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Adolescent girls at UDAAN Center. Photo Credit:CARE Nepal for USAID

SEPTEMBER 2023

USAID ADOLESCENT REPRODUCTIVE HEALTH (ARH) SOCIAL AND BEHAVIOR CHANGE (SBC) STRATEGY

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SEPTEMBER 2023

LIST OF ACRONYMS

ARH	Adolescent Reproductive Health
AWD	Adolescent with Disabilities
AYON	Association of Youth Organizations Nepal
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CEHRD	Centre for Education and Human Resource Development
ECP	Emergency Contraceptive Pill
FCHV	Female Community Health Volunteer
FP	Family Planning
GBV	Gender-based Violence
GESI	Gender Equality and Social Inclusion
GEWV	Gender Equality Women's Voice
GoN	Government of Nepal
HDI	Howard Delafield International
HFOMCs	Health Facility Operation and Management Committees
HMG	Health Mothers Group
HMIS	Health Management Information System
IPC	Interpersonal Communication
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MEL	Monitoring, Evaluation, & Learning
MHH	Menstrual Health and Hygiene
MoHP	Ministry of Health and Population
MoST	Ministry of Education, Science and Technology
NHEICC	National Health Education Information and Communication Center
OOS	Out of School
RH	Reproductive Health
SAA	Social Analysis and Action
SBC	Social and behavior change
SBCC	Social and behavior change communication
SDG	Sustainable Development Goal
SNAP	Social Norms Analysis Plot (SNAP)
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
UCPVA	Underlying Cause of Poverty and Vulnerability Assessment
USAID	United States Agency for International Development

Acknowledgements

USAID Adolescent Reproductive Health (ARH) is a five-year, USAID-funded project supporting the Government of Nepal (GON) to improve adolescents' reproductive health in 11 districts and 60 municipalities of Madhesh, Karnali and Lumbini provinces from 2022 to 2027. This strategy is key to guiding activities and approaches that will empower adolescents to reach their full potential by ensuring they receive correct and appropriate Family Planning (FP) / Reproductive Health (RH) information and make informed decisions and practice healthy reproductive behaviors.

This SBC strategy was developed in close coordination and collaboration with the Government of Nepal (GoN), harmonizing with and complementing the National SRHR SBCC strategy, developed by Ministry of Health and Population (MoHP) and National Health Education Information and Communication Center (NHEICC). The strategy complements the National SRHR SBCC strategy by addressing the specific needs of adolescents, including adolescents with disabilities and LGBTQI+.

First and foremost, USAID ARH extends its heartfelt appreciation to the Government of Nepal (GoN), especially the National Health Education Information and Communication Center (NHEICC), Mr. Sunil Raj Sharma, Director NHEICC, Ms. Sheela Shrestha, Section Chief NHEICC and Ms. Kabita Aryal, Section Chief Family Welfare Division (FWD) for their unwavering support, invaluable guidance, and input in shaping this strategy.

We are equally grateful for the contributions and active participation of key field level stakeholders, including adolescents, for the development of this strategy. These collaborative efforts have ensured that the social behavior change (SBC) priorities, approaches, activities, and messages outlined in this strategy align with and contribute to the GoN's national strategic priorities in adolescent reproductive health, while harmonizing with the efforts of other development partners.

We would like to acknowledge Netra Prasad Bhatta, senior program specialist- FP/RH, USAID for his valuable inputs in the finalization of this strategy. Special recognition is extended to Sujata Singh, GESI, SBC and Social Norms Coordinator, USAID ARH, for her role in writing this SBC strategy. Our sincere thanks go to Suzanne Reier, Chief of Party, USAID ARH, and Shefa Sikder, Senior Technical Advisor, CARE USA, for their meticulous review and editing of this strategy. We also acknowledge Min Raj Gyawali, Deputy Chief of Party, USAID ARH, Santa Dangol, technical director for USAID ARH, and Suniti Neogy, senior technical advisor, CARE USA for their valuable inputs in the finalization of this strategy.

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Introduction

A participant of Focus Group Discussion from Bara. Photo Credit:CARE Nepal for USAID

USAID Adolescent Reproductive Health (ARH) is a five-year, USAID-funded project supporting the Government of Nepal (GON) in improving adolescents' reproductive health in 11 districts and 60 municipalities of Madhesh, Karnali and Lumbini provinces from 2022 to 2027. CARE Nepal leads USAID ARH in partnership with Howard Delafield International (HDI), Jhpiego, Association of Youth Organizations Nepal (AYON), and Nepal CRS Company. The project goal is to empower adolescents (10-19 years) to reach their full potential by ensuring they receive correct and appropriate family planning (FP)/reproductive health (RH) information and make informed decisions and practice healthy reproductive behaviors.

The program aims to reach 1.5 million individuals, targeting 560,000 adolescents across 596 wards in 60 municipalities in the three target provinces through an evidence-based, innovative approach focused on social and behavior change and enabling an adolescent-responsive health system. To achieve results, the program aims to use multichannel social and behavior change approaches, including group-based interventions, interpersonal communication, and youth- and girl-led activism for FP/RH and social norms change, supported by service linkages amplified by digital interventions (i.e. digital game, ARH web portal and social media campaigns).

The Social and Behavior Change (SBC) strategy outlined in the document is intended to guide USAID ARH to align interventions with key behaviors designed to build agency of adolescents to make appropriate decisions regarding healthy reproductive behaviors. The SBC strategy has outlined ten specific behaviors that are related to adolescent reproductive health. In line with the principles of adaptive management, this strategy will be flexible to add or change prioritized behaviors or approaches based on need and evolving context. This SBC strategy reflects ARH's focus areas of health system strengthening, quality assurance, private sector engagement, youth mobilization, governance and gender equality and social inclusion (GESI).

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Rationale for the USAID ARH Social and Behavior Change (SBC) Strategy

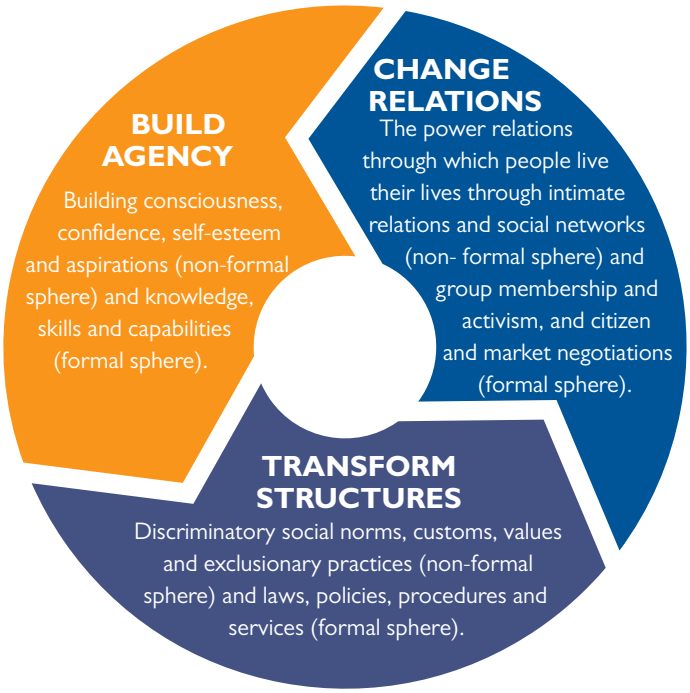
Adolescent girls during SAA session. Photo Credit:CARE Nepal for USAID

The science around changing health-related behaviors has shifted from an initial focus on communication to sustainable behavior change. The current terminology adopted by USAID and others is Social and Behavior Change (SBC) including not only communication, but also actions to create an enabling environment for sustained behavior change. The actions may be formulation of policy, provision of needed systems, services, or infrastructure, social support, or measures to shift social norms. We use the terminology SBC Strategy in this document.

