than outside of marriage. One of the biggest challenges undertaken by this project was to foster change in entrenched social and normative structures that encourage early marriage and childbearing for girls. This section reports on evaluation data that indicate that despite difficulty, the program design succeeded substantially in accomplishing this task.

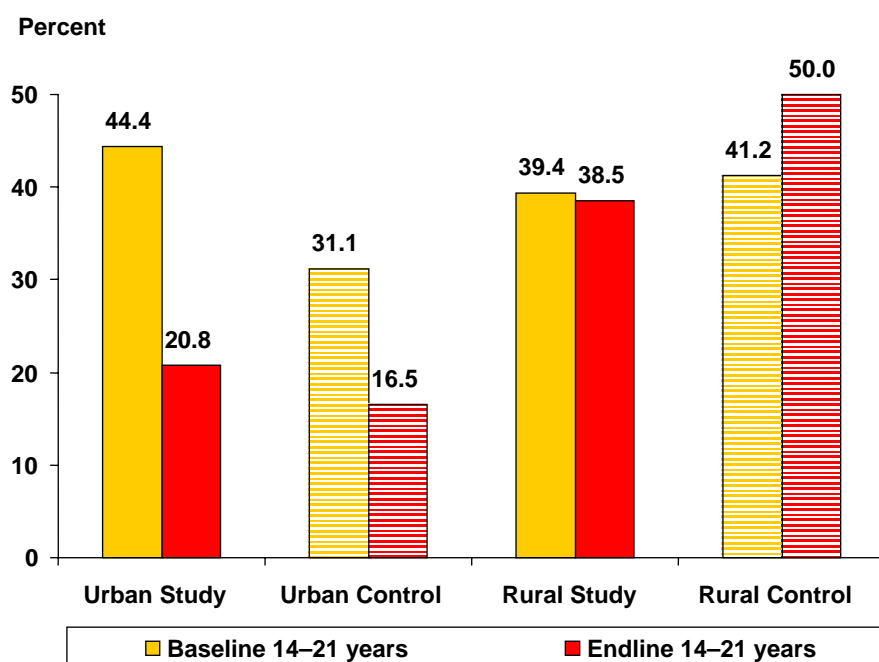
As detailed in the section on needs assessment, the baseline data showed that although youth and adults individually supported later marriages for young boys and girls, social norms have continued to encourage early marriage, especially for girls. Given the relatively short timeframe of the interventions, it would never have been possible to uproot the social system of early marriage. However, there is clear evidence of normative change on this issue at the study sites, where a strong public campaign to raise awareness and support for later marriages took place. The quote below relates to an intervention slogan that has permeated the community.

A popular saying, “Bihawari bees barsa pari,” suggests marriage only after twenty years of age and has brought about a certain level of awareness and a trend has been set to only marry after reaching twenty years of age. (Adult female, urban study site, endline.)

In fact, the quantitative data confirm that the intervention at the study sites, especially in the urban area, did make a significant difference in the proportion of youth who married. As Figure 9.16 shows, there was a decline from baseline to endline in the proportion of 14–21 year-old girls who are married at both of the urban sites, but the decline was much more substantial at the study site. On the other hand, the rural study site showed a negligible decline from baseline to

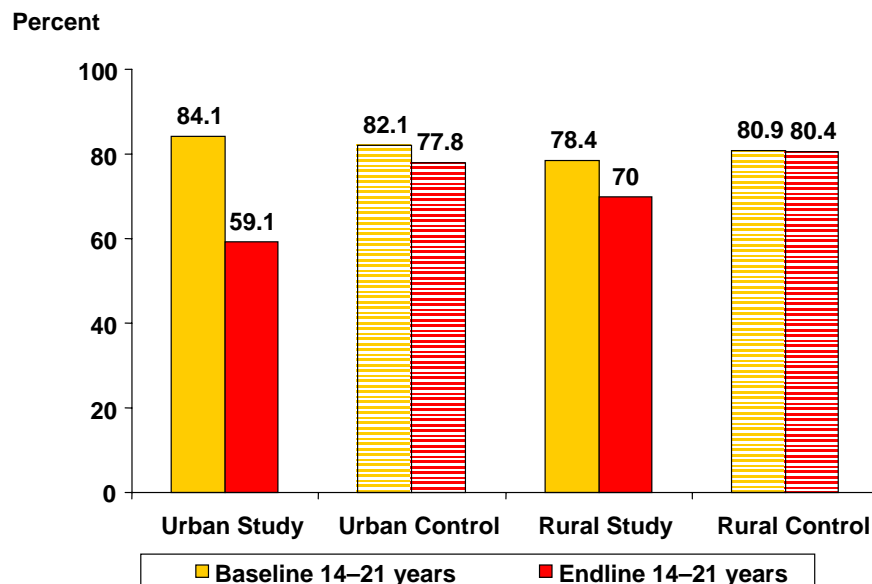
endline in terms of the proportion of girls married. However, given that the proportion of young girls who are married actually increased at the rural control site, the lack of change at the rural study site is a relatively favorable result.

Figure 9.16. Percent of Girls Aged 14–21 years who are Married



The data on childbearing are also encouraging, especially regarding the impact of the participatory approach. As figure 9.17 shows, the decline in the proportion of married young women aged 14–21 who experienced a pregnancy from baseline to endline was more substantial at the two study sites, compared to the control sites. The decline was especially remarkable at the urban study site, where the proportion went down from 84 percent in the baseline (the highest of all four sites) to 59 percent in the endline (the lowest of all four sites).

Figure 9.17. Married Females who have Experienced at least One Pregnancy



Care during Pregnancy

The project findings also show that the participatory interventions had a positive impact on young women who are married and have experienced a pregnancy. These women received more prenatal care and tended to deliver at a medical facility. Since the needs assessment showed that urban young women had relatively ready access to pregnancy-related health services even at baseline, considered here are the data for the two rural sites, where such access was lacking for significant proportions of the relevant population. As Figure 9.18 shows, the proportion of young women seeking prenatal care for a first pregnancy increased substantially at the study site, from less than one-half to about two-thirds. In contrast, the control site showed a slight decline in the proportion seeking prenatal care.

