REACHING THE POOR WITH HEALTH SERVICES

2007

Nepal

Participatory Planning Improves Reproductive Health for Disadvantaged Youth

In Nepal, a country where young people's reproductive health needs are especially acute, a grassroots participatory approach has reduced the gap in reproductive health outcomes for young people with disadvantaged backgrounds. This approach has improved access, service quality, as well as young people's knowledge and behavior toward reproductive health.

A Worldwide Crisis

The world now has the largest generation of youth ever, more than a billion young people between the ages of 10 and 19, most living in developing countries. Many of these adolescents marry and start families, but because of social and moral assumptions and judgments concerning youth sexuality and service needs, they do not have access to reproductive health information and services. The worst-off are the women—poor, rural, and uneducated. The gaps for accessing service and information, affect not only the lives of these individuals but also the future well-being of their societies.

The Nepal Adolescent Project (NAP)

The development communities see participatory approaches as effective in increasing empowerment and accountability—two of the key factors in improving health services for the disadvantaged. The Nepal Adolescent Project (NAP) was a 5-year project conducted from 1998 to 2003, in collaboration with an international service delivery organization (EngenderHealth), an international research organization (International Center for Research on Women), and local Nepali NGOs (New ERA Ltd. and BP Memorial Health Foundation). To test the effectiveness of participatory versus non-participatory approaches to youth reproductive health, the project implemented programs in urban and rural study and control sites, with a total of four sites.

In the study sites, there was focus on involving the community and actively engaging disempowered groups, such as the poor, young women, and ethnic minorities, at every stage of the program. NAP took into account broader development priorities voiced by diverse members of the community. Thus, interventions aimed at improving youth-friendly services, peer education and counseling, were linked with broader interventions which had been prioritized by the community aimed at improving the socio-economic environment and opportunities for youth. These interventions included adult education programs, activities to address social norms, and access to economic livelihood opportunities. Consequently, the entire intervention package addressed structural, normative, and systemic barriers to youth reproductive health. Further, youth, parents, and other community members were actively engaged in implementing study site program activities through a wide variety of community-based groups set up during the project. In contrast, in the control sites, project staff designed and implemented standard reproductive health interventions that addressed only the most immediate risk factors, such as STDs or unwanted pregnancies. Socioeconomic disadvantages—based on gender, rural-urban residence, wealth, ethnicity, schooling status, and marital status—were a specific focus of the intervention design and approach in the study sites, whereas this was not the case in the control sites.

Poverty by household asset ownership was measured. Although poverty is critical, it is not the only disadvantage that keeps young people from accessing appropriate information and services around reproductive health. The study

looked at multiple types of disadvantage among young people in addition to poverty, namely, gender, rural-urban residence, and education status. Prenatal care, delivery at a health facility, and knowledge of HIV transmission were chosen as important reproductive health outcomes for which to examine the impact of various types of disadvantage among young people. Data for this study came from baseline (965 households) and endline (1003 households) cross-sectional quantitative surveys, as well as qualitative and participatory methods. The target age group at baseline was 14–21 year old males and females, married and unmarried. At the end of the intervention program, data was collected on 14–25 year olds, so as to capture all youth who could have participated in or benefited from the project.

Findings

The participatory approach was generally more successful in reducing advantage-based differences in youth reproductive health outcomes. Results were measured on three indicators: institutional delivery, prenatal care, and knowledge of HIV/AIDS transmission. In both groups, the overlap between household wealth status and urban-rural status was almost synonymous with rural-urban residence, and the gap between the two groups was wide. Two other measures of disadvantage—education and ethnicity—also overlap substantially with both wealth and rural-urban residence.

Delivery in a health facility. At baseline, both the study and control sites showed substantial differences between rich and poor young women's access to a health facility for pregnancy delivery (Figure 1). By the endline, poor young women in the study sites were closer in their access to prenatal care when compared to better-off women, but a similar change was not evident in the control sites. As Figure 1 shows, this is because the improvement in access to delivery at a health facility was entirely among the poorer 50 percent of the population in the study site, whereas in the control sites, both the rich and the poor gained.

