

Finding A Voice:

Shifts in Reproductive Health Understanding, Attitudes, and Practices in Nepali Youth



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CONTEXT

In Nepal, the average age for marriage is 17.9 for women and 21.7 for men. Nationally, modern contraceptive use among married adolescents (15–19) is only 15%. Karnali Pradesh Province has the second highest total fertility rate and second highest adolescent childbearing rate in the country and a lower skilled birth attendance rate than the national average.¹ Young Nepali women are often forced to drop out of school, get married, and move to live with their new husband's family. They find themselves with limited social support; little to no knowledge about reproductive, maternal, and newborn health (RMNH); poor nutrition; few opportunities for financial gain; limited control of resources; and restricted mobility. Few programs address the unique health needs of young married adolescents in Nepal; fewer still engage young, married women's husbands and families, although it is widely recognized that they play an important role in decision making around reproductive health and seeking health care.

PROJECT APPROACH

In 2019, Save the Children launched the Healthy Transitions for Nepali Youth Project (HTNYP) in four districts of Karnali Pradesh Province in the hill region of Nepal to support unmarried and married adolescent girls and young women (AGYW) aged 15–24 years as they transition to marriage and parenthood. HTNYP engages young women, their husbands when applicable, their parents or in-laws, and the community in interventions to improve RMNH knowledge and practices, as well as increase gender equality in household decision making. HTNYP also supports quality improvement of RMNH services to ensure they are available and responsive to the needs of youth.

¹ Ministry of Health, Nepal; New ERA; and ICF 2017. *Nepal Demographic and Health Survey 2016*. Kathmandu, Nepal: Ministry of Health, Nepal.

WHAT MAKES HTNYP DIFFERENT?

HTNYP was designed around well-founded building blocks of first-time parenting (FTP) programs, including:

1. designing interventions at the individual, family, community, and systems levels of the socio-ecological model;
2. tailoring activities to the age, life stage, and other characteristics of the AGYW;
3. reaching both young women and men with synchronized gender-transformative approaches; and
4. improving access to and quality of RMNH and family planning (FP) services.²

HTNYP sought to build upon an existing, popular Save the Children activity for first-time mothers, called My First Baby. The My First Baby guidebook provided young women the opportunity to learn about RMNH in small groups of other young, first-time mothers and included space for exploring values, emotions, and plans for the future. HTNYP drew from the guidebook content and the small group approach while expanding the program activities to be more comprehensive to encompass the aforementioned building blocks of FTP programs.

PROGRAM OBJECTIVES

Over a three-year period (2019 – 2021), HTNYP aims to reach 14,400 adolescent girls and young women across 40 sites in Kalikot, Jajarkot, Dailekh, and Surkhet districts (sites are centered around health facilities). The project aims to meet the following key objectives through the activities on the following page.



Photo : Save the Children/Victoria Ziegler

EVALUATION OF THE FIRST HTNYP COHORT

METHODOLOGY

To assess HTNYP's relevance, effectiveness, and sustainability, we evaluated a representative sample of the first cohort of 8,758 AGYW. We used a mixed-method approach consisting of collecting and analyzing quantitative and in-depth qualitative data. The evaluation included: 1) a quantitative survey to assess AGYW knowledge, attitudes, and practices, and 2) focus group discussions and key informant interviews with program participants (unmarried AGYW, married AGYW, husbands, and mothers-in-law), program implementers (SMs, mentors, and Save the Children and partner NGO staff), and community leadership (municipality government and health facility staff). This brief presents results of selected FP, MNH, and gender equality indicators from the endline evaluation, compared to the baseline evaluation finalized in June 2019.

² Save the Children, USA; *Beyond the ABCs of FTPs: A deep dive into emerging considerations for first time parent programs*. 2019. Washington, DC: Save the Children, USA

OBJECTIVES

KEY ACTIVITIES

Young women have improved knowledge and capabilities to care for their RMNH and participate in household financial management.



Small-group, curriculum-based sessions for 8,758 AGYW aged 15-24 years (married and unmarried) supported by trained local mentors. AGYW groups meet 24 times over 12 months for participatory sessions.



Link activity with RMNH services by organizing an exposure visit to health facilities.

Husbands of young women have more gender-equitable attitudes and support RMNH care-seeking behaviors among young women.



Home visits to husbands/newly married couples by social mobilizers (SMs) who use videos and flipbooks to trigger discussion around gender equality, delaying and spacing childbearing, and healthy RMNH practices.



Social events, such as debates, and dialogues organized by SMs to engage husbands timed with migratory patterns.

Families and community members are supportive of more equitable household gender norms and of RMNH care-seeking behaviors among young women.



SMs work with Family Community Health Volunteers to engage with existing health education groups for mothers, using games and discussions around fertility, healthy timing and spacing of pregnancy, and contraceptive methods.