Figure 9.18. Prenatal Care during First Pregnancy

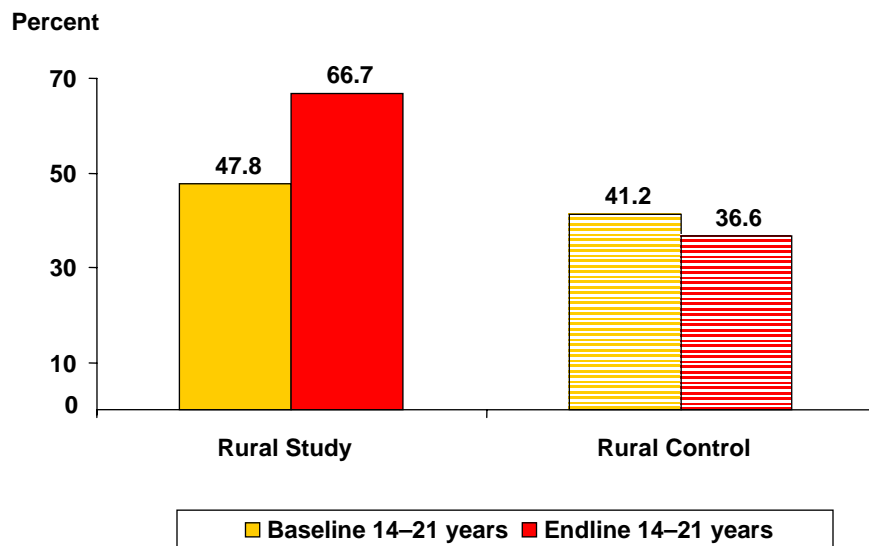
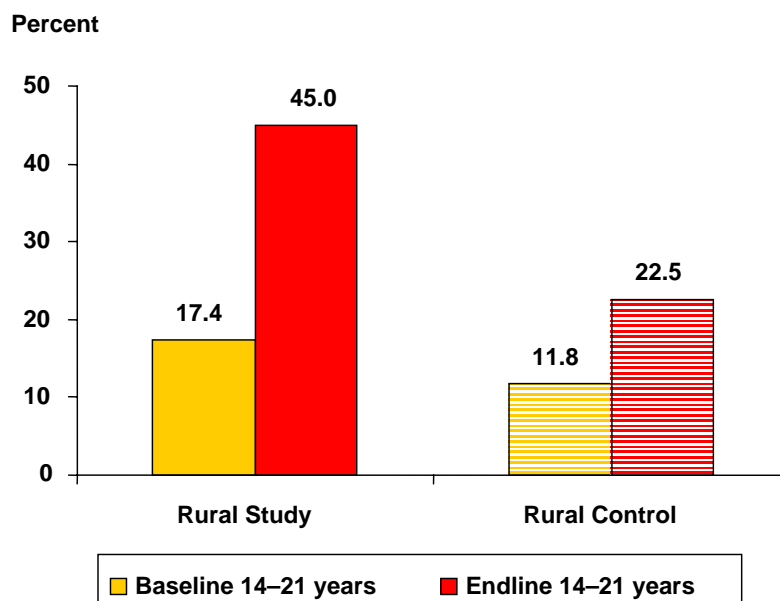


Figure 9.19 also shows that although delivery in a medical facility increased at both rural sites, the increase was much more substantial at the study site. At endline, while less than one-quarter of the deliveries at the control site took place at a medical facility, this was the case for almost one-half of the deliveries at the study site.

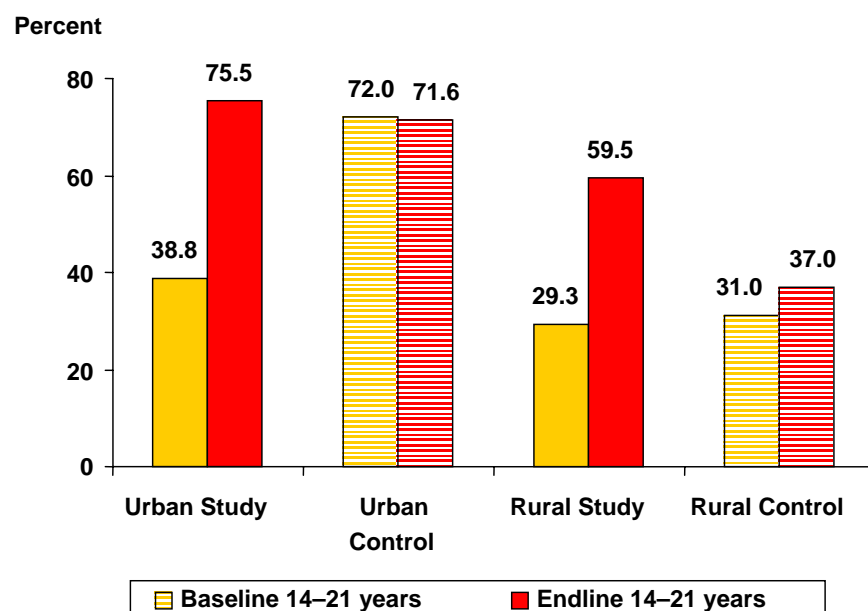
Figure 9.19. Delivery of First Pregnancy in a Medical Facility



The data also show that the participatory approach was successful in making young men more aware of complications related to pregnancy. Figure 9.19 shows that compared to a minor or no

increase at the control site, the proportion of young men with knowledge regarding problems during childbirth doubled at the two study sites.

Figure 9.20. Knowledge of at least One Serious Problem during Childbirth



Broader Normative and Institutional Factors

As indicated earlier, at the study sites the intervention design targeted more than direct and indirect reproductive health outcomes. The project goal was to also create a more enabling environment for long-term investment in YRH by addressing the broader normative, cultural, and institutional factors that define the basic parameters of reproductive health outcomes for young people.