Prenatal care. Regression results show that before the intervention, an urban young woman in the study site was 16 times more likely to get prenatal care than her rural counterpart. By the end of the project she was only 1.2 times more likely to receive prenatal care. The control sites do not show a similar improvement of access to prenatal care among rural young women (Malhotra et al. 2004).

Accurate knowledge of HIV transmission. In all the sites at baseline, girls were less likely to be able to correctly identify at least two modes of HIV transmission when compared with boys. In the urban study site, the intervention led to such a substantial improvement in knowledge among girls that the proportion of girls who were knowledgeable about HIV actually surpassed the proportion of boys. A similar change was not observable in the control sites. At the same time however, neither type of intervention was able to substantially reduce the difference in knowledge regarding HIV among the educated and the uneducated (Malhotra et al. 2004).

Why Did the Participatory Approach Work?

The participatory approach succeeded mainly due to three aspects of the approach: (1) facilitating coproduction of services; (2) empowering young people and increasing the accountability of service providers and policy makers to the community; and (3) increasing community demand for information and services.

Coproduction

The nature of adolescent reproductive health makes it especially amenable to coproduction and self-service by clients, and the participatory intervention design facilitated such coproduction. Well-informed and trained peers, and reliable social networks, emerged as sources of service provision. The study site interventions tapped and strengthened social networks for information exchange and counseling, while the control site interventions did not. Young people's understanding of what the services mean and how best to use them also showed greater improvement in the study sites than in the control sites.

Empowerment and Accountability

An active effort was made to impart information and build decision-making structures and coalitions. The participatory approach was more successful in empowering youths and adult community members and increasing the accountability of providers and policy makers to the communities. Committees, task forces, and youth clubs set up in the study sites fostered community skills in consensus building, decision making, planning, organizing, consulting, and demanding resources and accountability from the various actors. For example, adults and young people learned to negotiate with the village development committee and came to feel that *jointly* they could demand government funds to continue project activities. Providers were trained by the program to be

youth-friendly, courteous, and responsive, and young people were made aware that they could enforce these expectations.