SMs reach mothers-in-law through home visits and influential community leaders through community events to discuss topics related to delaying marriage and childbearing, using contraception, and using maternal and newborn health (MNH) services.

High-quality RMNH services are available and responsive to the needs of youth.



Health facility assessment for 40 facilities followed by training and coaching for 274 service providers on RMNH and youth-friendly health services.



Quality improvement and social accountability through the use of the Partnership Defined Quality for Youth method that brings together service providers and service users to develop action plans.

The pre/post approach tracked changes in outcomes for the same project beneficiaries over the course of one year, from before participating in HTNYP to after program completion. The evaluation team located and surveyed 565 of the 786 AGYW surveyed at baseline, a 72% response rate. 210 AGYW couldn't be reached because they migrated and 11 couldn't be surveyed for other reasons. The survey included indicators on MNH knowledge and practices; perceptions on pregnancy, marriage, and gender roles; knowledge and use of FP; mental health; self-efficacy; and financial literacy. In addition, we held 24 focus group discussions with both unmarried and married young women, their husbands, mothers-in-law, and implementers of the HTNYP: SMs and mentors. Focus groups with participants, families, and community members used a structured discussion tool that started with a participatory fictional character game to help people open up and talk about sensitive topics. We also visited partner non-governmental organizations (NGOs), health posts, and municipality governments to hold Key Informant Interviews (KIIs) and small group interviews with 50 program implementers, local government leaders, and health staff in each district.

KEY FINDINGS

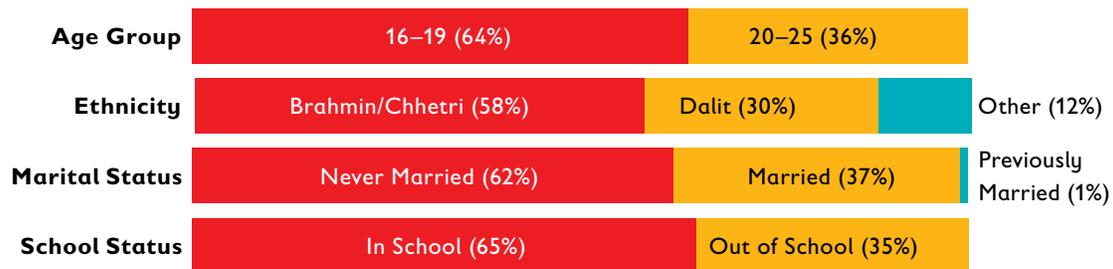
Data is presented according to selected RMNH and gender equality indicators and as an aggregate across all four districts.

PARTICIPATION IN HTNYP

Participant characteristics

The majority (64%) of the 565 AGYW surveyed at endline were 16-19 years of age, with an average age of 19. Over half of the sample (58%) were from the Brahmin/Chhetri group (higher caste), 30% were Dalit, 9% were Janajati, 3% were Thakuri, and less than 1% were Dashnami (lower castes and minority ethnicity groups). The majority of the AGYW were still in school (65%). Marital status corresponded closely with school status, with the majority of unmarried girls being in-school still. Of 210 married AGYW, only 29 were currently enrolled in school.

Figure 1. Endline characteristics of AGYW survey respondents



Source: AGYW survey, authors' calculations. $N_{EL}=565$.

Participation in activities

HTNYP offered 24 bi-monthly, small group sessions for the enrolled AGYW using a participatory, comprehensive curriculum, *Swastha Rupantaran* (Healthy Transitions), designed for the project. Overall, 75% of AGYW surveyed at endline attended all or almost all HTNYP group sessions, and very few attended fewer than half of the sessions. There was little variation in attendance across the program districts or between married and unmarried AGYW.

The videos for home visits were ready for use in August 2019. At the time of the endline data collection, of the 210 married AGYW, only 36% reported having a home visit from a SM and about half (51%) of those reported receiving only one visit. As no family reported receiving the program goal of six visits, it is unlikely that any family viewed all six videos.³ To offset this, SMs increased their efforts to reach the husbands of AGYW during the festival season when men were most likely to be home.

SUPPORT FOR DELAYING MARRIAGE AND CHILDBEARING

Focus group participants noted that, along with HTNYP, a number of initiatives have sensitized the HTNYP communities to the legal age of marriage in Nepal being age 20. The endline data showed increases among AGYW in their belief that their families and communities would support them delaying marriage (average +20% points) and motherhood (average +20%) until age 20.

³ The maximum reported number of home visits an individual family received was 4.

Despite the widespread knowledge and perceived support for delaying marriage, focus group discussants agreed that child marriage remains a challenge in their communities. Mentors in one focus group expressed the belief that, “People rarely marry at the right age in our locality. Guardians feel that since others are marrying their children off at a young age, they should not delay their children’s marriage. The children get married by the age of 16 to 18 years. Parents believe this is the time children get into bad habits, so they feel it’s best to get them married and settled down. It is also the prevalent norm followed in the community.”

