Underlying Causes of Poverty and Vulnerability Assessment (UCPVA): An Effective Tool to Prioritize Programs Geographically

USAID Adolescent Reproductive Health (ARH) Program

Underlying Causes of Poverty Analysis workshop in Karnali Province

Program Snapshot

Life of Project: 2022 – 2025

Geographical Focus: 60 municipalities across 11 districts in 3 provinces: Madhesh (41), Lumbini (12), Karnali (7)

Prime Partners: CARE Nepal

Consortium Partners: Howard Delafield International (HDI), Jhpiego, Associations of Youth Networks of Nepal (AYON), Nepal Contraceptive Retail Sales (NCRS) Company

Digital Partners: Social Awareness Center Nepal (Surkhet), Dalit Development Society (Salyan), Rural Development and Awareness Society Nepal (Rolpa), BEE Group (Banke), Mallarani Rural Development Concern Center (Pyuthan), Aasaman Nepal (Dhanusha), CNRD (Rautahat), Bagmati Welfare Society

About the Program

USAID Adolescent Reproductive Health (ARH) was a three-year (initially five-year), USAID-funded project led by CARE Nepal in partnership with HDI, Jhpiego, AYON, and Nepal CRS Company from 2022 to 2025. The project supported the Government of Nepal (GoN) in improving adolescents' reproductive health with the goal of empowering adolescents (10-19 years) to reach their full potential and practice healthy reproductive behaviors. To achieve these goals, USAID ARH employed multichannel social and behavior change strategies, including group-based interventions, interpersonal communication, and youth- and girl-led activism for reproductive health and social norms change, supported by service linkages amplified by digital interventions.

The Government of Nepal launched the National Adolescent Health and Development Strategy in 2018 to address key issues identified in the Nepal Demographic and Health Survey, particularly the high rates of adolescent marriage and pregnancy. The strategy underscores the critical need to create an environment that promotes healthy reproductive health practices among adolescents. In 2022, the GoN reinforced this effort by endorsing the Adolescent-Friendly Reproductive Health Services Guidelines. Aligned with these national initiatives, USAID ARH collaborated with federal, provincial, and municipal governments in Madhesh, Lumbini, and Karnali Provinces to improve the reproductive health of adolescents aged 10-19, with a focus on disadvantaged populations.

Introduction: Underlying Causes of Poverty and Vulnerability Analysis (UCPVA)

The UCPVA is a participatory, reflective, empowering, and action-oriented approach with a set of tools and is one of the signature approaches of CARE Nepal. This assessment assists in identifying poverty-stricken areas, disadvantaged groups, and their specialized requirements by considering social structures, discrimination, access to public resources, land tenure, and political culture. It investigates poverty's political, social, economic, and environmental causes by focusing on state systems and social programs to evaluate economic possibilities and environmental circumstances. The UCPVA tool includes a variety of approaches such as Power Mapping, Social Resource and Vulnerability Mapping, Class or Well-Being Ranking, Dependency Analysis, Historical Timelines, Wage Analysis Matrices, and Seasonal Calendars.

CARE has been working in Nepal since 1978. Initially, CARE addressed basic needs through infrastructure development, agricultural extension, and natural resource management. However, in the 1990s, its approach shifted to a diversified portfolio emphasizing community-based "human infrastructure development." During this period, CARE Nepal used various Participatory Rural Appraisal (PRA) tools to understand community needs to plan, implement, and monitor projects. Although these approaches improved living conditions, they did not significantly enhance social status and dignity. Learning from this, CARE evolved its approach from need-based to rights-based, transitioning from direct service delivery to partnerships with local organizations. This shift led to the development of the **Underlying Causes of Poverty and Vulnerability Assessment (UCPVA),** an enhanced tool built upon PRA methodologies.

Why did we do it?

- To assess and rank the most vulnerable wards across 60 USAID ARH working municipalities.
- To enable the program to target interventions toward the most vulnerable communities, with strategies tailored to address their unique challenges.
- To strengthen stakeholder collaboration and ensure that interventions were holistic and responsive to local needs.

What did we do?

Step 1. Desk Review & Design: CARE Nepal published and reviewed the UCPVA manual with USAID ARH-related information and relevant ARH policies. The assessment tools were adopted and customized for the USAID ARH program. The relevant tools, such as Power Mapping, Matrix Ranking, Seasonal Migration Analysis, Social Mapping, and Mobility Analysis, could be adapted for different contexts.
Before finalization, a pre-test of the municipality mapping and matrix ranking was conducted in a non-USAID ARH program area at Barahatal Rural Municipality, Surkhet, in the presence of the chairperson, deputy chairperson, ward chairperson, and other representatives. Feedback from the pretest was incorporated to finalize the tools.