Adolescents continue to face specific challenges in practicing healthy reproductive behaviors, including gaps in knowledge and behaviors. Among adolescent girls aged 15-19 surveyed in Nepal's 2016 Demographic and Health Survey, only 23% had accurate knowledge of the fertile period and only four percent of surveyed married women aged 15-19 years reported use of a modern contraceptive method. Evidence shows that adolescence involves a unique phase of rapid physical, cognitive and psychosocial growth which affects decision-making including around reproductive health. To address the unique needs of adolescents, USAID ARH has developed a tailored Social and Behavior Change Strategy to address specific barriers to practicing healthy reproductive health behaviors. We also include considerations to address factors of marginalization among adolescents including those adolescents with disabilities (AWD), Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+) and other marginalized groups.

Building on evidence and strong theoretical foundations on human and behavior-centered design for social change, the SBC strategy of USAID ARH is grounded in CARE's Gender Equality and Women's Voice (GEWV) framework (Figure 1). This framework operates at each level of the socioecological framework to simultaneously address individual agency, family and community relations, and formal and informal structures for sustainable behavior

Figure 1. CARE's Gender Equality and Women's Voice Framework

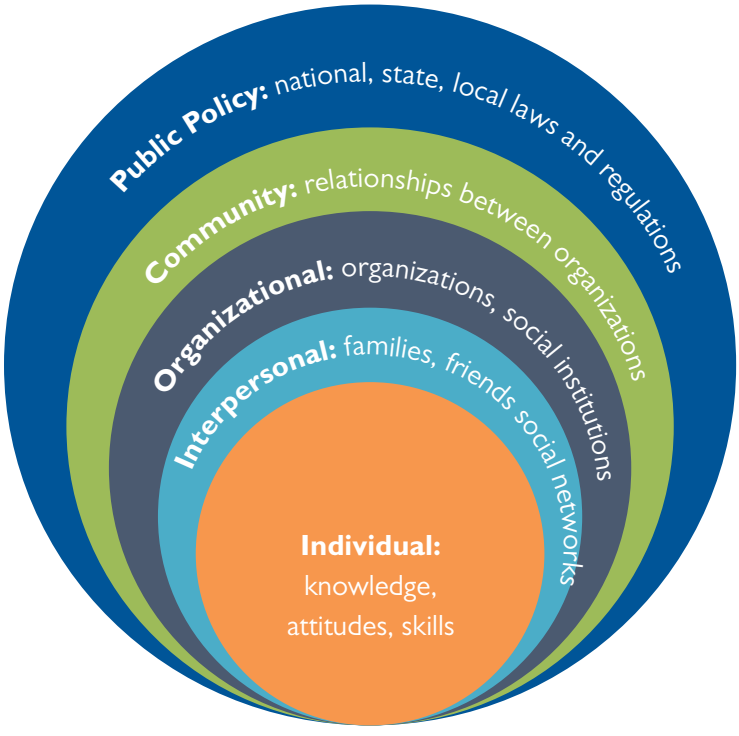


change. The USAID ARH-SBC strategy leverages gender-transformative approaches to address social norms. These approaches support sustainable behavior change by addressing reflective knowledge, norms, and reflexive (habit) drivers. The SBC strategy focuses on interventions at multiple levels, based on the socio-ecological model (Figure 2).

Furthermore, the Ministry of Health and Population (MoHP) and National Health Education Information and Communication Center (NHEICC) is in the process of endorsing the National Sexual Reproductive Health and Rights (SRHR) SBCC Strategy (2022-2026), which focuses on improving and increasing awareness, demand, and utilization of SRH services and rights. Harmonizing with and complementing the National SRHR SBCC strategy, USAID ARH's SBC strategy will fill gaps that address the specific needs of adolescents including adolescents with disabilities and LGBTQI+.

The government of Nepal has several policies supportive of adolescent reproductive health. The Constitution of Nepal 2015 has described health as a basic fundamental right, with every woman entitled to the right to safe motherhood and reproductive health. The Government of Nepal is committed to achieving the Sustainable Development Goals' (SDG) targets, with SDG 3 focused on "Ensuring healthy lives and promoting well-being for all at all ages." Nepal's Right to Safe Motherhood and Reproductive Health Act, 2075 (Act No. 9) envisions that every woman and adolescent shall have the right to obtain education, information, counseling, and services relating to SRH. The Act has been endorsed by the government and is in the implementation phase, with the accompanying Right to Safe Motherhood and Reproductive Health Regulation 2077 also endorsed. Nepal's National Health Policy 2076 (2019) indicates that there is a need to improve coordination among three levels of government to strengthen the existing health system, increase access to quality services, and strengthen health awareness and practices. The National Adolescent Health and Development Strategy 2075 (2018) and implementation guideline (2022) also recognizes the importance of identifying facilitating factors to take appropriate measures to minimize obstacles to practicing healthy reproductive behaviors. It also emphasizes the need for extensive cooperation and collaboration with multiple stakeholders, and other related sectors.

Figure 2. Socio-ecological model adapted for USAID ARH



3
Guiding Principles of the SBC Strategy

Participants of a Focus Group Discussion on game concept testing conducted in Bara. Photo Credit:CARE Nepal for USAID

Human Centered Design: USAID ARH's approach puts adolescents at the center by engaging adolescents not only as recipients but also in co-design to help ensure that intervention strategies will sustainably address the barriers faced by adolescents to adopt healthy reproductive behaviors. During the SBC strategy development, USAID ARH held a series of interactive events and co-design sessions with adolescents to understand the barriers that they face and identify the facilitators to healthy reproductive behaviors.

Voluntarism and Informed Choice: USAID ARH's approach is based on ensuring that adolescents have access to comprehensive information on reproductive health to enable voluntary decisions free from coercion.

Inclusivity (disability, LGBTQI+ and other marginalized groups): Discriminatory socio-cultural norms marginalize and exclude various adolescents from accessing RH information and services based on factors such as disability, LGBTQI+, caste, ethnicity, age, etc. Therefore, social inclusion is at the core of this ARH SBC strategy to ensure that no adolescents are left behind.

Evidence based and data driven: This strategy is informed by USAID ARH's formative research and baseline survey, field visits and co-design sessions reflecting the lived experiences of adolescents in different program geographies and contexts.

Family Inclusion approach: USAID ARH formative research has identified that adolescents' mothers and fathers are important behavior influencers and gatekeepers for adolescents to adopt healthy reproductive behaviors. Therefore, only targeting adolescents for behavior change will not contribute to adolescents' sustainable behavior change. Based on formative research findings, USAID ARH prioritizes engaging influencers including mothers and fathers of adolescents as secondary target groups to change family relations and power dynamics within the family while empowering adolescents.

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SBC Strategy Development Process

Adolescent girls at UDAAN Center, Madhesh Province. Photo Credit:CARE Nepal for USAID

USAID ARH undertook a human-centered approach to develop this Social and Behavior Change Strategy. Consultations with adolescents in the three provinces and influencers of adolescents (parents, young male husbands, teachers, religious leaders, health service providers and government stakeholders) were conducted to understand the context and validate approaches. In addition to these consultations, the team conducted the following steps to complete this SBC strategy:

Desk Review: All relevant documents were reviewed in the process of this SBC strategy development. These include the SRHR-SBCC Strategy (2022-2026), Right to Safe Motherhood and Reproductive Health Act, 2075, National Health Policy 2076 (2019), Adolescent Friendly Health Service Guideline, and the National Adolescent Health and Development Strategy among others.

Focus Group Discussions (FGDs): Focus group discussions were conducted in five districts with adolescents, parents, religious leaders, teachers and service providers. The FGDs were selected to cover a range of geographic areas (i.e. Dailekh and Surkhet of Karnali province, Bardia of Lumbini province and Dhanusha and Mahottari of Madhesh province). These discussions centered on adolescents' lived reality, determinants affecting their ARH behaviors, and social norms barriers to practice healthy reproductive behaviors.

