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USAID ADOLESCENT REPRODUCTIVE HEALTH

FORMATIVE RESEARCH REPORT

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Cover Photo: USAID Adolescent Reproductive Health focus group discussion for formative research data collection.

Table of Contents

ABBREVIATIONS AND ACRONYMS

ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
CEFM	Child, Early and Forced Marriage
DDA	Department of Drug Administration
ECP	Emergency Contraceptive Pill
FAM	Feedback and Accountability Mechanism
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GoC	Game of Choice
HFOMC	Health Facility Operation and Management Committee
HMG	Health Mothers' Group
HMIS	Health Management Information System
KII	Key Informant Interview
LG	Local Government
MHM	Menstrual Hygiene Management
MoEST	Ministry of Education, Science and Technology
MoHP	Ministry of Health and Population
MoWCSC	Ministry of Women Children and Senior Citizens
MSS	Minimum Service Standard
NHRC	Nepal Health Research Council
OOS	Out-of-School
RH	Reproductive Health
RM	Rural Municipality
RYG	Red Yellow Green
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Background: USAID Adolescent Reproductive Health (ARH) is a five-year activity implemented across 3 provinces (*Madhesh, Lumbini and Karnali*), 11 districts and 60 municipalities. This youth co-led initiative aims to support adolescents in attaining their adolescent reproductive health rights by strengthening public systems and private entities to create an enabling environment for healthy ARH behaviors. Adolescents in Nepal face significant challenges in attaining their reproductive health rights due to the prevailing health system barriers, social norms, poverty, and poor education.

Objective: The formative research aims to assess the prevailing social, normative and behavioral norms that affect the adoption of reproductive health and family planning behavior among adolescents, identify the current operating context of the districts, and assess feasibility of program approaches.

Methodology: A qualitative methodology was adopted with 32 focus group discussions (adolescent girls and boys 10-19 years, parents, Health Mothers Groups) and 39 key informant interviews (local government officials, health coordinators, health service providers (public and private), school teachers/school health nurses, Female Community Health Volunteers) in four program districts (*Bara, Mahottari, Banke* and *Salyan*). Districts were purposively selected representing all provinces and agro ecological variations. Strata of urban and rural municipalities were generated, and sample municipalities were selected purposively from each stratum (M/RM) for the study. Based on the objective of the study, initial themes were identified, and further sub themes were created as suggested by the data. A deductive and inductive approach was used to analyze the data gathered through FGDs and KIIs. The data was analyzed based on identified themes and sub-themes.

Findings: The findings of the study are presented in three main categories 1. Behavioral, normative and social barriers 2. Program operating context 3. Results impacting program approaches and adaptations.

Behavioral, Normative and Social Barriers
● The findings of the study suggest several social and gender norms exist in the society that impede adolescents from achieving their reproductive health. Some existing social norms are child marriage, dowry, early pregnancy, untouchability during menstruation, societal/family pressure to have children immediately after marriage, son preference, mobility restrictions before marriage for adolescent girls, family planning decision making by males. Additionally, misconceptions around use of sanitary pads- that using pads leads to a swollen vagina and they might not conceive later -also exist in some study areas. Open discussion about family planning/reproductive health (FP/RH) is often taken negatively and the character of the adolescent is considered questionable if found freely talking about family planning.
● Unmarried adolescent girls are now 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 for menstruation hygiene management.
● Unmarried adolescents using family planning methods is unacceptable, however married adolescents using FP contraceptives for birth spacing after at least one birth is considered normal.

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 visited six public health facilities were adolescent friendly and some of the challenges for providing adolescent friendly services were lack of confidence and clarity among health workers, lack of trained health service providers, lack of communication/counselling 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 take FP/RH services from private health facilities than public facilities because of the confidentiality, behavior of the service providers, and quick service.
- No adolescent-focused FP/RH-related communication materials were found in the studied health facilities. The adolescents preferred Nepali language for printed materials and local languages (Nepali, Maithali, Bhojpuri, Awadhi, etc.) for any audio-visual aids.
- None of the health facilities were prepared for inclusion of disabled adolescents. The visited health facilities are not accessible to people with disabilities and have no mechanism to ensure that the needs of adolescents with disabilities are addressed.
- Adolescents are not the priority population 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 the gender sensitive polices 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 HMGs while those in *Lumbini* and *Karnali* province have heard about HMGs but don't know what happens in the group meeting. The adolescent girls (both married and unmarried) showed interest to be a member of the group but were skeptical if they would fit in the mothers' group and be able to open up.
- Other than menstrual pad distribution, Iron Folic Acid (IFA) distribution, school health nurses in some municipalities, and the school meal program, no other than health related programs were

being implemented in the six schools visited. Additionally, the majority of the municipalities have not taken any steps to develop RH curriculum.