Step 2. Capacity Development: A practicum-based UCPVA training was organized to enhance the knowledge and skills of USAID ARH project staff about UCPVA and its use in real settings. This ensured they could follow the process and use tools properly. The tool use exercise was carried out in a working setting, which provided an opportunity to practice the tools in a realistic situation.

Step 3: Municipality Workshop for Assessment: A workshop was organized at the municipality with the presence of key local-level stakeholders' executive members, health workers, teachers, social workers, FHCV, and adolescents to conduct municipality mapping and matrix ranking.

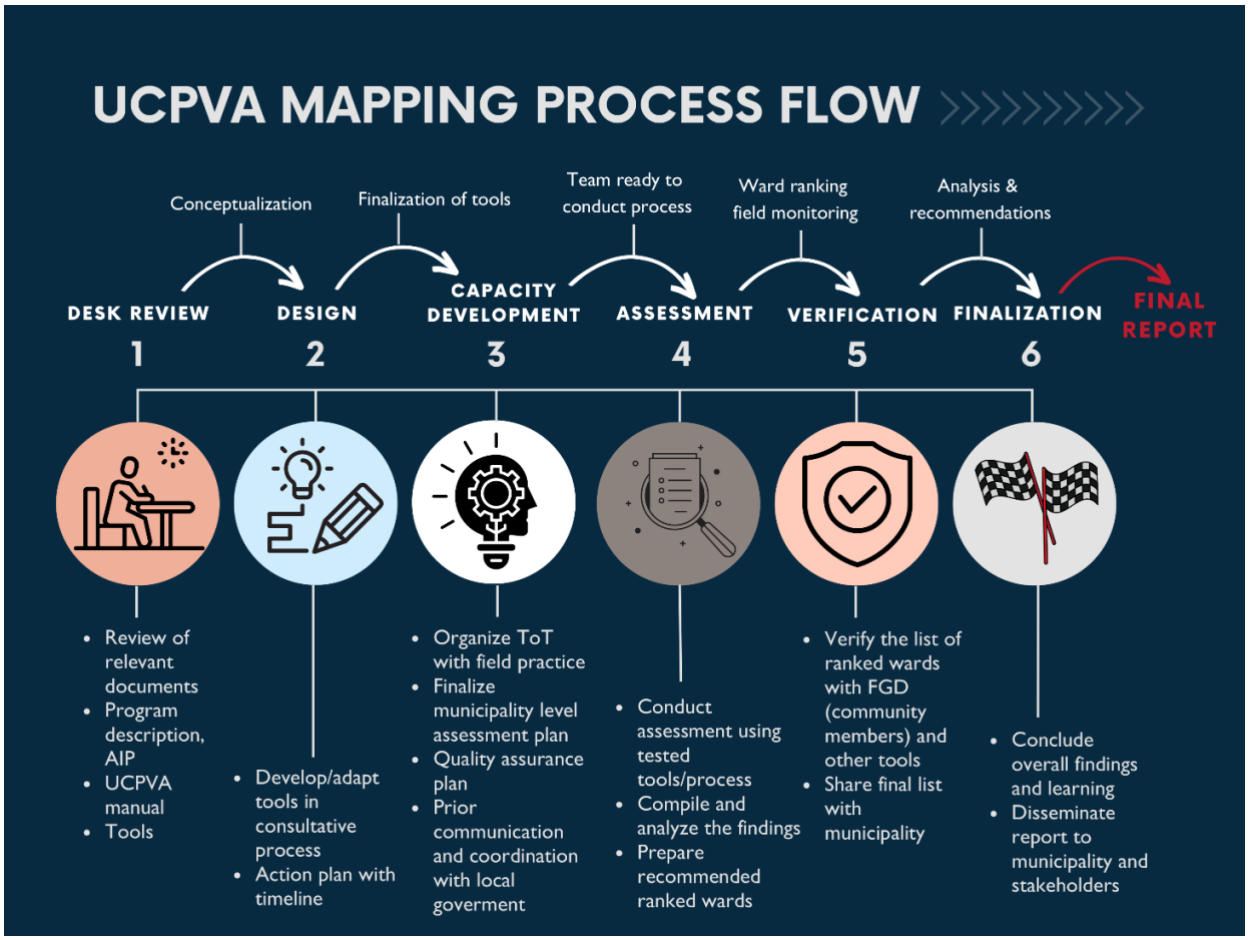
- **Municipality mapping** was the first step during the workshop. To facilitate informed decision-making, a detailed map of the local level was presented. This map served as a visual aid to assess the distribution of key services across each ward. Municipality mapping was done to prioritize the ward through the use of processes like *social mapping-locating.* This process helped locate the health facilities, road networks, schools, settlements of disadvantaged communities, and so on, within the municipalities. This participatory approach ensured a well-rounded understanding of each ward's strengths and weaknesses and provided a basis for ward ranking.