Formative Research: The project also conducted formative research to identify the key social norms barriers to adolescent reproductive health across project provinces. The strategy identified ten priority behaviors targeting adolescents and secondary target groups.

Consultation Workshop with government and stakeholders: A consultation workshop was organized with the National Health Education and Information Communication Center (NHEICC), Family Welfare Division (FWD), USAID, and other relevant stakeholders working on ARH to share the draft SBC strategy for input. This workshop also served to harmonize and refine already existing ARH-related messages developed by NHEICC and other development partners with the USAID ARH SBC strategy.

Finalization of the SBC strategy: Based on feedback and inputs received during the stakeholder validation workshop, this SBC strategy was finalized.

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Key Findings of Formative Research

Adolescent boys during SAA session. Photo Credit:CARE Nepal for USAID

Key findings from USAID ARH's formative research are presented in three main categories 1. Behavioral, normative, and social barriers and enablers, 2. Program operating context, and 3. Information related to program approaches and adaptations:

1. Behavioral, Normative and Social Barriers and Enablers

- The findings suggest several social and gender norms exist in society that impede adolescents from achieving their reproductive health, including child marriage, the practice of dowry, early pregnancy, untouchability during menstruation, societal and family pressure to have children immediately after marriage, son preference, mobility restrictions before marriage for adolescent girls, and dominance by males in family planning decision-making. Additionally, misconceptions around use of sanitary pads (e.g., use of pads affects girls' ability to conceive) exist in some study areas. Open discussion about family planning/reproductive health (FP/RH) is often taboo and the adolescent's character is brought into question if they are found to be talking about family planning.

- Unmarried adolescent girls are not allowed to talk about FP at all and conversations about family planning are limited to married adolescents. There is a perception that unmarried adolescent girls do not need any FP/RH services except those related to menstrual health and hygiene.

- Unmarried adolescents using family planning is unacceptable, however married adolescents using contraceptives for birth spacing after at least one birth is considered normal.

- Enabler to leverage aspirations: Formative research findings show that the main aspiration for both parents and adolescents is to get a good

education and become independent. Adolescents want to complete schooling, start a career, and thus, through education, have a good life in the future. Most adolescents responded that a good education and having a career in the future can lead to a good life, otherwise they will end up marrying early and live an unsatisfied life.

2. Program Operating Context

- Major sources of information for adolescents were school, teachers, books, friends, digital platforms, sisters-in-law, mothers, social media (Facebook and YouTube), health workers and FCHVs.
- Family planning services are provided in most of the health facilities including those offering postpartum and post abortion services.
- None of the six visited public health facilities in the targeted geographies were adolescent responsive. Some of the challenges in providing adolescent-responsive services were lack of provider confidence, training, and clarity among health workers in counseling or providing services for adolescents, and lack of communication/ counseling materials for adolescents.
- Unmarried adolescent girls rarely visit health facilities to seek FP/RH services. Some adolescent boys go to seek condoms and emergency contraceptive pills (ECP).
- Adolescents preferred to access FP/RH services from private health facilities rather than public facilities because of confidentiality, behavior of the service providers, and quick service.
- Adolescents preferred print materials to be in Nepali and audio-visual aids to be in local languages (Nepali, Maithali, Bhojpuri, Awadhi, etc.).
- None of the health facilities were prepared for inclusion of disabled adolescents. The visited health facilities are not accessible to people who have physical disabilities and have no mechanism to ensure that the needs of adolescents with disabilities are addressed. The health workers are unaware of reproductive needs of people with disabilities hence they have a perspective that FP/ RH related services are not necessary for people with disabilities.
- The needs of adolescents have not been prioritized while planning programs and budgeting at the local level.
- None of the key stakeholders reported receiving complaints/cases of gender-based violence (GBV) from the community even though they are aware of many GBV cases happening in their community. No legal action has been taken as none of the municipalities visited had a GBV policy in place to address those issues and not many cases are formally reported.
- Although some municipalities have a Gender Equality and Social Inclusion (GESI) plan, there remain challenges in implementation as gender-sensitive policies are largely influenced by social norms.
- There is no separate FP/RH coordination committee in the six municipalities visited.
- Adolescents in Madhesh province have not heard about health mothers' groups (HMGs) while those in Lumbini and Karnali province have heard about HMGs but don't know what happens in the group meeting.
- The secondary schools visited implemented menstrual pad distribution and iron folic acid (IFA) distribution. Most municipalities have not taken any steps to develop an RH curriculum.
- The school health nurse program exists in two municipalities among the geographies where formative research was conducted. Some of the challenges faced by the school health nurse were lack of adolescent sexual and reproductive

health training, session plans, teaching aids and communication materials.

3. Information Influencing Program Approaches and Adaptations

- Mothers were identified as the most important person in the life of adolescent girls and boys; however, adolescents feel more comfortable talking to friends about FP/RH issues but will talk to their mothers about other personal matters not related to reproductive health.

- Girls and boys both wanted to be financially independent before getting married. They aspire to become doctors, engineers, nurses, police officers (among school-going adolescents) and obtain foreign employment (among out-of-school adolescent boys). School dropouts are found to be common among adolescent boys and girls in Madhesh province, including in Muslim communities where girls face pressure to drop out of school to get married. Poverty, unemployment, and poor quality of education were some of the reasons for dropping out of school. All the adolescent boys and girls were keen to be a part of a group where they could discuss reproductive health matters. They wanted this group to be homogenous in gender and within their school (for in-school) and community (for out-of-school). Parents preferred to have separate groups for mothers and fathers for parental engagement activities.

- Adolescents have never been exposed to peer mentoring approaches in the study areas. When explained, all of them liked the concept and preferred to have a peer mentor who is of the same sex, a little bit older than them, and more knowledgeable than them.

- Private service providers were interested in collaborating with the public sector in ARH. If provided training, they showed their readiness to report in the integrated Health Management Information System (HMIS). All service providers unanimously agreed that streamlining private facilities' reporting in the government HMIS system is a necessity.

- Health facility operations and management committees (HFOMCs) were functional in all areas except for some health facilities in Madhesh province. The proactiveness of the HFOMCs in the overall management of the health facility varied across the districts with some providing support on an as-needed basis and others delaying decision-making to resolve health facility-related issues. Only one of the health facilities included adolescents in these committees.

6

Major Elements of the SBC Strategy

Adolescent girls and boys engaged in mapping process during SAA session. Photo Credit:CARE Nepal for USAID

In this section, we outline the priority behaviors addressed by USAID ARH and describe the primary, secondary, and tertiary target groups.

Priority behaviors

USAID ARH has prioritized ten priority behaviors related to adolescent reproductive health which will be supported, followed up and measured through program interventions. These behaviors are informed by formative research findings on barriers to achieving ARH as well as consultation meetings with government and development stakeholders, and co-design sessions with adolescents. For details on alignment of these priority behaviors with ARH interventions for each target group, please refer to Annex 1.

10 Priority Behaviors:

1. Adolescents practice healthy menstrual health and hygiene.
2. Adolescent girls complete secondary school.
3. Adolescents delay marriage until the age of 20.
4. Sexually active adolescents make informed decisions to use modern methods of contraception.
5. Married adolescents and young couples plan their first pregnancy and space pregnancies by at least two years.
6. Adolescents access health facilities for adolescent-responsive services and counseling (including FP).
7. Household members and community influencers support positive social norms for healthy RH behavior among adolescents (delaying marriage and first pregnancy, spacing pregnancy, keeping girls in school, promoting adolescents' access to services)
8. Sexually active adolescents practice safe sex for HIV/STIs' prevention (awareness of HIV and STIs; condom use).
9. Adolescents recognize and seek appropriate care for reproductive tract infections (RTIs) and sexually transmitted infections (STIs).
10. Adolescents understand healthy boundaries to prevent gender-based violence and report any abusive behavior.