- The School health nurse program was available in two municipalities. Some of the challenges faced by the school health nurse were lack of ASRH training, session plans, teaching aids and communication materials.

Results Impacting Program Approaches and Adaptations

- Mothers are the most important person in the life of adolescent boys and girls, however, adolescents feel more comfortable talking to friends about FP/RH and other personal matters than their mothers.
- 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 common among adolescent boys and girls. Girls in Muslim communities are forced to drop out in order to get married while for adolescents in *Madhesh* Province poverty, unemployment, and poor quality of education were some of the reasons for dropping out of school. All of 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 of 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 the peer-to-peer approach in the study areas. When explained, all of them liked the concept and preferred to have a peer mentor who is of same gender, a bit older adolescent and more knowledgeable than them.
- All the health workers were exposed to a mentoring and coaching approach. Onsite coaching and mentoring was liked by all of them and appreciated the idea of onsite coaching and mentoring. At the same time, they also expressed the need for refresher training when new guidelines and protocols are endorsed.
- 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 (IHMIS). All the service providers unanimously agreed the necessity of streamlining the reporting of private facilities to the government HMIS system.
- 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 of them providing support on a need basis while some delaying decision-making. Only one of the health facilities included adolescents in these committees.
- No accountability and governance tools are in use in the study areas except during public hearings. The public health facilities of *Lumbini* and *Karnali* province were familiar with the community score card, however, in *Madhesh* Province the health workers were unaware of this approach. The health

workers in *Lumbini* and *Karnali* province acknowledged that the Community Score Card (also referred to as Community Health Score Board- CHSB) would be an effective tool to reflect on the progress made by the health facility.

Conclusion

The study identified various social norms across the program areas relating to reproductive health and family planning behaviors among adolescent boys and girls. Findings suggest adolescents and parents are interested in engaging in various group sessions and community platforms. Near peer mentors and parental engagement sessions would be efficient platforms for group engagement in the program. Adolescents preferred private facilities for service seeking, implying a demand for quality improvement approaches to strengthen public health facilities to be more adolescent-responsive. The private sector would like training, and regular supportive supervision, onsite coaching and mentoring to improve the quality of service in the private facilities. Currently adolescents are not prioritized/engaged in program planning and budgeting at municipality level, therefore there's a need for advocacy to prioritize adolescent needs. Disability is not considered when designing any health services or activities for any population. Given the lack of experience in this area, the issue is even less understood for adolescents and therefore it is imperative to ensure participation from adolescents with disabilities in policy planning, budgeting and implementation to make it more GESI sensitive.

Recommendations

Based on the evidence generated from the formative research, some of the key recommendations are:

- Social analysis and action (SAA)[1] is necessary to transform various social norms identified in this formative research by developing separate SAA content for each of the identified social norms.
- Advocating with the local government on the importance of adolescent reproductive health to ensure adolescents' health needs are prioritized in planning/budgeting at local level and participation from adolescents with disabilities while planning and designing ARH activities to make it more GESI responsive.
- Onsite coaching and mentoring are essential to ensure the quality of services offered by private providers and mainstream private sector reporting to the government information management system. While the program has envisioned onsite mentoring/coaching for the public sector, the same needs to be provided for private service providers too.
- Since adolescents are found to have been seeking FP services from private service providers, training the private sector (polyclinic, private hospitals) on proper counseling services to adolescents needs to be incorporated in the programming.
- Explore the possibility of providing mobile FP/RH services to cater to the FP/RH needs of adolescents through the public and private sector.
- Formation and or reactivation of existing platforms like child clubs, health mothers groups, HFOMC, FP/RH committees to discuss adolescent health issues with participation of adolescents

[1] SAA is a facilitated process through which individuals explore and challenge the social norms, beliefs, and practices that shape their lives and health

/youth (most likely near peer mentors) would allow them to discuss challenges faced by the adolescent and support adolescent sensitive program design.