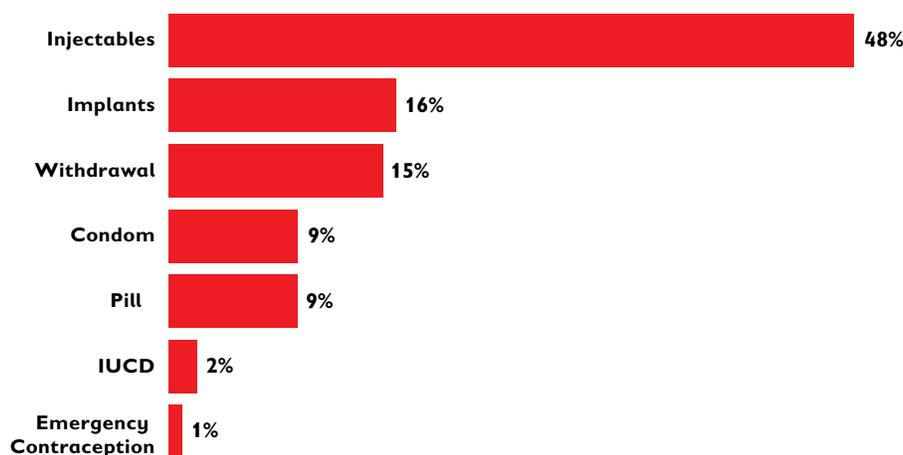
FAMILY PLANNING

Being familiar with FP methods is one aspect of being able to make informed choices about contraceptive use. All AGYW were able to name at least one contraceptive method at baseline. The AGYW surveyed at endline could name 9.6 of 10 contraceptive methods at endline, a significant increase from 7.2 at baseline.

Family planning use significantly increased from baseline to endline. As no unmarried AGYW in our sample reported using contraceptives, the data reflect 212 ever-married women. For the ever-married women in our sample, the contraceptive prevalence rate (CPR) for all methods statistically significantly increased from 29% at baseline to 38% at endline. The rate for modern contraception use also significantly increased from 26% at baseline for married women to 33% at endline.

The data showed similar trends for *ever use* of contraceptives, with statistically significant increases for all methods (54% at baseline, and 77% at endline) among married women reported as well as statistically significant increases in ever having used modern contraception (50% at baseline and 71% at endline). Current contraceptive use by method among married AGYW is shown in Figure 2.

Figure 2. Current Contraceptive Use by Method



Source: AGYW survey, authors’ calculations. $N_{EL}=81$.

At endline, all women (100%) who obtained an FP method at a health facility were very satisfied with the way they were treated by the health provider, a significant 38-percentage point increase from baseline, where only 62% were very satisfied with their treatment by the health provider.

“We used to be shy to ask for family planning methods and contraceptives, but now we can easily talk to the health practitioners at the health center.”

-Married AGYW focus group participant

Qualitative findings suggest that attitudes toward FP use are shifting, however, it remains more acceptable to use FP to space pregnancies and limit family size (particularly after having a son) rather than to delay first childbirth.

ANTENATAL CARE KNOWLEDGE AND USE



Receiving routine antenatal care (ANC) and being able to recognize danger signs during pregnancy are critical to enabling women to make timely and appropriate decisions that can reduce maternal mortality and morbidity. At baseline, the AGYW in our sample universally were aware of the need for ANC, and every respondent agreed that during pregnancy, women should have check-ups at a health institution. Of the 41 AGYW in our sample who gave birth during the past year, all reported receiving ANC, and 95% reported receiving ANC 4 times or more during their pregnancies.

When asked to identify danger signs during pregnancy, on average AGYW named 2.6 out of 5 danger signs, up from 1.8 at baseline. Over half of AGYW identified severe headache, dizziness, blurred vision, swollen hands and face, and extreme lower abdomen pain to be danger signs. Less than half recognized vaginal bleeding and stiff limbs/seizure/headache as danger signs.

LABOR AND DELIVERY KNOWLEDGE AND SERVICE USE



Knowledge of danger signs during labor statistically significantly increased as well at endline. Out of 6 danger signs, AGYW were able to identify 2.5 at endline compared to 1.8 at baseline. Hemorrhage and prolonged labor were recognized as danger signs by 60% and 63%, respectively. Other danger signs, such as breech pregnancy or cord prolapse were recognized by less than 1/3 of the AGYW.

32 of the 41 pregnant women in our survey gave birth in a facility and 9 had a home birth. 35 of the 41 women said that they had a say in where she would give birth, with 27 saying she decided jointly with her husband. By far the biggest challenge in accessing health facilities for delivery in the project area is the geography. For many women, they face difficult terrain, long distances, and a lack of transport that make getting to a health facility challenging.