Audience Segmentation: Priority Groups

Based on the socio-ecological model approach, the USAID ARH SBC strategy has categorized its target population into three major categories as primary, secondary, and tertiary audiences. The primary target groups are the focus of behavior change interventions. Secondary target groups are key influencers of primary target groups for behavior change. Tertiary target groups influence the overall policy environment for ARH.

Primary target groups: The primary target groups for USAID ARH are adolescents aged 10-19 years, including adolescents with disabilities, LGBTQI+ and marginalized groups. We have segmented this primary target group per the following characteristics:

- Adolescent girls* aged 10-14 in school
- Adolescent girls* aged 15-19 in the community (inclusive of in-school, out-of-school, married and unmarried)
- Adolescent girls* aged 10-19 out-of-school in the accelerated learning program (UDAAN)
- Adolescent boys* aged 10-19 (inclusive of in-school, out-of-school, married, unmarried)
- Adolescents from LGBTQI+ community*
- Adolescents aged 10-19 with disabilities*
- Married/pregnant adolescents and young mothers* cleiming age 15-24 years (considering some may not be truthful about being below 20 years old)
- Husbands of married adolescent girls*

*Note: *implies that all groups will be inclusive of marginalized populations (LGBTQI+, adolescents with disabilities, marginalized castes, ethnicities, and religions, those living in remote geographies, etc.)*

Secondary target groups: Key influencers of attitudes and behaviors of primary target populations.

- Mothers, mothers-in-law, or other household maternal figures
- Fathers, fathers-in-law, or other household father figures
- School principals and teachers
- Religious leaders
- Community leaders
- Near peers (slightly older adolescents aged 20-24 years who can serve as peer mentors and sources of reliable FP/RH information for primary target groups)
- Youth Club members
- Health service providers (public and private sector)
- Female Community Health Volunteers (FCHVs)
- ARH program staff

This group includes USAID ARH staff because as program implementers they also affect changing normative behavior and adolescents' access to services. Addressing unconscious bias around reproductive health and gender and social norms among program staff is an important step in enabling social and behavior change interventions and create a space for critical reflection.

Tertiary target groups: Groups who influence the overall policy environment and affect the provision of ARH services and ability of primary target populations to access services.

- District and municipality/ward level health and social development functionaries
- Policy makers and planners
- Development partners, civil society organizations, private sector, and academia

7

SBC Approaches across Multiple Platforms

Reinforcing and aligning key messages and interventions across multiple platforms helps support behavior change. Therefore, the SBC strategy has identified multiple intervention platforms to harmonize social and behavior change approaches including:

- Interpersonal communication
- Group-based approaches
- Community mobilization
- Mass and social media
- Digital game and web portal

Content will be aligned across platforms to appeal to and inspire adolescents, household and community influencers for adolescents, and health workers and policy makers to become agents of change to advocate for healthy reproductive behaviors. This core package of interventions will be implemented across all identified geographies, with additional intensive interventions at ward level girls' groups, boys' groups, groups for married adolescents, pregnant girls and young mothers identified as most vulnerable according to the Underlying Causes of Poverty and Vulnerability Assessment (UCPVA).

Interpersonal Communication (IPC)

USAID ARH will use IPC not only to disseminate ARH messages but also to provide support to adolescents and families to overcome the barriers they face in practicing desired healthy reproductive behaviors. USAID ARH will introduce adolescents to information on ARH, menstrual health and hygiene, fertility awareness, relationships, consent, contraception, and other ARH topics.

Specific attention will be made to build responsive IPC skills among field staff, youth champions and near peers, FCHVs and health service providers both public and private, for effective counseling. A 'near-peer' model will be used to provide support to adolescents through interpersonal communication and group dialogue. Youth between 20-24 years old from marginalized communities whom adolescents potentially see as role models, will be selected as near peers for the project. These near peers will be trained in facilitation & communication skills and social analysis and action (SAA). They will then be mobilized to reach additional

Youth on adolescent's reproductive health agenda during the stakeholders' meeting in Madhesh Province. Photo Credit: CARE Nepal for USAID

adolescent girls and boys by facilitating SAA group dialogue sessions and disseminate and communicate ARH and family planning messages and support in challenging harmful social norms. As the near peers will be from the same communities, are educated and have more life experience, they will be viewed as credible, inspirational sources of information for adolescents. Once the digital game and website are functional, these near peers will proactively ensure that adolescents who have no access to mobile phones, will still get access to the web portal, game-based learning, and other digital interventions to benefit from these communication platforms.

Health service providers play a crucial role in the health system (both public and private) to ensure adolescents access these services and fulfill their needs given their face-to-face interactions with them. Formative research findings suggest that health service providers' behavior toward adolescents is influenced by many factors, including values, social norms, skills, knowledge, and structural context. These factors sometimes limit health workers from providing adolescent responsive services, quality treatment and services, and communicating effectively with adolescents who seek services. Therefore, the SBC strategy has prioritized working with health systems, both public and private, to create an enabling environment for all adolescents (including AWD and LGBTQI+) to access health services with respect, dignity, and non-judgement. The SBC strategy

outlines health service providers' behavior change and communication beyond traditional interpersonal counseling. Findings from the Total Market Assessment will be used to target interventions to address health service providers' knowledge, skills, attitudes, and values to motivate them to provide quality adolescent-responsive services across the public and private sector.

Group-Based Engagement & Community Dialogue

The cornerstone of the USAID ARH SBC approach is group-based interventions, which are an essential component to challenge social norms and facilitate social and behavior change. As there are different FP/RH needs of adolescents based on their age and other characteristics (marital status, schooling status, aspects of marginalization, etc.), USAID ARH will ensure a segmented approach to ensure that content is tailored to the unique needs of each group. CARE's flagship approach for social norm change, Social Analysis and Action (SAA), will be used to facilitate group dialogue and create action plans to change norms and behaviors. SAA is a community-led reflective process for critical dialogue and reflection on social norms. USAID ARH will develop SAA modules integrating topics like FP/RH, relationships, menstrual health and hygiene, gender and social norms, mental health, etc. to discuss with adolescents and build their knowledge and agency to challenge social norms and practice healthy reproductive behaviors. These modules will incorporate and adapt the previously tested and proven USAID tools like the Pragati game toolkit and CARE's Tipping Point project's tools and guide.

Girls' groups

Adolescent girls 10-19 will be divided into two groups 10-14 and 15-19 as they have different needs and experiences and require tailored FP/RH messages. Adolescent girls 10-14 will be reached through groups in school. Girls aged 15-19 years will participate in community level groups which may include in-school, out-of-school, married or unmarried girls. These groups will be inclusive of adolescents with disabilities and other marginalized groups. Using SAA modules, bi-monthly reflective dialogue sessions on various FP/RH related social norms will be conducted. The SAA program will include a ten-month package of modules having twenty sessions in total. Groups will be formed at ward level for wards that were prioritized as most vulnerable through the Underlying Cause of Poverty and Vulnerability Assessment (UCPVA).

Accelerated learning program for out-of-school girls (10-19 years)

USAID ARH will leverage CARE's flagship UDAAN model which is an accelerated learning program (non-formal education) targeted to out-of-school (OOS) girls. The program aims to get OOS girls back into school at a level which is appropriate for their age. UDAAN learning centers will use a child-centered learning process, following the new accelerated curriculum for level 1 (grades 1-3) and level 2 (grades 4-5) developed and endorsed by the Ministry of Education, Science and Technology (MoST) and Centre for Education and Human Resource Development (CEHRD).

Although USAID ARH will target implementation of level one and two courses to start, based on need, some UDAAN centers may include girls aged 15 and above with level 3 courses, which is in the process of being endorsed by MoST and CEHRD. Through UDAAN, girls will follow the 9-11-month long program which will not only teach core school subjects but also give girls an opportunity to learn leadership, life skills, and become empowered to successfully transition into formal public schools. To teach the condensed course, UDAAN facilitators will follow a seven-day training on UDAAN pedagogy and interactive learning. Additionally, to transform social and gender norms and create a conducive environment for girls' education, a reflective dialogue with parents, teachers, and school management committees (where UDAAN graduates will transit) will be an integral part of the program. Fifteen UDAAN centers will be established in the most marginalized wards of Madhesh province where the rate of school dropout among adolescent girls is high.