- Design and implement more school-based integrated activities to impart knowledge, skills and practice on FP/RH among adolescents.
- Given that some adolescents are not interested in formal education, linkage to vocational and skill-based training for mobile repairing, sewing, cosmetology / beautician, mechanical, plumbing for adolescent girls and boys should be considered.
- Advocate for integrating the School Health Nurse Program in all schools of working municipalities and build capacity of school health nurses in ASRH.
- Design self-efficacy sessions for girls to boost their confidence and ability to communicate about their reproductive health needs and delaying marriage with their parents/community members.
- Adapt context specific digital technology as a means of communication for conveying FP/RH information to adolescents.
- Include capacity building activities for health workers to offer services to adolescents living with disabilities to cater to their reproductive health needs.

1. BACKGROUND

1.1 Adolescent Reproductive Health and Family Planning Context in Nepal

Adolescence is the transition period from childhood to adulthood marking many physical, emotional, cognitive and bodily changes and exposure of the adolescent to many health needs and risks. [1] In Nepal, adolescents (10-19 years) comprise almost a quarter (24%) of the total population. [2] The mean age of menarche in Nepal is 13.5 years, marking the onset of puberty. [3] The median age of marriage for men is 21.7 years and for women 17.9 years despite the legal age of marriage being 20 years. Among girls aged 15-19 years, 27.1% are already married and 16.7%, are already pregnant or have a child. [4] Data from the Nepal Adolescent and Youth Survey 2010–2011 shows that adolescents from disadvantaged ethnic groups, religious minorities and adolescents with no education were more likely to have given birth than adolescents from advantaged groups and with higher education. [3] Age-specific fertility rate is 71 births per 1,000 women age 15–19 years according to NDHS 2022. [5] Contraceptive use is extremely low among married adolescents- 14.2% compared with the national average of 43%. Unmet need is highest among the adolescent 15-19 years with 30.9% compared with the national average of 20.8% among women of the reproductive age group [5]. The proportion of never-married male adolescents and youth who had ever had sexual intercourse was 22% and only 1% among never-married female adolescents in 2011.

Adolescents in Nepal face critical challenges in meeting their Reproductive Health (RH) needs and attaining RH rights. Poor access to RH information and low utilization of RH services in addition to cultural taboos on adolescent sexuality and health are some of the challenges for adolescents. Adolescent girls face additional challenges due to prevailing social and gender norms such as child, early and forced marriage (CEFM), dowry related violence, marital rape, sexual harassment, early childbearing, restrictions on physical movement, and gender-based violence (GBV). [6]

Considering adolescent health and development needs, a National Adolescent Health and Development Strategy in 2000 and (revised in) 2015, National Adolescent Sexual and Reproductive Health (ASRH) Program Implementation Guidelines 2011, and a National ASRH Communication Strategy (2011- 2015) was developed by the Government of Nepal which ensures the delivery of Adolescent Friendly Services (AFS) with standard operating procedures. [7] As of 2021/22, 108 health facilities have been certified as adolescent friendly sites. [8] However, existing ARH services are limited and are not adolescent friendly due to factors such as lack of privacy and confidentiality in service delivery, gender mismatch of service providers, fear of embarrassment as well as unawareness of the existence of services. [9] To bolster past efforts, a new Adolescent Reproductive Health Strategy has been recently developed at federal level, however is yet to be implemented by all the local levels.

1.2 Description of USAID ARH

USAID Adolescent Reproductive Health (ARH) is a five-year activity supported by the U.S. Agency for International Development (USAID) led by CARE Nepal and in partnership with the Association of Youth Organizations Nepal (AYON), Howard Delafield International (HDI), Jhpiego, and Nepal CRS Company (Nepal CRS). USAID ARH is you co-led initiative to empower girls and boys, 10-19 years, including the most marginalized, to attain their adolescent reproductive health (ARH) rights. The primary goal of USAID

ARH is to support adolescents to reach their full potential and strengthen public systems and private entities to create an enabling environment for healthy ARH behaviors. USAID ARH will contribute to a healthy, resilient, well-nourished population in Nepal through three main results: i. adolescents have an improved understanding of their reproductive health, have developed skills to make healthy decisions, and are empowered to adopt healthy behaviors, ii. adolescent-responsive FP/RH services and products are available and accessible to adolescents in each municipality, and iii. successful approaches and mechanisms addressing adolescent FP/RH are institutionalized.