Gender Inequality: Schooling and Social Spaces

The structure of gender inequality in Nepali society is one of the most important constraints on positive reproductive health for youth, in particular young women. One of the main findings during the needs assessment phase was the extent to which the experience of adolescence diverges for males and females. For girls, marriage serves as a disjuncture from schooling, as well as social and leisure activities, constraining their ability to develop and interact with a social support network. The results presented above show that the contextual approach to interventions at the study sites was successful in changing community norms and practices with regard to early marriages and early childbearing for girls. Ambitious as the project was, the data also show that the study site interventions served to increase options for schooling and social spaces for girls in particular.

Figure 9.21 shows the proportion of girls who have had some secondary schooling. During the intervention period, this proportion increased at all four sites, in part due to social change more

generally and in part due to intervention efforts. However, the increase is greater for both the rural and urban study sites, as compared to the two control sites. Similarly, a shift in social spaces for boys and girls did take place, primarily at the study sites. As Figure 9.22 shows, male membership in group activities increased moderately at the urban study site and radically at the rural study site. In contrast, a decline was observed at the urban control site and a modest increase occurred at the rural control site. Figure 9.23 shows that among young women, there was no change in terms of participation in group activities at either of the two urban sites. However, at the rural study site there was a dramatic increase, while at the control site there was a decrease. These results largely reflect the much greater acceptance and appreciation of the participatory approach and related activities at the rural, as opposed to the urban, site. The normative shift at the rural site extends to a greater acceptance of social activities and spaces for girls.

Since the program started running in this community, there are relatively few obstacles. Even the parents allow the girls to go out and roam along with their friends. (Female youth, rural study site, endline)

Figure 9.21. Percent of Girls who have Completed Grade Six or Higher

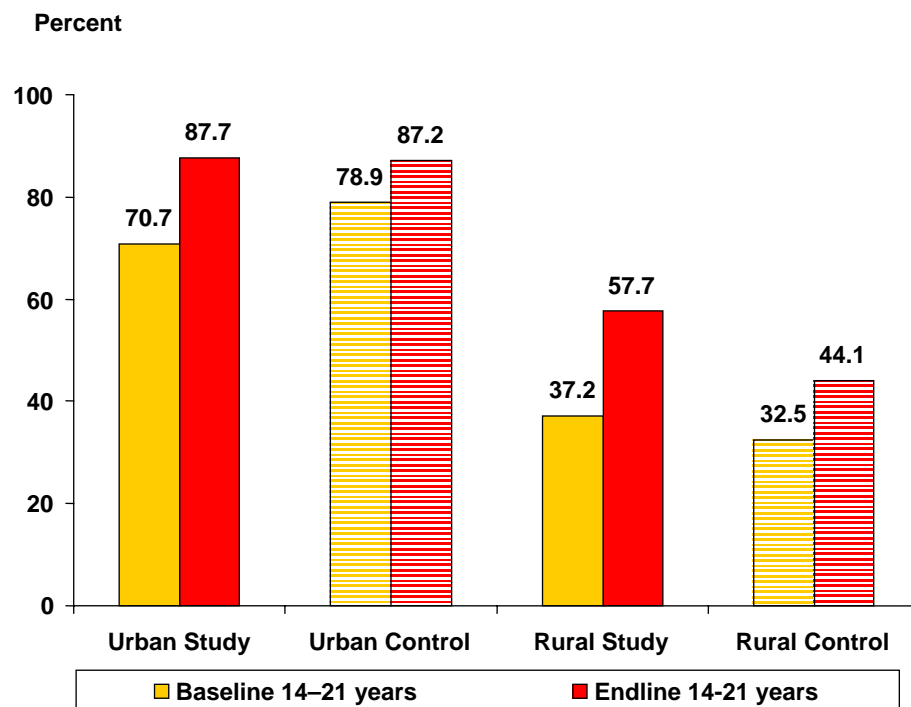


Figure 9.22. Male Membership in Group Activities
Percent

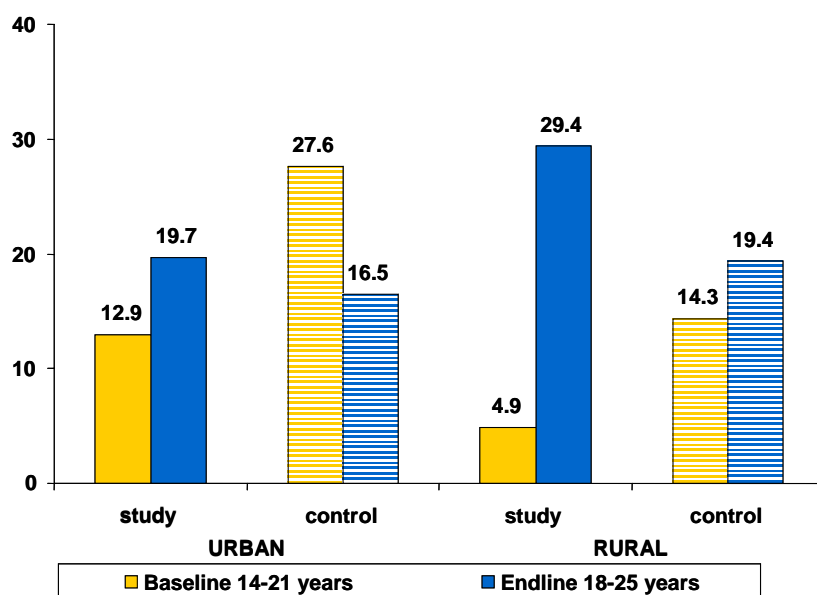
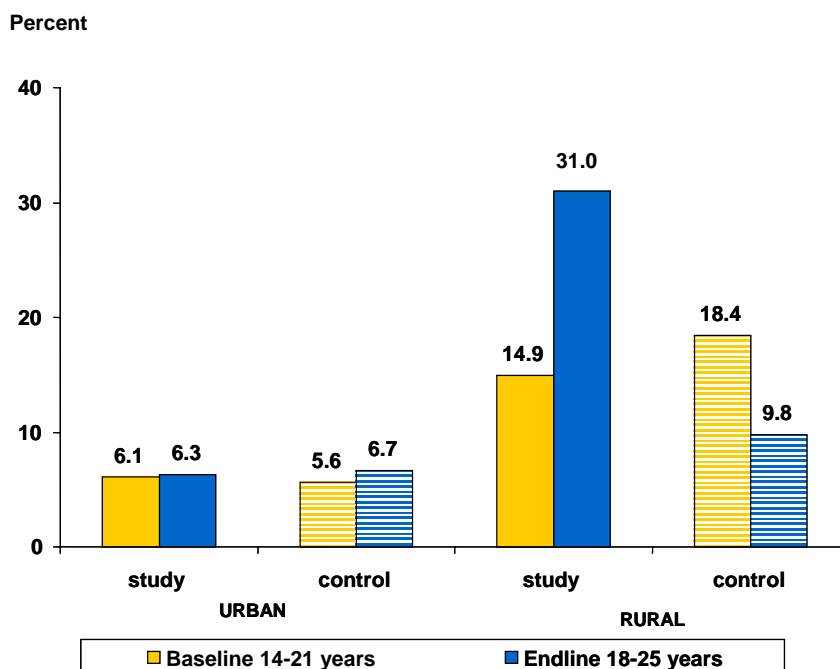