Boys' groups (age 10-19)

The boys' groups will be formed in communities at ward level that were prioritized by the UCPVA process for intensive program interventions. These groups will be combined for boys aged 10 to 19 in-school and OOS, married and unmarried and will be inclusive of adolescents with disabilities and other marginalized groups. Through SAA modules bi-monthly reflective dialogue sessions on various FP/RH related social norms topics will be conducted. The SAA program will be a ten-month package with a total of twenty modules.

Married and pregnant adolescents and young mothers' groups

Married and pregnant adolescents and young mothers have specific family planning and reproductive health needs. Therefore, groups will be formed for them in wards prioritized by the UCPVA process for intensive program interventions. These groups will meet on a monthly basis and discuss various FP/RH topics, and social norms issues using the SAA modules. The husbands of these married adolescent girls or young mothers will join them quarterly for discussion. Once FCHVs will be trained in ARH and will better understand adolescents' issues and feel more comfortable to engage with them, they will also be invited to this monthly session to be part of the group dialogue. Eventually, FCHVs could welcome these young mothers into the existing health mother groups. Where health mothers' groups don't exist, in coordination with health facilities and FCHVs, these young mothers' groups may convert or branch into health mothers' groups. In addition, FCHVs will become more familiar with the issues of adolescents and eventually be regarded as a resource in their community.

Groups for adolescents from LGBTQI+ communities and with disabilities

USAID ARH is committed to ensuring the inclusion of marginalized people and addressing the specific family planning and reproductive health needs of diverse populations including adolescents from the LGBTQI+ community and adolescents with disabilities. The project will collaborate with local community-based organizations run by and for people with disabilities and the LGBTQI+ community to form groups for reflective dialogue. This is in addition to including these populations within the other girls' and boys' groups mentioned above. To start with, the project will form two province level LGBTQI+ groups and start a reflective dialogue based on the SAA modules but adapted to the groups' needs. Likewise, groups of adolescents with disabilities will be formed in schools for children with disabilities. The numbers of these groups will be increased based on need. These groups will meet monthly and discuss about social norms, family planning and reproductive health through reflective sessions.

Community Mobilization

Influencer groups

USAID ARH targets working with the secondary target groups (family and community members) who influence adolescents in adapting healthy reproductive behaviors. Based on formative research findings, the project has identified adolescents' mothers, fathers, and community and religious leaders as primary behavior influencers. Separate groups of adolescents' mothers and fathers will be formed in the same ward where adolescent girls' and boys' groups exist. The mothers and fathers' groups will have monthly SAA sessions. Additionally, all parents and their adolescent children will come together on a quarterly basis for intergenerational dialogue to discuss adolescents' dreams, aspirations, menstrual health and hygiene, reproductive health and how parents can support their children in practicing healthy behaviors.

Likewise, a group of religious and community leaders who are influential people in the community will be formed representing USAID ARH working municipalities. These groups will come together on a quarterly basis to discuss FP/RH issues and social norms and encourage them to become community ambassadors to promote healthy reproductive behaviors for adolescents and create an enabling environment for them to practice those behaviors.

Girl-Led ARH Activism

To extend girls' leadership and raise awareness in the community to facilitate social and behavior change, girls' groups will be trained, mentored, and supported to run community campaigns. USAID ARH will use CARE's "Tipping Point Project's Learning Communities on the Move" model to build the capacity to organize girl-led activism. The girls' groups described in the previous section will identify social norms that are barriers to their health and well-being such as child, early and forced marriage, sexual harassment, menstrual health and hygiene, adolescent pregnancy, accessing adolescent-responsive health services, etc. on which they will organize various community campaigns. These adolescents will expand their activism to advocate with local government for budget allocation to address adolescents' reproductive health related needs. The girls' groups will conduct these campaigns in coordination with boys' groups who will act as allies supporting these campaigns and mitigating any backlash. These girls will also be linked with municipal level youth clubs and youth councils to organize community activism and campaigns and

advocate for issues affecting adolescents to become part of social and political agendas so that policy makers are accountable to address the needs of adolescents.

Mass and Social Media Engagement

The formative research suggests that most adolescent girls and boys have access to a phone and social media. Facebook, Tik Tok and YouTube are their main sources of information and entertainment. Based on this fact, USAID ARH will use social media campaigns on Facebook and YouTube to disseminate key ARH messages to influence adolescents' behavior. Short educational videos on ARH will be developed and disseminated through relevant social media platforms. The project will also engage popular young Nepali social media influencers (both local and national) as ARH goodwill ambassadors to produce short videos and social media reels to promote positive ARH messages, challenge taboos and social norms. Regional television and community mobile vans will also be used as means of mass communication to disseminate ARH messages to a wider population.

Digital Interventions

Leveraging the fact that growing numbers of adolescent girls and boys have access to mobile phones and internet within their household, USAID ARH will leverage digital platforms. Building on evidence that game-based learning can affect behavior change for reproductive health among adolescents, USAID ARH will use these digital interventions:

Digital Game

A digital game will be developed leveraging Howard Delafield International's existing direct-to-consumer model from the USAID-funded *Go Nisha Go* a game developed for India to engage and educate adolescent girls on reproductive health through a game-based learning experience. The game will be targeted at girls aged 15-19 years. This type of simulation game can help users develop a deeper understanding of the consequences of their decisions related to adolescent reproductive health. Keeping this in mind, the digital game will provide adolescents with an opportunity to practice informed choice-making in a relatable and interactive game world, and experience how their decisions shape the course of their lives. They will also be directly connected to information about health products and services through the Android game. The content of the game will be available in Nepali with reference to the local socio-cultural context to increase adolescents' relatability and preferences. The research, field testing of prototypes and feedback collected by all stakeholders including adolescents will lead to the creation of a Nepal-based game. In the game, players will be provided with ARH messaging and learning resources through roleplay mechanics to interact with, further empowering players to make healthy, real-life choices. Their interaction will be collected through various data points and the processed data will feed into the program's Monitoring, Evaluation and Learning (MEL) system, building understanding of the behavioral profiles of the program's segmented groups. The digital game will be a tool that the group-based platforms (girls' groups and young mothers' groups, etc) can use as a resource.

Web Portal

The interactive web portal will provide comprehensive adolescent reproductive health education as well as partner health products, and services, all in one place. The portal will feature health information in various mediums, such as videos, listicles, and audio, functioning as a digital magazine. Moreover, it will provide links to existing RH digital apps (e.g., Meri Sangini) and quality-assured referral sites, including hotlines, for accessing adolescent-responsive services. The content will be available in both English and Nepali. Importantly, in the areas where adolescents don't have access to internet or phone, these resources and information will be made available through group sessions and near peer mentors.

Virtual Influencer

An animated character who portrays the central figure (protagonist) of the digital game to help influence healthy decision-making for adolescent girls is the virtual influencer. Social media handles for the virtual influencer will be created on Meta and Google platforms as a communication vehicle for promoting ARH messages and digital interventions. These platforms will also provide a space for collaboration with local and national social media influencers.

These digital interventions will collect users' feedback, digitize monitoring outcomes, and consumer insights.

8

Monitoring Social and Behavior Change

An adolescent girl with her family in Madhesh Province. Photo Credit: CARE Nepal for USAID

The project will monitor the effectiveness of the social and behavior change intervention through a monitoring plan covering intervention implementation, social and behavior change and most significant change monitoring.

Intervention implementation monitoring: Monitoring will be carried out by the internal MEL and program team. An activity monitoring checklist will be developed to ensure the activity is implemented correctly ensuring quality delivery.