USAID ARH works with the Government of Nepal, private sector, relevant stakeholders and young people to support adolescents in Nepal to reach their full capacity by choosing and practicing healthy reproductive health behaviors. This program will work in coordination with the Government of Nepal's Ministry of Health and Population (MoHP), Ministry of Education, Science and Technology (MoEST), Ministry of Women Children and Senior Citizens (MoWCSC) and relevant province level ministries along with Provincial Health Directorates, Provincial Health Training Centers, ARH Civil Society Organizations (CSOs), private sector organizations, and professional associations.

1.3 Rationale of the study

This formative research was conducted on a sampling basis using qualitative methods with adolescents, community members, parents and health workers using in-person techniques. The findings of the formative research will be used to inform and improve program strategies and approaches from an early stage and to tailor effective ARH interventions to the context. Formative research will also inform segmentation and allow program teams to better develop materials, mass media, digital applications, and group-based curricula to address specific behavioral and normative barriers. The findings from the formative research will inform the operationalization of the work plan and planned budget.

2. OBJECTIVES

The general objective of the formative research was to assess the operating context of the districts, identify specific needs of adolescent boys and girls and provide guidance for adjustments needed in proposed interventions planned in the USAID ARH project.

Specifically, the formative research will seek to answer the research questions below:

2.1 Research Questions

- What are the key behavioral, normative and systemic barriers to achieving the goals of the USAID ARH project?
- What are the most important factors/gaps in the program operating context affecting key target groups (adolescents aged 10-19 years and their influencers – parents, community members, school teachers, service providers) to account for in program implementation?
- What considerations are necessary when planning key interventions and approaches of USAID ARH in terms of geography, age, ethnicity and other socio demographic factors?

3. METHODS

3.1 Conceptual framework

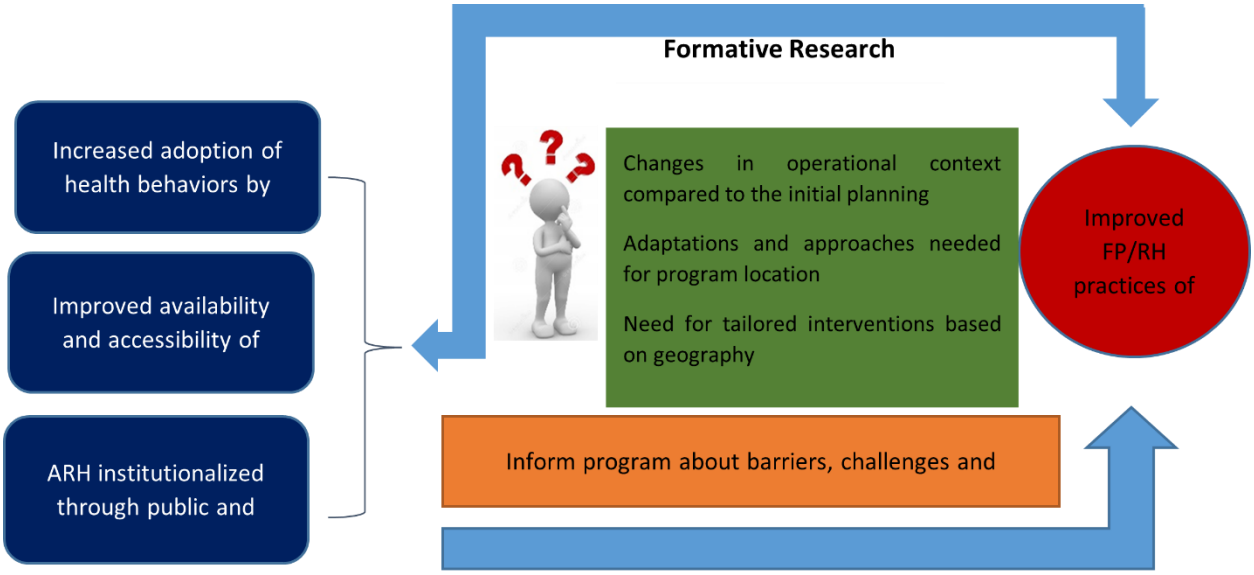


Figure 1: Conceptual Framework

ARH has envisioned to improve the reproductive health and family planning behavior of adolescents by increasing adoption of healthy behaviors, improved availability and accessibility of FP/RH services and institutionalizing ARH services. The formative research sought methods to generate evidence to assess the operating context of the districts, identify specific needs of adolescent boys and girls and provide guidance for adjustments needed in proposed interventions planned in the USAID ARH project. For this, a qualitative study was designed as shown in Figure 1 to identify the necessary changes in the operational context compared to the initial planning. Adaptations to interventions and approaches based on geography and the identification of barriers and challenges will be made as a result of findings.