POSTNATAL AND NEWBORN CARE KNOWLEDGE AND SERVICE USE



Essential newborn care and postnatal care improve the health and survival of newborns and mothers by identifying and managing immediate complications and promoting the continuation of appropriate care in the postpartum period. AGYW expressed a high level of awareness of and positive attitudes toward postnatal and newborn care at both baseline and endline in our sample. At endline, all AGYW agreed that newborn babies should have regular health checkups and vaccinations, and that women should have checkups after giving birth. In addition, AGYW were able to name 3.2 (of 6) practices they considered essential newborn care at endline, a significant increase from 2.3 at baseline. Likewise, AGYW were able to name on average 2.6 danger signs in the postpartum woman, an increase from 1.7 at baseline.

At endline, all 39 newborns⁴ born during the study period received at least one vaccination and 34 received all required vaccinations. The 39 mothers reported that they were currently breastfeeding

⁴ Two of the 41 infants born to AGYW in the survey did not survive. Cause of death is not available.

or that their infant was breastfed until at least 6 months of age. Focus group participants mentioned that traditional practices are slowly changing, including improper cord care, immediate bathing, and considering the postpartum mother to be “untouchable” or unclean.

GENDER EQUITABLE ATTITUDES



Changing gender attitudes, behaviors, and norms takes time. HTNYP measured AGYW’s perceptions on gendered statements related to sex, gender-based violence, and equality in the household by asking survey participants whether they agreed or disagreed. We found improvements across all statements, with some very large attitude changes toward some norms. Over half (55%) of AGYW agreed at baseline that a woman cannot refuse to have sex with her husband. At endline this decreased to only 39% of AGYW agreeing with the statement. Agreement with the statement, “it is a woman’s responsibility to avoid getting pregnant”, improved from 37% believing this at baseline to 24% agreeing at endline.

Focus group discussions indicate, however, that strong societal preferences for a son still prevail. According to project SMs, “When women give birth to a daughter, they are pressurized to give birth to a son soon after.”

LESSONS LEARNED

Evidence from the first cohort of AGYW who participated in HTNYP demonstrates that reaching them using a robust socio-ecological approach has potential for short- and long-term positive outcomes for RMNH behaviors. Our findings show that women’s attitudes towards RMNH care-seeking behavior, as well as their knowledge, significantly increased for several key indicators. The program included an integrated approach that addressed MNH, FP, gender; developed a high-quality curriculum; and intervened at multiple levels of the socio-ecological model, with AGYW, their husbands, families, community members, and health system to achieve positive changes to knowledge, attitudes, and health behaviors.



Photo : Save the Children/Shashank Shrestha

HTNYP has contributed to the available tools in Nepal by developing its participatory, comprehensive curriculum, Healthy Transitions (*Swastha Rupantaran*), for AGYW that can be used by projects in the future. The curriculum built upon tested interventions for first-time mothers and is aligned with the Adolescent Health & Development Strategy 2018 of Nepal.

The project has already seen the start of sustainability of AGYW groups as some groups have converted to community-based mothers groups and registered with their local government. In addition, several local governments allocated budget for these group activities to continue beyond the project. Finally, our work with the health facilities and providers has laid the foundation for adolescent-responsive services for the future.

LOOKING TO THE FUTURE

While our findings showed many positive changes, the 12-month evaluation time period did not allow sufficient time to assess long-term health outcomes, such as improved timing and spacing of pregnancies, and shifts in deep-rooted gender or social norms. Support of family and community members is necessary to progress and sustain the improvements in healthy behavior among AGYW.

“It is difficult to make the elder generation and the in-laws understand about the harms of orthodox practices...Though there has been change, significant change cannot be brought in such a short time. Therefore, the program must be conducted for a longer duration.”

-Social mobilizer focus group participant

Social mobilizers and mentors reported being more successful in their efforts when they had the support of municipality and ward governments, and collaboration will likely increase the economy of scale for desired outcomes.

Additional investments in the future would be well utilized in:

- **Adapting the program curriculum to be tailored to AGYW's life stage and existing knowledge base.** Unmarried and married AGYW perceived different sessions to be the most relevant to their lives, based on their life stage and experiences. Future cohorts of HTNYP or future projects in this area could consider adapting the curriculum based on the existing knowledge base of the program participants, and NGOs providing similar assistance in the same areas.
- **Consider adding a program component specifically targeted at young men.** As male migration is particularly high in the districts where HTNYP operates, continuing to generate evidence on effective ways to reach AGYW's husbands is needed. In addition, linking to programs that target boys and young men at an earlier age before they finish school, start formally working, and get married may increase effectiveness.



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