Social and Behavior Change Monitoring: Social and behavior change takes time. USAID ARH will use a qualitative norms assessment tool using "vignettes" which will be based on Social Norms Analysis Plot (SNAP) to measure the social norms change related to adolescents' reproductive health among girls, boys, young mothers and health workers. The baseline qualitative norms value will be collected before the implementation of the group-based interventions. The endline evaluation (after implementation of the 10-month SAA program) will be conducted using the same vignettes to measure if the attitude of adolescents and service providers are changing and whether ARH related negative norms are starting to crack and weaken with increasing acceptance towards positive practices in the community. Changing social norms for parents was already measured through the baseline survey and will continue to be measured through the midline and endline surveys.

Most Significant Change (MSC) methodology: MSC will involve a collection of stories of the most significant changes in the lives of adolescents. These significant change stories will be tracked and documented as evidence of social and behavior change. These stories will cover the journey of a change process that adolescents or any influencers have taken to challenge the social norms or to practice recommended ARH behaviors. These stories will be written case stories, pictorial stories, and video stories.

9

Annex 1. Priority Behaviors & Key Messages Matrix

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to Address Barriers and Promote Actions
1. Adolescents practice healthy menstrual health and hygiene	**Primary:** Adolescent girls aged 10-19 years	Misconceptions and restrictions related to menstrual health and hygiene causing menstruating persons to feel embarrassed and limit their freedom of activity including attending school.	- Change sanitary pads or cloth every 4-6 hours and tampons every 4-8 hours. - Dispose of sanitary cloth after 3 months of use. - Discard used menstrual products properly in a trash bin. - Dry washed cloth in direct sunlight and store cloth in a dry and safe place. - Bathe every day. Wash hands with soap. - Use menstrual products properly to remove barriers to attend classes.	- Reusable sanitary pad making training. - Bi-monthly SAA sessions with adolescent girls to discuss, reflect, challenge social norms, and build self-efficacy. - Virtual influencer and social media campaign to widely disseminate behavior change messages. - Interactive web portal for adolescents providing comprehensive adolescent reproductive health education, health products, and services, all in one place.
	Secondary: Parents, boys, religious leaders, teachers, school health nurses	- Menstrual blood is considered 'dirty' or 'impure', and the menstruating person is often viewed as shameful and impure and are often restricted from eating nutritious food, touching water taps and living in their own house for seven days. - Teachers often lack skills to deliver lessons on topics like FP, contraception, ARH, menstrual health and hygiene.	- Provide a well-balanced diet for adolescents, especially when they are menstruating. - Make schools a welcome place for adolescents in terms of issues related to menstruation. - Promotion of equipped toilets, referrals to health facilities/ school health nurse, when necessary, provide pads, place to rest, etc. - Religious leaders stand strong with adolescents to change social norms. and discriminatory practices around menstruation.	- Bi-monthly SAA sessions with boys to discuss, reflect, challenge social norms, and build self-efficacy. - Monthly SAA sessions with groups of mothers and fathers of adolescents. - Quarterly interaction with religious leaders. - Development of additional teaching/ learning materials for teachers/school health nurses to educate adolescents about key ARH behaviors including menstrual health and hygiene. - Mobilization of school health nurses and school management committees to provide information on Menstrual Health Hygiene (MHH) and establish ARH corner in schools to provide FP, ARH, and other social norms related information.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to Address Barriers and Promote Actions
2. Adolescent girls complete secondary school	**Primary:** Adolescent girls aged 10-19 years	- Early marriage and pregnancies are still a common reason for girls to drop out of school. - Girls are less valued in society and are forced to drop out of school to attend to familial duties.	- Think of your future even after marriage and having had a baby. You can still go to school and have a bright future. - Talk to your parents. Share your dreams and desire to stay in school and complete your education.	- Bi-monthly SAA dialogue sessions to build self-efficacy of adolescents. - UDAAN, an accelerated learning class for out-of-school girls. - Virtual influencer and social media campaign to disseminate behavior change messages.
	Secondary: Family and community members, school management committees, youth clubs	- Girls in rural communities are less valued and often forced to drop out of school to get married or help with household chores.	- There is nothing that girls can't do. - Encourage your girls to stay in school and realize their dreams – They will grow up to be healthy and prosperous. - It's possible for OOS girls to return to school. It's never too late.	- Monthly SAA sessions with groups of mothers and fathers of adolescents. - Quarterly meetings with school management committees. - Youth and adolescent-led community campaigns. - UDAAN classes targeting out-of-school girls, including dropouts. - Virtual influencer and social media campaign to disseminate behavior change messages.
	Tertiary: Policy makers and local governments (Women and Development and Education Unit)	- Poverty, unemployment, and poor quality of education are some of the reasons for dropping out of school. - Lack of collaboration of sectoral units (Health, Women & Development, and Education) to address underlying gender and social inequities and RH issues.	- Local governments (Women and Development and Education unit) work together for girls education and allocate budget for girls from poor households to continue education.	- Youth led advocacy dialogue with sectoral units to allocate budget and design transformative programs for girls education and empowerment.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
3. Adolescents delay marriage until the age of 20	**Primary:** Adolescent girls and boys aged 10-19 years	- Self-initiated marriage is prevalent as adolescents fear their parents will marry them off to someone they don't love. - Early marriage is still prevalent in many communities.	- Think about your future and finish school before thinking about marriage. - Let's build girls' agency and self-esteem so that they can realize their aspirations before getting married.	- Bi-monthly SAA sessions with girls and boys to build self-efficacy and negotiation skills. - Youth champion development and support to youth clubs and girl-led campaigns to end early marriage and stop other negative social norms. - Virtual influencer and social media campaign supporting delayed marriage.
	Secondary: Partners of girls and boys; teachers, family and community members, youth clubs	Parents marry their children early as they believe if they wait, their children will be engaged in a romantic relationship and ruin the family honor.	- Talk to your children/students about relationships, love, and adolescents' FP/RH needs. - Inspire your children/students to have a healthy, prosperous future that encourages them to finish their schooling, wait until they are at least 20 to get married, plan their first pregnancy and space all subsequent births.	- Quarterly intergroup sessions (with girls and boys) and intergenerational dialogue among girls, boys, and their parents. - Quarterly interaction sessions with religious and social leaders.
	Tertiary: Policy makers and local governments	- Local government allocates limited budget for activities like awareness raising, supporting girls' education, economic empowerment, etc. - There is limited financial support for poor parents to support them sending their children to school.	- Empowered adolescents and youth are the future of the country. - Investments made today in adolescents will produce a huge return for the future.	- Youth led advocacy dialogue with local government and participation in seven step planning process to negotiate/ allocate budget for adolescents and youth economic empowerment.
4. Sexually active adolescents make informed decisions to use modern methods of contraception	**Primary:** Adolescent girls (married and unmarried) aged 15-19 years	- Discussion about sex is considered taboo particularly for un-married adolescents. - Adolescents have limited access to correct information related to FP/ARH. - Adolescents are not confident to make informed decisions about the use of FP/ RH services even if they need it. - Misconceptions and myths about modern contraceptive use.	- Making informed decisions about your FP/ARH needs and practicing healthy behaviors will protect you from unwanted pregnancies and ensure your future well-being. - To receive correct information about FP/RH, visit a nearby health facility to consult with the health service provider who provides adolescent responsive services.	- Bi-monthly SAA sessions with girls and boys to discuss FP/RH and building their agency and self-efficacy. - Monthly SAA dialogue sessions with married adolescents and young mothers' groups, inviting their husbands on quarterly basis to address FP/RH issues and encourage healthy behaviors. - Digital game targeted at 15-19 year-old adolescent girls empowering them through role play experiences to make healthy, real-life choices.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