3.2 Study Design

The formative research was conducted using a qualitative design. The qualitative methodology was comprised of Focus Group Discussions (FGD) and Key Informant Interviews (KII) with selected stakeholders (explained in sample section below).

3.3 Study sites

The study sites for formative research were selected from the 11 program implementation districts. A two-stage sampling process was followed where districts were selected at the first stage and municipalities at the second stage. The selection of the districts was made purposively, representing all provinces and ecological diversity/language/ culture and social norms. Out of six districts of *Madhesh* Province, two of them were selected which best represent the *Terai* context. Likewise, one district from *Lumbini* Province and one district from *Karnali* Province was selected. The study districts for the formative research are:

- *Madhesh* Province: *Bara* (*Bhojpuri)* and *Mahottari* (*Maithili*)

- *Lumbini* Province: *Banke*
- *Karnali* Province: *Salyan*

In the second stage, municipalities within these districts were selected. From each of the selected districts, strata were created for urban and rural municipalities and one urban municipality and one rural municipality was selected purposively from each stratum (R/UM) for the study. Hence, 8 municipalities were selected for the study.

3.4 Sampling

A purposive sampling method was used to select the respondents for the FGDs and KIIs. FGD participants included primary beneficiaries- adolescent girls and boys (disaggregated based on gender, age, and school going status and disability) and secondary beneficiaries - parents of the adolescents (with separate groups of mothers and fathers) and Health Mothers Groups (HMG). Each FGD consisted of six to ten participants. FGDs with adolescents with disabilities were not included in the planning phase, but the research team was able to consult with two groups of adolescents with disabilities- one in each of the *Madhesh* and *Karnali* Provinces. Likewise, KIIs were conducted with representatives from the Ministry of Social Development, the provincial health directorate (this was not in the plan initially, however later on the research team felt the need to collect their perspective as well, hence these interviews were conducted in *Madhesh* and *Karnali* Province), local government representatives, health coordinators/sub coordinators, service providers from both the public and private sectors, teachers, school health nurses (if available), and Female Community Health Volunteers (FCHVs). The following number of qualitative consultations were conducted for the formative research.

3.5 Data collection Instruments

For data collection, separate semi-structured FGD and KII guides for various types of stakeholders were used.

Focus group discussion guidelines

FGDs were conducted among adolescent girls, boys, out-of-school adolescent girls/boys, their parents, representatives from HMGs and adolescents with disabilities. FGDs helped to explore the information in line with the research questions. The respondents participating in the FGD were encouraged to openly discuss what is acceptable to them and what works and what does not work for them regarding the key program approaches and interventions. Results will address the objective of identifying the barriers and determine if the planned activities will work as planned or need adaptations. The semi-structured FGD guides were developed for each type of stakeholder which included FGD instructions, key questions, and a note-taking outline.

Methods	Respondents	Total sample planned	Total Sample achieved	Remarks
FGD	Adolescent girls (10-14)	4	4	
	Adolescent girls (15-19)	4	4	
	Adolescent OOS girls	4	3	Could not find group of OOS girls in Salyan
	Adolescent boys (10-14)	4	4	
	Adolescent boys (15-19)	4	4	
	Adolescent OOS boys	4	3	Could not find group of OOS boys in Salyan
	Health Mothers group	4	4	
	Parents	4	4	
	Adolescents with disabilities	0	2	Was not planned initially
Total FGDs				**32**
KII	Service provider (public)	6	6	
	Service provider (private)	6	6	
	FCHVs	6	6	
	Teachers	6	6	
	Local government representatives	6	6	
	Health section coordinator from LG	6	6	
	Representatives from Provincial Health Directorate	0	3	Was not planned initially
Total KIIs				**39**

Key Informant Interview guidelines

Interviews with key informants helped to record the perception, opinions, and suggestions of specific stakeholder representatives. The KII also specifically probed the government and private sector stakeholders' experience and challenges they have faced in relation to ARH service delivery. A semi-structured KII was designed for each of the different stakeholders to dig deep into different aspects of program implementation and identification of barriers and also provide an opportunity for in-depth exploration of the context, enhancing our understanding of the context of ARH interventions.