Figure 9.23. Female Membership in Group Activities
Percent



Understanding and Articulation of Reproductive Health

Project results indicate that the existence of an enabling environment for good reproductive health has improved at the study sites because the participatory approach has generated a new mindset in communities, one with a deeper, more sophisticated understanding of youth reproductive health and its implications.¹³ Community members are better able to understand and articulate the basic connections between youth reproductive health and a range of critical life outcomes. They are also clearer about how family, gender, and social structures and norms currently constrain healthier sexual and reproductive behaviors. This richer, more enhanced understanding is likely to be an important factor in the communities' ability to sustain many of the positive changes brought about by the intervention program.

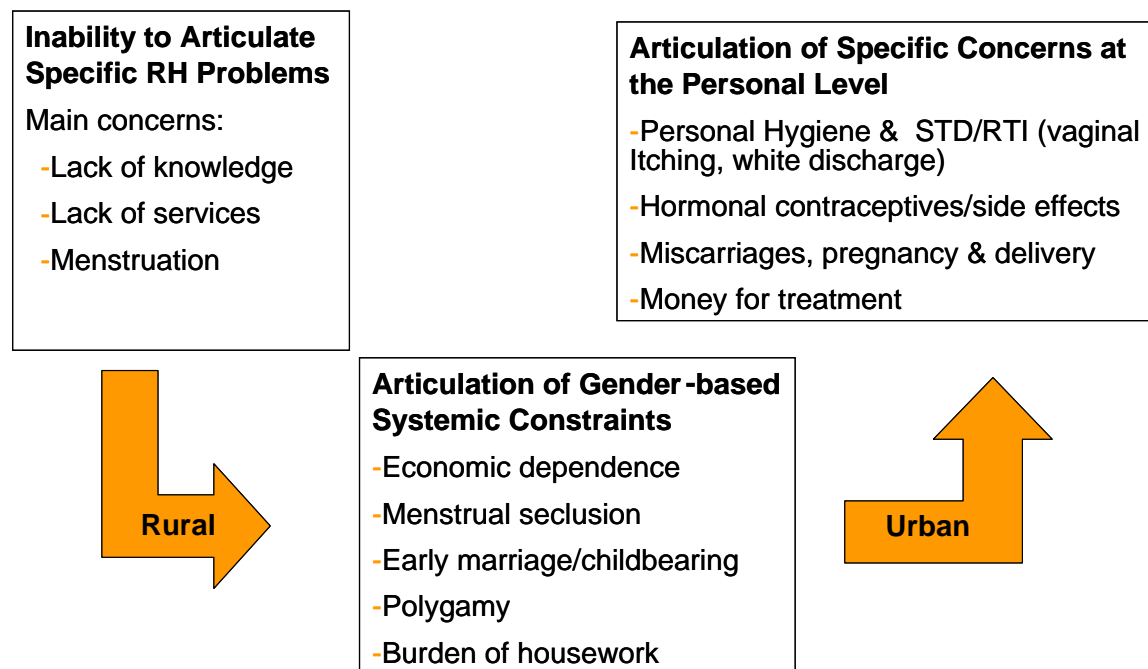
Figure 9.24 depicts the nature of the shift in the articulation by both young and adult women of reproductive health concerns over time in the rural and urban study communities. The box furthest to the left depicts the manner in which women at the rural study site expressed their reproductive health concerns at baseline. These were identified in terms of lack of information and services, in broad and generic terminology. Menstruation was the only specific concern mentioned. In fact, the qualitative data indicate that at baseline, rural women had given little thought to, and had little comprehension of, what young girls' reproductive health concerns were or how their lives were impacted by those concerns.

The middle box shows the synthesis of data from the baseline for these same issues, as articulated by urban women. Even at baseline, urban young and adult women were more sophisticated than their rural counterparts in their ability to identify the manner in which gender-based norms constrained their sexual and reproductive behavior. Thus, women emphasized issues such as girls having to engage in sexual activity for money or security, lack of mobility and options because of seclusion during menstruation, early marriage and childbearing, the constant threat of husbands taking on a second wife, and difficulties in meeting housework-related obligations when suffering from reproductive problems.

The progress made in thinking and articulation among both sets of women as a result of the intervention was remarkable. By the endline, rural women had reached the point where urban women had been at baseline. Instead of talking in abstract terms, they were now able to articulate their reproductive health concerns in systemic terms, especially by emphasizing the gender-based constraints they face. At the same time, urban women progressed to a higher level of specificity in their articulation of reproductive health concerns. As the third box on the right shows, by the endline, both young and adult women at the urban site were discussing these issues in personal rather than systemic terms. Rather than more broadly describing how familial, social, gender-based systems impact their sexual and reproductive lives, these women were now talking about specific concerns, such as the side effects of contraceptives, how the symptoms of STDs and RTIs affect their lives, and the financial burden that families associate with reproductive health care.