- Following this, **matrix ranking** was done to further verify/triangulate the rank of the wards. Decisions were based on the relative qualitative perspective of six key indicators: 1. school drop-out status, 2. child marriage, 3. access to ARH service, 4. participation of adolescents in different group activities, 5. limited number of people with disabilities, and 6. minimally disadvantaged population. The essential data was considered in coordination with the municipal office and reliable sources like the National Survey. This participatory reflective discussion facilitated ranking the wards from high-performing to low-performing, successfully identifying the 6 lowest-performing wards as the most vulnerable wards.

- Furthermore, **Mobility Mapping tools** were used to identify mobility patterns, including the type, trend, place, and purpose in the prioritized wards. **Seasonal Migration tools** were utilized to identify the seasonal migration trends of adolescent boys and girls in the prioritized wards of the respective R/Municipality. The purpose of using these tools with adolescent boys and girls was to find out their beliefs/perceptions on RH and service-seeking practice/behavior. This also helped identify the status of service accessibility, seasonal migration patterns, and their impact on RH services.

Step 4: Validation: FGDs were conducted in the ranked wards at the community level to verify and validate the final ranking results obtained from municipality mapping and matrix ranking. The FGDs were carried out in 20% of the six lowest-performing wards. The FGDs were conducted with mixed participants, including schoolteachers, public/private health facility representatives, FCHVs, persons with disability, adolescent girls and boys, who provided valuable insights from participants, offering qualitative information that enriched the findings.

Step 5: Dissemination: The team documented the results, key findings, and lessons learned from the UCPVA process and developed a concise report for distribution to the municipality and stakeholders. This shared knowledge product helped to ensure transparency, a shared understanding, and informed decision-making while promoting accountability in follow-up actions.



What were the enabling factors?

- **Participatory tools:** The active engagement of stakeholders and community members in the UCVPA tools ensured their voices were heard in the assessment and prioritization. This approach strengthened community ownership and enhanced the effectiveness of the interventions.
- **Comprehensive Implementation Guideline:** A fully developed and detailed guideline, outlined with clear explanations and rationales, helped facilitators grasp the process thoroughly. By standardizing the process, the guideline ensured consistency within the team.
- **Capacity Building:** A hands-on UCPVA training bolstered the knowledge and skills of USAID ARH project staff, enabling them to navigate the process and utilize its tools.

Key Challenges

- **Ranking Wards in Larger Municipalities**: Due to limitations in the matrix tool, it was difficult to rank sub-metropolitan or metropolitan cities with more than 15 wards.
- **Lack of Evidence-Based Data**: Some indicators were challenging to assess due to the absence of reliable, evidence-based data at certain local levels. However, the challenges were mitigated by leveraging contextual scenarios and first-hand experiences of stakeholders, which provided valuable qualitative insight to guide the process effectively.

- **Tool Limitation in Differentiation**: The UCPVA tool could not accurately differentiate and prioritize wards in diverse socio-economic and geographic contexts.

Key Lessons Learned

- **Utilizing Stakeholder Insights**: The integration of qualitative insights proved instrumental in addressing the absence of evidence-based data. Stakeholder perceptions, contextual analyses, and firsthand experiences provided valuable guidance for effective decision-making and process optimization.
- **Advantages of a Participatory Approach**: Active involvement of local governments and stakeholders in participatory methodologies, like the UCPVA, significantly enhanced their ownership of project components. This approach strengthened their comprehension of project objectives and facilitated collaborative engagement and accountability.
- **Promoting Awareness and Accountability**: Disseminating findings to municipal and ward officials raised awareness about adolescent reproductive health issues. This practice also reinforced accountability by ensuring these issues were incorporated in local governance planning and budgeting processes.
- **Facilitating Open Dialogue**: Participatory frameworks fostered platforms for open discussions among political representatives. This enabled a more comprehensive understanding of ward-level challenges and realities, leading to informed decision-making.

Way Forward

To advance program effectiveness, it is imperative to refine tools such as the UCPVA to improve ward prioritization in larger municipalities, supported by robust systems for evidence-based data collection and management at the local level. Institutionalizing participatory methodologies within local government planning processes and fostering collaboration across multiple stakeholders will promote sustainability and inclusivity. Targeted capacity-building initiatives for local officials and stakeholders are critical for enhancing their competencies in addressing adolescent reproductive health challenges while implementing comprehensive monitoring and evaluation frameworks that will enable iterative, data-driven improvements. Furthermore, strategic advocacy should prioritize securing policy endorsements, increasing budget allocations, and integrating adolescent reproductive health priorities into local development frameworks to ensure sustained and impactful outcomes.

To effectively scale up adolescent reproductive health (ARH) initiatives, it is imperative to institutionalize tools such as the UCPVA within governance frameworks, ensuring their integration into planning and decision-making processes. Expanding stakeholder engagement through multi-sectoral partnerships will foster broader collaboration and resource sharing.