3.6 Training, Pretest and Field Work

The tools developed in English were translated into Nepali. A comprehensive 2-day orientation was provided for all program team members from CARE Nepal and consortium partners who were involved in the data collection process. The orientation covered the formative study methodology, ethical considerations, data collection tools, process of collecting data, and note taking template including a mock interview to familiarize the teams with the tools. Following the orientation, three teams were mobilized

to *Panchkhal- Kavrepalanchok*, *Surkhet* and *Janakpur* to pretest the tools in December. A debriefing meeting was organized among the team members to share the findings of the pretesting. The M&E team revised and finalized the tools based on the findings from pretesting.

Upon completion of the orientation, team members were divided into 4 groups in total and 2 groups for each district consisting of 5 members in each group. (Refer to the annex for the detailed data collection plan). The team spent 9 working days for data collection. Each of the teams was led by a USAID ARH MEL team member. The team composition considered gender, age dynamics and local language proficiency (female data specialists paired with girls' KII and FGD groups, male data specialists with boys' groups, etc.). Translators were used as necessary to facilitate the interview in *Bara* and *Banke* districts. Each of the teams were responsible for coordination at local level, acquiring written/ oral consent and maintaining quality of the collected data. Necessary arrangements for informing participants and setting up the venue was done by partner staff. Each of the teams was provided with a recorder for recording the interview which was used as a reference for detailed notetaking. Following the data collection, notes were completed and compiled on the same day. Upon completion of the detailed note-taking process, the recordings are kept safe and confidential in CARE's database management system. The saved recordings will be destroyed once the report is finalized.

3.7 Quality Control Mechanism

To ensure the quality of the research, various approaches were taken by the research team. The protocol was developed with feedback and input from technical advisors of CARE USA, USAID ARH consortium partners as well as suggestions from reviewers from the Nepal Health Research Council (NHRC). Once the protocol was finalized, the tools were developed by the research team with input from consortium partners and global advisors. The tools were revised multiple times based on recommendations from the program team to ensure that the tools gather information needed for program adaptation. The research teams were oriented on the tools prior to their pre-testing in respective study areas. In addition to the pre-testing of tools by the province team in the non-sampled study districts of *Madhesh* and *Karnali* Provinces, the dummy analysis was done and discussed among the research team based on the findings of the pre-testing. After the debriefing within the team, initial findings of the pretesting were presented to the Chief of Party (CoP), Deputy Chief of Party (DCoP) and Director of Data Collection, Analytics and Use. Final comments and feedback were taken from them and necessary revisions in the tools were made.

The principal investigator and co-investigator oriented the team on the final tools. Following the orientation, the research team was deployed to the field for data collection. Each of the field teams were led by the principal investigators of the research. All FGDs and KII were led by two researchers, one of whom took notes. Recording of the interviews/discussions was done so that no information was missed. After the completion of data collection in the field, a debriefing session was organized separately by each team at the end of the day and triangulation of the findings was done. The Director for Data Collection, Analytics and Use was updated daily on the progress and major findings. The principal investigator and co-investigator, each leading a separate team, met virtually each day to share findings, identify gaps and discuss any need for the collection of additional information from the field. Monitoring of the data collection was done in the field by the DCoP and Director for Data Collection, Analytics and Use.

3.8 Data Analysis

3.8.1 Debriefing and reflection

Debriefing and reflection was done on each day within the different research teams (*Madhesh* Province and *Lumbini/Karnali* Province) to share the major findings and key learnings of the day. Upon

completion of the field-level data collection, the research team organized an in-depth debriefing session with all the researchers involved. The process contributed to the analysis of data based on the observation and experience of researchers.

3.8.2 Thematic analysis

FGDs and KIIs were recorded and fully transcribed and translated into English before analysis. A deductive approach was used to analyze the qualitative data gathered through FGDs and KIIs. Guided by the deductive approach, initial themes were identified based on the objectives of the research which was also used as a basis for tools development. These themes were further consolidated to provide further insights into the relationship between various issues and concepts brought forth in the study. In addition to the deductive approach an inductive approach was used to identify possible barriers and challenges. For both the deductive and inductive process, the frequency of the themes and the patterns for each category were coded for the next step of data analysis. All the analytical work was done manually.

3.9 Ethical consideration

The research team received ethical approval from Nepal Health Research Council (NHRC) before conducting the study. Additionally, written consent forms and assent forms were developed and read to the participants and signed prior to conducting FGDs and KIIs. Written consent from parents and assent from minors were taken when adolescents were participating in the research. Participants were also provided the opportunity to withdraw at any time and ask questions if they have any. Only those who agreed to be in the study were interviewed. Further, the study team received permission from the respondents/participants before the sessions were recorded or pictures were taken. The research team followed the good research practice of "do no harm" while working with participants.