TP¹³PT Here only data from the study sites are presented, since this goal was not part of the program design for the control sites and comparable data were not collected.

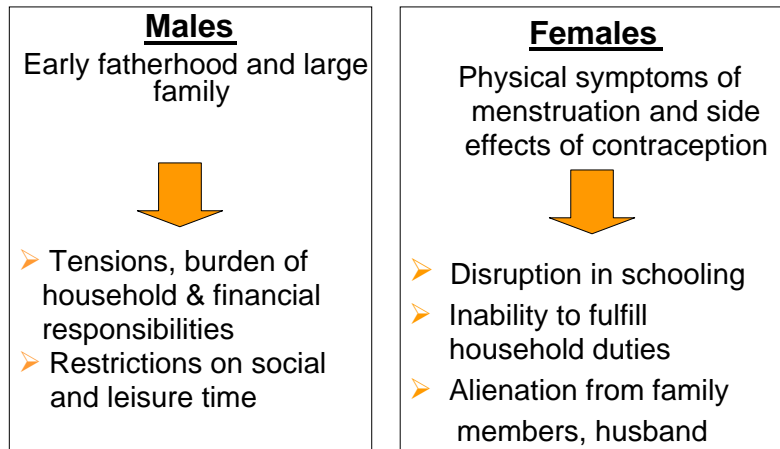
Figure 9.24. Abstract vs. Specific Articulation of RH Concerns: Females



Similarly, Figure 9.25 shows how by the endline, both young men and young women articulated many of the linkages between specific reproductive health concerns and resulting consequences. In discussions, young men were able to make the connection between early fatherhood and subsequent social and economic responsibilities equally, if not more, clearly than most academic analyses of these issues.

At this age, they [young fathers] have to spend much time with their family, after realizing their responsibility toward them...they have to be more bothered about the upbringing of the children and their education, etc., so their personal desires and all take secondary importance. (Male youth, rural study site, endline)

Figure 9.25. Articulation of RH Linkage to Life Conditions and Outcomes



Young women were also clear about the implications of routine experiences with menstrual problems or the side effects of contraceptives.

During menstruation, there is a feeling of lethargy, which hampers one's willingness to work...if married, the mother and sister-in-law are angry and complain that the girl did not look after the children...the woman cannot perform her chores properly due to weakness ... money is spent on medication, then this may result in friction between husband and wife. (Female youth, urban study site, endline)

Such clear, analytical understanding of what reproductive health means at various life stages, some of the reasons for poor sexual and reproductive health outcomes and behaviors, and some of the short-term and long-term implications provides perhaps the strongest motivation for continued efforts by young people themselves to change the status quo.

Evidence of Sustainability

The ultimate goal of development projects in general, and the banner of participatory approaches in particular, is to build sustainable programs that remain in place after the duration of a specific intervention and continue to impact the lives of community members in meaningful ways. With regard to the current project, the central goal was to develop fundamental capacities and structures and to initiate momentum for participatory processes in the study communities so that some of the new initiatives would continue in the long run. Although without conducting a second evaluation after a significant lapse of time (1–2 years), it is impossible to confirm that the programmatic efforts at the study sites are indeed sustainable, monitoring and evaluation data do show evidence of mechanisms and systems at the study sites that point toward greater sustainability of project activities, ideas, and processes.

1. Empowered, more capable youth and adults. As noted in the pages above, there is ample evidence that both the youth and adults in the study communities have an enhanced understanding of their needs, the capacity of youth and adults to bring about change, and the

systemic and organizational barriers that prevent change. Greater awareness of facts and systems, as well as participatory mechanisms, has created an empowered citizenry in the study communities that is more likely to organize, build coalitions, access government resources, and hold providers and policymakers accountable for continued improvements in youth reproductive health.

2. Structures and mechanisms built within the communities. During the intervention period, important new institutional structures have been created that are likely to take on a life of their own, at least in the immediate future. For example, a network of local service providers has been created at the study sites that serves the interests of providers, and is therefore likely to continue. Similarly, the youth club and the drama club have established their own space, legitimacy, and mechanisms for membership, fundraising, and other activities during the project period. These groups have become established entities in the study and neighboring communities, and their skills and products are in great demand. The rural drama group, for example, has been hired by other organizations to perform plays with messages on a variety of subjects. To the extent that these groups continue to recognize this demand and respond to it, they are well-placed to continue providing safe social spaces for young people, while at the same time serving an educational and informational function with regard to YRH.
3. Cooptation of interventions into the programs of partner organizations. A strategic step toward sustainability has been the incorporation of specific interventions into the larger programs and structures of local organizations that served as implementing partners. For example, the intervention team worked with the Nepal Red Cross to develop and implement the peer education program at the study sites. As a result, peer groups at urban and rural study sites have now become part of the Junior Red Cross and will continue to receive access to training and information through that organization's structures.
4. Community training on planning and sustainability. In order to address the sustainability issue directly, the intervention team organized a community meeting in both the rural and urban study areas to discuss and plan for ways to continue some of the interventions after the project implementation period ended. Along with project staff, the meetings were attended by all representatives of the ACT and PAC, as well as community members involved in the various interventions. The focus of the meetings was on identifying activities and processes that were most desirable and feasible to continue without significant external technical assistance.

Attendees at these meetings developed action plans with specific steps necessary, and the individuals or groups responsible, for ensuring continuation of certain processes. For example, as a result of this planning exercise, the youth club in the urban area was reestablished under the authority of the local high school. An 11-member joint committee (consisting of school teachers, youth representatives, and others) was identified to ensure support for and oversee the functioning of the youth club, including adequate provision of books, instruments, sports equipment, and other resources.

5. Diffusion of information from participants to nonparticipants. Many intervention programs, especially those aimed at youth, hope for the diffusion of information through social

networks and community interaction. Yet it is often difficult for interventions specifically targeted to youth to assess whether diffusion is truly taking place. The project evaluation revealed substantial evidence of diffusion at the study sites, but not at the control sites. In the focus group activities conducted during the endline, community members were specifically asked about how they felt the program had impacted them. At the study sites, repeated discussions took place about the spread of information from those whom the interventions reached to those outside the specifically targeted groups and those whom the interventions did not reach.