	Secondary: Girls' partners; family and community members, health workers & FCHVs, teachers, project staff	- Social taboos to discuss and seek services related to FP/RH by unmarried adolescents and newly married young couples. - Parents/husbands of married girls have little FP/RH knowledge. - Staff may harbor unconscious bias about ARH, influencing program delivery.	- Let's normalize talking about contraceptive use and body awareness. - When adolescents make informed decisions related to their FP/RH needs, it not only empowers adolescents but also the communities and entire nation. - Create a safe space to discuss gender and power, sexual health issues and encourage non-judgmental attitudes towards ARH at home, in school, in health facilities and the community.	- Monthly SAA sessions with groups of mothers and fathers of adolescents. - Quarterly meetings with school management committees. - Quarterly reflective dialogue session with religious leaders. - Training FCHVs on FCHV modular package including ARH content. - Hub-and-spoke mentorship program training health providers in adolescent-responsive service provision. - Regular staff reflection through SAA conducted among project staff and near peers.
5. Married adolescents and young couples plan their first pregnancy and space pregnancies by at least two years	**Primary**: Adolescent girls and boys aged 15-19 years, partners, and husbands of girls	- Lack of knowledge and awareness among couples about FP methods and spacing between pregnancies. - Husbands and partners often dominate decision- making about family planning.	- Think of your future even after marriage and having a baby. You can still go to school and have a bright future. -Making informed decisions about your FP/ARH needs will protect you from unwanted pregnancies and help to plan for your future. -You can become pregnant as soon as four weeks after birth if you are not exclusively breastfeeding. - During ANC visits, ask about FP options to use after birth to protect yourself against an unplanned pregnancy.	- Monthly discussions with married adolescents and young mothers inviting their husbands on a quarterly basis. - Digital game targeted at 15–19-year-old adolescent girls empowering them through role play experiences to make healthy, real-life choices. - Training FCHVs on FCHV modular package including ARH content. - Hub-and-spoke mentorship program focuses on ASRH training to health service providers. - Training to private health providers on ASRH.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
	Secondary: Family/ community members, health service providers, FCHVs	- Social pressure and stigma toward newly married couples to bear children immediately and prove their fertility.	- Men, as husband, partner, father have an important role to play in changing norms around FP/RH service use. - Be supportive of your wives and partners in making decisions about FP and seeking services from nearby health facilities.	- Monthly discussions with married adolescents and young mothers inviting their husbands on a quarterly basis. - Monthly SAA sessions with groups of mothers and fathers of adolescents. - Quarterly reflective dialogue session with religious leaders. - Hub-and-spoke mentorship program focuses on ASRH training to health service providers.
6. Adolescents access health facilities for adolescent-responsive services and counseling (including FP)	**Primary:** Adolescent girls and boys aged 10-19 years	- Adolescents are stigmatized for accessing health facilities especially for RH related issues. - Adolescents don't trust health workers especially regarding maintaining their confidentiality.	- To receive correct information about FP/RH and adolescent-responsive services, visit a nearby health facility and consult with trained health service providers.	- Bi-monthly SAA sessions with girls and boys and inviting health workers as guest speakers to discuss FP/RH. - Adolescent information corners in schools. - Develop youth champions and mobilize them to support youth and girl-led community campaigns. - Interactive web portal for adolescents providing comprehensive adolescent reproductive health education, health products, and services.
	Secondary: Health service providers, FCHVs	- Health service providers' reluctancy to provide FP/ARH services to adoles-cents, especially unmarried. - Negative behavior of health service providers towards adolescents. - FCHVs are not aware of adolescents' needs nor how to address them. -Lack of confidentiality by health workers.	- Be supportive and compassionate towards all girls and boys including adolescents with disabilities and from the LGBTQI+ community, so that they can feel comfortable seeking services and can share their FP/ RH issues openly. - Share simple and clear FP/RH information with adolescents so that they understand and can practice healthy behaviors.	- Capacity building of health service providers and FCHVs on providing inclusive (AWD & LGBTQI+) adolescent responsive services. - Onsite mentorship support to health workers through hub-and- spoke mentorship model. - Advocacy with HFOMCs to include adolescents in HFOMCs.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
7. Household members and community influencers support positive social norms for healthy RH behaviors among adolescents (delaying marriage and first pregnancy, spacing pregnancy, keeping girls in school, promoting adolescents' access to services)	**Primary:** Maternal and paternal household figures, community and religious leaders, teachers	- Parents and teachers are reluctant to talk openly about FP/RH behaviors with adolescents, considering it as a taboo. - Even though religious leaders are well positioned in the community and influence people's attitudes and behavior, they haven't realized their social responsibility to advocate for MHH and social norms change, and against child marriage.	- Initiate open discussions with your children and students about relationships, love, and FP/RH needs. - Create a safe space to discuss gender, power, sexual health issues and encourage non-judgmental attitudes towards ARH at home, in school, in health facilities and the community.	- Monthly SAA sessions with groups of mothers and fathers of adolescents. - Quarterly interaction sessions with religious and social leaders and intergenerational dialogue. - Develop youth champions to advocate with local government to allocate resources for ARH issues in municipal annual plans. - Virtual influencers disseminate and raise awareness on FP, ARH and breaking stereotypes
	Secondary: Policy makers and local government representatives	- ARH is not a prioritized issue for local government to allocate resources. - Local government has limited ARH strategies, guidelines, or action plans. - Limited integration of ARH issues in annual health programs.	- Investment in issues related to adolescent FP/RH needs will empower not only adolescents but the community and the country as a whole. - Gender equality, inclusion and ARH are interconnected. - Joining together, local government, policy makers and development partners can address the diverse ARH needs of adolescents by creating an enabling environment to practice healthy reproductive behaviors.	-Training to local representatives and policy makers on ARH and GESI. - Policy dialogue with policy makers. - Support local government to review and develop ARH and GESI policy, strategy, and action plan.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
8. Sexually active adolescents practice safe sex for HIV/STI prevention (awareness of HIV and STIs; condom use)	**Primary:** Adolescents aged 10-19 years	Discussion on safe sex is considered as a taboo.	- Having unprotected sex of any kind puts you at risk for STIs and HIV. - Always use a condom for safe sex; it protects you against unintended pregnancy and some common STIs and HIV.	- Monthly sessions with girls and boys. - Digital game targeted at 15–19-year-old adolescent girls empowering them through role play to make healthy, real-life choices. - ARH corners in schools will provide comprehensive information about FP, ARH, and other social norms related information, including HIV/STIs.
	Secondary: Partners of adolescents; family/ community members, teachers, health service providers	Teachers and health service providers feel uncomfortable giving information about HIV/ STIs to adolescents especially unmarried adolescents.	Unwanted pregnancies, HIV and STIs are preventable; it's our responsibility to break taboos and talk openly.	- Monthly SAA sessions with young mothers and quarterly inviting their husbands will cover FP/RH healthy behavior including HIV/STIs. - Monthly SAA sessions with groups of mothers and fathers of adolescents - Support teachers and school health nurses to develop additional teaching/ learning materials to educate adolescents about key ARH behaviors including awareness of HIV, STIs and use of condoms. - Capacity building of FCHVs on ARH and engaging with adolescents. - Provide onsite mentorship support to health workers through hub-and- spoke mentorship model.
9. Adolescents recognize and seek appropriate care for reproductive tract infections (RTIs) and sexually transmitted infections (STIs)	**Primary:** Adolescents aged 10-19 years	- Adolescents have little knowledge about their reproductive health care needs. - Adolescents are not confident to talk about these topics even if they want/need them. - RTIs and STIs are considered taboo topics to discuss.	Awareness of STIs and RTIs helps you to protect from certain diseases, don't hesitate to seek information and support.	- Monthly sessions with girls and boys. - Digital game targeted at 15-19 year old adolescent girls empowering them through role play experiences to make healthy, real-life choices. - Establish ARH corners in schools to provide comprehensive information about FP, ARH, and other social norms related information. - Virtual influencer and social media campaign to disseminate behavior change messages.