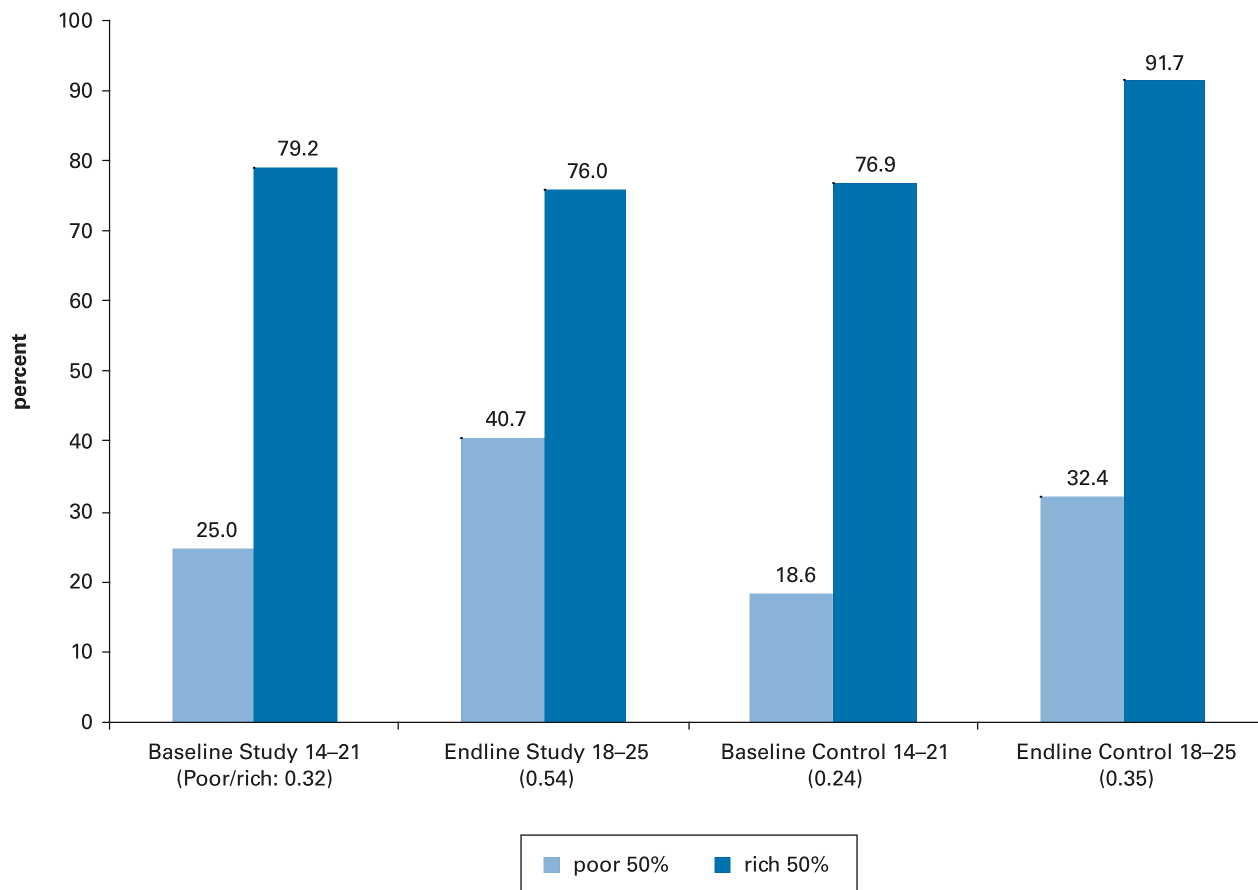
Community Demand

In the study sites, the focus was not just on altering reproductive health outcomes but also on changing basic social norms and institutions, as a major factor in increasing demand for information and services among the disadvantaged. The participatory approach generated a new mindset in the communities, marked by a deeper, more sophisticated understanding of youth reproductive health and its implications for a range of life outcomes. The communities are also clearer about how family, gender, social structures, and norms constrain healthier sexual and reproductive behavior. This enriched understanding is an assurance for a sustainable demand for youth reproductive health services.

Conclusions

Small-scale community efforts can achieve empowerment and accountability. Specifically, participatory approaches can successfully provide youth, especially disadvantaged youth, the means to negotiate for appropriate, accessible, and accurate information and services from parents, providers and policy makers. The critical need for broader definitions of disadvantage should be recognized. There is no dispute that poverty is a key and powerful measure of disadvantage. Nonetheless, in many rural communities in the developing

Figure 1. **Delivery in a Medical Facility: First Pregnancy, Poor and Nonpoor Young Married Women, Nepal**



Source: Nepal Adolescent Project, 1999 baseline adolescent and household surveys and 2003 end-line adolescent and household surveys.

world, those who are most disadvantaged owe this disadvantage to complex and interwoven interactions between various contextual factors that need to be considered. Analyses of poverty as a measure of disadvantage need to be accompanied by analyses of rural-urban residence, gender, and educational access as other important markers of social, cultural, and economic differentials.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It is based on "Nepal: The Distributional Impact of Participatory Approaches on Reproductive Health for Disadvantaged Youths, chapter 11 in Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why" (Washington, D.C.: World Bank, 2005); and the special report "Do Participatory Programs Work? Improving Reproductive Health for Disadvantaged Youth in Nepal" in the World Bank Institute's Development Outreach, May 2006 issue. The views expressed in this note do not necessarily reflect those of the World Bank.