In the rural area, for example, several disadvantaged youth reported in the evaluation that, despite the project team's efforts, they were unable to access the intervention activities in a consistent manner due to the objections of their parents. Yet, when asked about the importance or impact of the project on their lives, these same youth were very positive because they had received information and support from their peers who were able to participate. To the extent that youth and adults who participated in the intervention continue to be seen as reliable sources of information and support, diffusion is likely to be a critical mechanism through which project efforts are sustained.

Capacity Building among Partner Organizations

At a broader level, sustainability has also been achieved through the capacity built among partner organizations. Due to the depth of technical assistance and partnership achieved with the implementing partners, a group of international and local organizations with varying mandates—research, reproductive health programs, and community development—is now quite capable of effectively developing, implementing, and evaluating a participatory approach to youth reproductive health. Data obtained through the process documentation indicates that the project was highly successful in developing capacity and synergy at multiple levels of partnership, as follows.

1. Effective collaboration on research and program implementation. In the United States, two highly specialized research and implementation organizations, ICRW and EngenderHealth, have learned how to work together toward a common objective. Each organization has benefited immensely from the perspectives and expertise of the other. Similarly, project partners in Nepal have had the opportunity to learn and expand their skill sets. The NGOs that implemented the project have seen the value of and steps required for evaluation, while at the same time the research partners have had the opportunity to better understand implementation processes and objectives.
2. Local organizations recognized as the experts. Increasingly, the project's local partners in Nepal are being asked to provide technical support to other NGOs within Nepal for developing and implementing participatory approaches to youth reproductive health, conducting participatory monitoring and evaluation, and incorporating gender into programmatic approaches. As a testament to this growing skill and capacity, the implementation team's first principle investigator went on to develop participatory monitoring and evaluation for a large-scale YRH project in Nepal.

3. Field staff highly trained and in demand. Not only are the partner organizations and principle investigators, but also field staff, are now seen as experts. As a result of a highly intensive project timeline and workload, the core field staff gained not only research and implementation, but also analytical and monitoring, skills, and they are now in high demand for a number of ongoing program and research activities being conducted by NGOs and government organizations.
4. Tools, skills, and resources developed. One of the biggest contributions of this project has been the development and adaptation of tools and resources needed to implement and evaluate both youth reproductive health and participatory approaches. As a result of the constant innovation required at each stage of the project, several resources were developed, including manuals and training modules for conducting participatory research and training field staff; intervention models and manuals for direct and indirect YRH activities; models of project management; and tools for monitoring and evaluating such efforts. These tools, resources, and experience are now available for conducting current and future activities with similar aims.

10. Summary and Conclusions

U.S. and Nepali partners have worked jointly and intensively over five years to implement and test the participatory approach for improving youth reproductive health in Nepal. Following a conceptualization of participation and youth reproductive health within the Nepali context, various project elements were differentially implemented at the study and control sites. The figure below summarizes the major program elements and their execution at the study versus control sites.

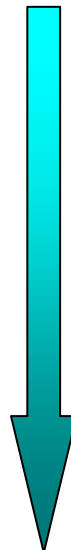
Table 10.1. Major Program Differences at Study and Control Sites

Project Element	Study Sites (Rural and Urban)	Control Sites (Rural and Urban)
Baseline and needs Assessment	Extensive baseline and needs assessment using quantitative, qualitative, and participatory methodologies.	Matching baseline, but limited needs assessment; no participatory methodologies.
Intervention framework	Youth reproductive health defined to include risk factors (unwanted pregnancy, risk of STDs), socioeconomic determinants (age at marriage, early childbearing, education) and social and normative constraints.	Youth reproductive health defined to include basic risk factors.
Structures and mechanisms	Participatory Action Committee (PAC) consisting of community adults and Adolescent Coordination Team (ACT) consisting of community youth set up early and maintained throughout with increasing authority and decisionmaking power. Frequent	No similar mechanisms.

	creation of task forces, consultative committees, engagement with leaders and stakeholders.	
Intervention design	Action planning process through sharing and discussion of needs assessment with community, creation of task forces to prioritize and design feasible and desirable interventions.	Interventions designed by professional project team.
Intervention components	Package of eight linked and coordinated intervention components consisting of direct youth reproductive health programs (adolescent-friendly services, peer education and counseling, information and education) and indirect reproductive health programs (adult education and peer program; youth development; social norms; economic livelihoods).	Three noncoordinated intervention components (adolescent-friendly services, peer education and counseling, and teacher training).
Implementation style	Participatory, consultative, providing substantial initiative and decisionmaking power to community adults and youth.	Didactic, nonparticipatory
Attention to diversity, differentials, and disadvantage	Focus on differentiated needs of disadvantaged populations a major program component; critical differentials and disadvantages identified (gender, rural versus urban, wealth, ethnicity, marital status).	Limited attention to differentials.
Monitoring and evaluation	Extensive tracking of implementation processes and endline evaluation using quantitative, qualitative, and participatory methodologies	Matching monitoring and endline measurement with quantitative methodologies, limited qualitative methods, and no participatory methods.

The evaluation reveals that for the outcomes of interest, the participatory approach did indeed yield more positive results. Although the effect was only marginally more positive in terms of the basic indicators of youth reproductive health, it was substantially more positive in terms of the broader, more contextual factors that influence YRH, as well as capacity building, empowerment, and sustainability.