Priority Behaviors	Target Groups	Key Barriers Faced	Key Messages to Promote Behavior Change	Interventions to address Barriers and promote Actions
	Secondary: Teachers, health service provides, FCHVs	- Teachers often skip the FP/RH chapters in school. - Health service providers' negative attitudes towards adolescents who seek information and treatment for RTIs and STIs.	Provide sources of accurate information on STIs and RTIs to all adolescents and break the taboos around it.	- Support for teachers and school health nurses to develop additional teaching/ learning materials to educate adolescents about key ARH behaviors including RTIs and STIs - Establish ARH corners in schools to provide comprehensive information about FP, ARH, and other social norms related information.
10. Adolescents understand healthy boundaries to prevent gender-based violence and reporting any abusive behavior	**Primary:** Adolescents aged 10-19 years	- Culture of silence to report against GBV. - Fear of retaliation - Lack of awareness of support and referral services available in the community.	- Learn to say 'no' if someone is doing something that is making you uncomfortable. - Listen to survivors/victims of violence, show them support, do not judge, and link them with trustworthy, available helplines and social support.	- Bi-monthly SAA sessions with girls and boys on circles of violence, GBV and referral services. - Capacity building of FCHVs on ARH, GBV, engaging with adolescents, recognizing signs of abuse, and ways to respond. - Mapping district/municipal GBV support service information and developing a directory of services.
	Secondary: Partners of adolescents; family/ community members Health service providers, teachers, youth clubs	- Weak enforcement of laws and actions against GBV. - Culture of victim blaming. - Normalizing violence against women and girls.	- Nothing can be an excuse for violence against women and girls. - Have zero tolerance for GBV and hold the perpetrator accountable by enforcing laws.	- Modules for health care providers in hub-and-spoke facilities address GBV and adolescents. - Training for FCHVs on ARH and GBV. - Mapping district/municipal GBV support service information and developing a directory of services. - Training to project staff on protection from harassment, sexual exploitation, and abuse (PSHEA) including child abuse and safeguarding. - Establishment of functional Feedback Accountability Mechanisms in health care facilities, program activities, schools. - Support to local government (women and children unit) to develop GESI policies and anti-child marriage strategies.
	Tertiary: local government (women and children unit), CSOs working on GBV support system	- Weak enforcement of laws and policy against GBV.	- Have zero tolerance for GBV and hold the perpetrator accountable by enforcing laws.	- Policy dialogue with policy makers. - Support local government to review, develop and implement GESI policies and strategies.

USAID ADOLESCENT REPRODUCTIVE HEALTH

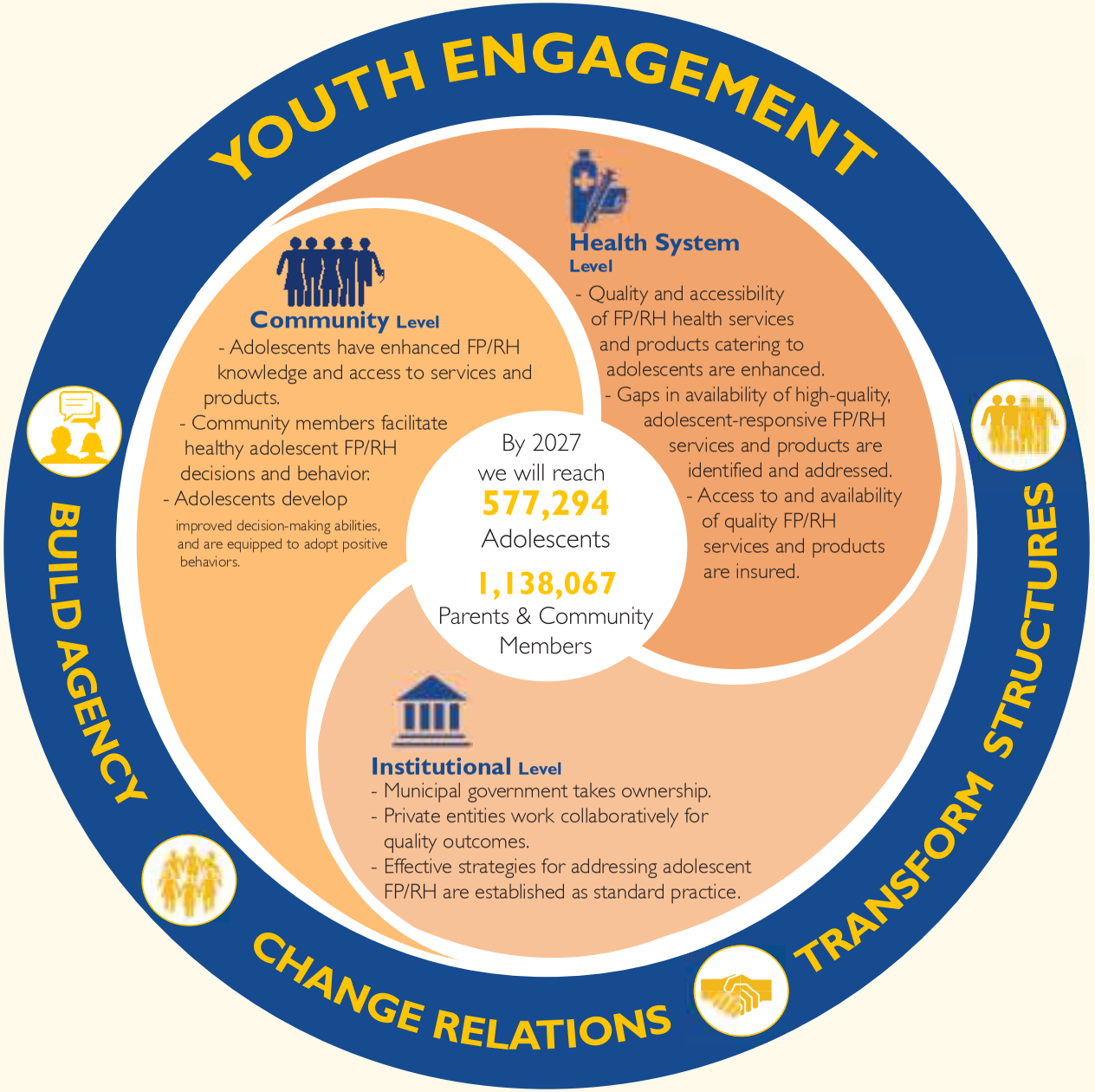
GOAL: TO SUPPORT ADOLESCENTS IN NEPAL TO REACH THEIR FULL POTENTIAL BY CHOOSING AND PRACTICING HEALTHY REPRODUCTIVE BEHAVIORS

APPROACHES

Multichannel Social Behavior Change

Adolescent-responsive Health Service System

Capacity Strengthening



IMPACT

* Increase in voluntary family planning.
* Decrease in unintended pregnancies.

* Improvement in menstrual hygiene.
* Improvement in healthy timing and spacing of pregnancy.

* Decrease in child, early and forced marriages.
* Reduction in school dropouts.

USAID ARH has prioritized ten priority behaviors related to adolescent reproductive health which will be supported, followed up and measured through program interventions.

01 Adolescents practice healthy menstrual health and hygiene.

02 Adolescent girls complete secondary school.

03 Adolescents delay marriage until the age of 20.

04 Sexually active adolescents make informed decisions to use modern methods of contraception.

05 Married adolescents and young couples plan first pregnancy and space pregnancies by at least two years.

06 Adolescents access health facilities for adolescent-responsive services and counseling (including Family Planning).

07 Household members and community influencers support positive social norms for healthy RH behavior among adolescents (delaying marriage and first pregnancy, spacing pregnancies, keeping girls in school, promoting adolescents' access to services)

08 Sexually active adolescents practice safe sex for HIV/STI prevention (awareness of HIV and STIs; condom use).

09 Adolescents recognize and seek appropriate care for reproductive tract infections (RTIs) and sexually transmitted infections (STIs).

10 Adolescents understand healthy boundaries to prevent gender-based violence and report any abusive behavior.

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