Figure 10.1. Effects of the Participatory versus Nonparticipatory Approach



Outcomes of Interest	Study Sites	Control Sites
Basic reproductive health outcomes	●○	●
Service availability and access	●●	●
Reproductive health outcomes contextually relevant in Nepal	●●●	●○
Broader normative and institutional factors	●●●	●
Capacity building and empowerment	●●●	-
Sustainability	●●●	-

- weak positive effect
- moderate positive effect
- strong positive effect
- very strong positive effect
- effect undeterminable

1. With regard to basic reproductive health outcomes, the participatory approach was found to be generally more effective than the traditional approach, although not consistently so. For example, results on only some of the measures of knowledge of STDs or HIV/AIDS were more positive at the study sites. In fact, for some measures (such as contraceptive use), the results were mixed at both sets of sites. However, results on the communication of reproductive health concerns and understanding of sexuality were consistently more positive at the study sites.
2. While the availability of and access to services increased at both the control and study sites, findings indicate some additional qualitative benefits at the sites where the participatory approach was implemented. Both the system in which the providers function and young people's understanding of how to best use the options available to them improved more substantially at the study sites. In particular, data from the study sites underscore the importance of peers and social networks as critical sources of service provision for young people.
3. The participatory approach was substantially more effective in improving reproductive health antecedents and outcomes that are especially relevant in the Nepali context, including age at marriage, initiation of childbearing, prenatal care, institutional delivery, and increased male awareness of the reproductive health needs of women.

4. The participatory approach was also much more effective than traditional approaches in making the broader environment more conducive to positive reproductive health outcomes for youth. From baseline to endline, a number of fundamental contextual changes were evident at the study sites. These included increased secondary schooling for girls and more social spaces for young men and, in particular, young women. Other changes included higher demand for information and services and better, more specific, in-depth understanding of YRH issues among both youth and adults at the study sites.
5. The continuous and strategic engagement of youth and adult community members was substantially more successful in increasing skills, capacity, and empowerment among youth and adult community members at the study sites than at the control sites. By the end of the project, youth at the study sites were recognized for their abilities to coordinate, organize, and lead social and development activities, and a number of structures indicative of community initiative, mobilization, and commitment with regard to YRH were in place.
6. Capacity at a broader level was also built through the intensive involvement and joint engagement of research and program organizations, as well as southern and northern partners, in developing and implementing a participatory approach to improving YRH. The resulting expertise, tools, and resources make the expansion of this program at both the local and international levels both feasible and desirable.
7. As a result of the participatory approach taken at the study sites, improved skills and capacity, along with structures and mechanisms involving local ownership and authority, have been instrumental in laying the foundations of sustainability. In particular, it is evident that diffusion of information and support through social networks is playing a strong role in spreading knowledge and ideas beyond individuals directly targeted by the interventions.

11. Insights and Recommendations

Both the program and the evaluation process implemented through this project were part of a pioneering effort that aimed to scientifically test the proposition that participatory approaches are more effective in improving youth reproductive health than are nonparticipatory approaches. Because of this pioneering aspect, the implementation and evaluation components of the project were by necessity elaborate, comprehensive, and experimental. However, since this effort has yielded results that support the proposition that participatory approaches are indeed more successful, others should be able to replicate and expand this work in a less experimental and more efficient manner. Therefore, our insights and recommendations are aimed at identifying the most strategic, targeted, and resource-effective lessons learned from our project experience.

We have three insights and recommendations with regard to participatory processes:

1. Participation should be strategic, not all encompassing. Rather than requiring the involvement of all possible actors at all times, participation requires the strategic

involvement of stakeholders at key points. In the experience of the project teams, the most critical points for stakeholder engagement are initial entry to the community and program design.

2. For the most part, participation requires the custom-tailoring and adaptation of existing tools and mechanisms to local needs, rather than the creation or reinvention of new tools and mechanisms
3. Participatory processes are time- and resource-intensive, but no more so than other high quality programmatic inputs that yield positive, high-quality returns. In the long run, positive results from participatory processes may be much more cost-effective than indeterminate results from a number of other approaches that have smaller upfront costs.

Three insights and recommendations with regard to substantive implementation of the program that can also be identified here:

1. For effective programming on YRH, a high-quality needs assessment followed by a well-planned program design are the most critical components. In order to yield results, both these processes need to focus on not just the outcomes of interest, but also on the structure of the project communities.
2. Our experience indicates that a minimum “basket” of YRH interventions must include:
 - An intervention that improves the provision of information and services to young people.
 - An intervention that develops human and/or social capital among youth, for example through education, expansion of livelihood opportunities, improvement of life skills, and youth clubs.
 - An intervention that mobilizes youth and community members to change norms, attitudes, and social systems.
3. When implemented through participatory processes, interventions aimed at youth development (such as youth clubs) or social norms and systems (such as street theater) have the potential to yield both community buy-in and sustainable results at minimal costs. Contrary to conventional wisdom, such interventions are highly cost effective because they allow for the effective mobilization of local resources and initiative.

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Appendix A: Regressions of Key Evaluation Variables

Odds Ratio of project versus control, controlling for age and socioeconomic status

Variable	Data source (n)	Odds Ratio	P-value	CI
Reproductive Health Problems: STDs and HIV				
Rural females: knowledge of STD symptoms	Baseline (208)	1.027	.932	(.557, 1.894)
	Endline, ages 18–25 (140)	.582	.244	(.234, 1.447)
Rural males: knowledge of STD symptoms	Baseline (165)	.453	.018*	(.235, .872)
	Endline, ages 18–25 (113)	.976	.956	(.406, 2.342)
Urban females: self-reported experience of STD symptoms	Baseline (187)	1.425	.233	(.796, 2.549)
	Endline, ages 18–25 (170)	1.396	.293	(.750, 2.598)
Rural females: self-reported experience of STD symptoms	Baseline (208)	.977	.949	(.481, 1.986)
	Endline ages 18–25 (140)	.988	.975	(.466, 2.094)
Urban males: ever discussed RH problems with anyone?	Baseline (161)	.742	.413	(.364, 1.515)
	Endline, ages 18–25 (155)	1.062	.867	(.526, 2.145)
Rural males: ever discussed RH problems with anyone?	Baseline (165)	.460	.034*	(.225, .942)
	Endline, ages 18–25 (113)	2.077	.085	(.905, 4.766)
Urban females: ever discussed RH problems with anyone?	Baseline (187)	.097	.000**	(.046, .204)
	Endline, ages 18–25 (170)	1.249	.521	(.634, 2.460)
Rural females: ever discussed RH problems with anyone?	Baseline (208)	1.005	.987	(.567, 1.779)
	Endline, ages 18–25 (140)	1.282	.509	(.613, 2.680)
Urban females: correctly identified at least 2 modes of HIV transmission	Baseline (187)	1.371	.303	(.752, 2.498)
	Endline, ages 14–21 (215)	3.783	.049*	(1.006, 14.220)
Rural females: correctly identified at least 2 modes of HIV transmission	Baseline (208)	1.060	.859	(.559, 2.008)
	Endline ages 18–25 (140)	.308	.004**	(.139, .680)
Urban males: correctly identified at least 2 modes of HIV transmission	Baseline (161)	2.332	.031*	(1.079, 5.041)
	Endline ages 14–21 (189)	1.440	.589	(.383, 5.415)
Rural males: correctly identified at least 2 modes of HIV transmission	Baseline (165)	.548	.091	(.273, 1.100)
	Endline 14–21 (179)	1.821	.089	(.913, 3.631)
Premarital sex and sexuality				
Urban females: ever discussed sex with anyone?	Baseline (187)	.468	.013*	(.257, .853)
	Endline, ages 14–21 (215)	.635	.107	(.365, 1.104)
Rural females: ever discussed sex with anyone?	Baseline (208)	.723	.351	(.366, 1.429)
	Endline, ages 14–21 (180)	2.009	.043*	(1.023, 3.947)
Urban unmarried males: had premarital sex?	Baseline (140)	1.360	.567	(.475, 3.889)
	Endline, ages 14–21 (186)	5.088	.019*	(1.309, 19.774)
Rural unmarried males: had premarital sex?	Baseline (137)	2.491	.033*	(1.079, 5.753)
	Endline, ages 14–21 (154)	1.171	.762	(.421, 3.252)
Contraceptives				
Urban married females: Ever visited an organization for family planning advice?	Baseline (71)	.449	.132	(.159, 1.272)
	Endline, ages 18–25 (85)	.606	.275	(.247, 1.489)
Rural married females: Ever visited an organization for family planning advice?	Baseline (83)	1.018	.977	(.297, 3.491)
	Endline, ages 18–25 (121)	2.365	.066	(.943, 5.927)
Unmarried urban males: contraceptive use at first premarital sex?	Baseline (18)	.271	.236	(.031, 2.346)
	Endline, ages 14–21 (14)	.000	.879	(.000, 8.4 E44)
Unmarried rural males: contraceptive use at first premarital sex?	Baseline (32)	.810	.796	(.164, 4.002)
	Endline, ages 14–21 (19)	.100	.126	(.005, 1.914)
Urban youth married less than 2 years: current contraceptive use?	Baseline (39)	2.305	.249	(.558, 9.525)
	Endline, ages 18–25 (29)	2.648	.220	(.558, 12.568)
Rural youth married less than 2 years.: current contraceptive use?	Baseline (46)	2.217	.275	(.530, 9.628)
	Endline, ages 18–25 (38)	2.243	.321	(.455, 11.058)

Marriage and childbearing				
Urban females: marital status	Baseline (187)	.694	.365	(.316, 1.528)
	Endline, ages 14–21 (215)	.552	.217	(.215, 1.418)
Rural females: marital status	Baseline (208)	.969	.931	(.475, 1.976)
	Endline, ages 14–21 (180)	1.577	.288	(.681, 3.651)
Married urban females: experienced at least one pregnancy?	Baseline (71)	.982	.980	(.238, 4.052)
	Endline, ages 14–21 (40)	.398	.209	(.094, 1.677)
Married rural females: experienced at least one pregnancy?	Baseline(84)	.801	.702	(.257, 2.495)
	Endline, ages 14–21 (81)	.596	.382	(.187, 1.899)
Care during pregnancy				
Rural females: accessed formal prenatal care during first pregnancy?	Baseline (57)	.879	.822	(.286, 2.705)
	Endline, ages 14–21 (62)	.392	.126	(.118, 1.302)
Married rural females: was first delivery at a medical facility?	Baseline (57)	.697	.648	(.147, 3.295)
	Endline ages 14–21 (60)	.529	.329	(.147, 1.898)
Urban males: know of at least one serious problem during childbirth?	Baseline (160)	3.546	.000**	(1.791, 7.022)
	Endline, ages 14–21 (189)	.770	.435	(.399, 1.484)
Rural males: know of at least one serious problem during childbirth?	Baseline (165)	1.303	.462	(.643, 2.638)
	Endline, ages 14–21 (179)	.370	.002**	(.195, .703)
Gender inequality: schooling and social spaces				
Urban females: currently in school?	Baseline (187)	.918	.809	(.458, 1.839)
	Endline, ages 14–21 (215)	.704	.317	(.353, 1.401)
Rural females: currently in school?	Baseline (208)	1.141	.716	(.562, 2.314)
	Endline, ages 14–21 (180)	2.073	.061	(.967, 4.444)
Urban females: completed grade 6 or higher?	Baseline (187)	1.423	.328	(.702, 2.887)
	Endline, ages 14–21 (215)	1.002	.997	(.426, 2.357)
Rural females: completed grade 6 or higher?	Baseline (208)	1.129	.705	(.602, 2.118)
	Endline, ages 14–21 (180)	.752	.397	(.389, 1.454)
Urban female: membership in group activities?	Baseline (187)	1.244	.731	(.357, 4.334)
	Endline, ages 18–25 (170)	.962	.951	(.277, 3.339)
Rural females: membership in group activities?	Baseline (208)	.644	.267	(.296, 1.401)
	Endline, ages 18–25 (140)	3.343	.013*	(1.284, 8.708)
Urban males: membership in group activities?	Baseline (161)	.415	.039*	(.180, .955)
	Endline, ages 18–25 (155)	1.271	.568	(.557, 2.901)
Rural males: membership in group activities?	Baseline (165)	.161	.007**	(.043, .604)
	Endline, ages 18–25 (113)	1.563	.327	(.640, 3.813)

* p<.05 **p<.01

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