3.10 Limitation

The study does not cover all program implementation districts and municipalities. However, the districts have been selected to represent the geographical differences that will allow the findings to generalize within the province.

4. FINDINGS

4.1 Behavioral, Normative and Social Barrier

4.1.1 Existing social norms

Social norms are the unwritten rules of beliefs, attitudes, and behaviors that are considered acceptable in a particular social group or culture. Our society is guided by various social norms that affect the reproductive health and family planning behavior of adolescents. The key social norms referred to by the different stakeholders from our study were related to early marriage, dowry, early pregnancy, untouchability during menstruation, societal pressure to have children immediately after marriage, son preference and mobility restrictions for girls.

All the stakeholders consulted during KII including the participants from FGDs had knowledge about the legal age of marriage (20 years), however, it was perceived that in practice, this was not happening and parents are marrying their daughters early (before the age of 20). Furthermore, adolescent girls are also eloping and as a result teenage pregnancy was also high. A prevailing belief in *Madhesh* Province and the *Madheshi* community of *Lumbini* Province is that it is difficult for a girl's family to find an appropriate boy if girls wait until they reach 20 years to get married. Therefore, this has led to early marriage. Additionally, the practice of eloping was found high in Salyan district and was one of the reasons for early marriage.

Marrying girls early, before menstruation, is considered a holy ritual, therefore, in some areas adolescent girls are married before her menstruation starts.

> ***"People in our community think that if we marry daughters after their menstruation starts, then this ritual is not considered holy, it's not Kanyadaan"- an FCHV from Khajura Rural Municipality, Banke, Lumbini Province***

While some communities had strong reservations about girls eloping, they therefore force them to marry early. Other communities (in *Karnali* Province) have accepted the practice of eloping as a usual practice. This has led to girls dropping out of school early.

> ***"I eloped after dropping out of school at class 7, because it has become like culture in our society and also family has easily accepted"-an out- of-school married girl, Bangadh Municipality, Salyan, Karnali Province***

The norms around dowry play an important role in *Madhesh* Province as well as the *Madhesh* community of *Lumbini* Province where one of the major reasons of child marriage is dowry. Parents mainly marry their daughter at a young age because the more educated the groom is, the more dowry needs to be presented to the groom's family. Despite educating their girls and making them independent, a dowry still needs to be provided which leads to early forced marriage. Educating girls and waiting for her to complete her education means that they have to prepare for a hefty dowry. As a result, to avoid paying a lot for a girl's wedding (for dowry), they marry off their girl as early as possible.

> ***"Even though we keep our daughter at home and educate them we still have to pay dowry, so what is the point of keeping them at home" - Parents, Shamsi Rural Municipality, Mahottari , Madhesh Province***

> ***In the Madheshi community of my working area, there is this practice of buying the groom (jwain kinne). Girls' family provide heavy amount of money to get an educated and good boy for the girls - FCHV from Khajura Rural Municipality, Banke, Lumbini Province***

Son preference is another deeply engrained social norm leading to multiple pregnancies especially in the *Madhesh* Province. Sons are given priority with regards to education, mobility, and access to mobiles.

Parents validated the findings where they mentioned that adolescent girls are responsible for all the HH chores while boys go and play after school. Boys are sent to private school while public school is the first choice for adolescent girls. Likewise, the study team also witnessed that there are acts of gender-based violence as shared by key stakeholders consulted in the *Madheshi* community of *Lumbini* province whereby, females who give birth to a girl child are sometimes verbally and physically assaulted and no proper care for both the mother and child is provided. Often time their husbands will marry new girls with the hope of getting a male child.

FGD with Parents of Adolescents

There are many instances where I have met family members agreeing to spend any amount for further care of neonatal boy but let the neonatal girls to die if any complication arises right after delivery -Health Service Provider, Khajura Rural Municipality, Banke, Lumbini Province

However, the adolescents share a different perspective and feel that boys and girls should be treated equally. They prefer having two children irrespective of the gender of the child.

"We want 2 children irrespective of the gender because both male and female are equally important for development of the society, but in-laws and society want sons, that is the main problem." - Adolescent girls 15-19, Shamsi Rural Municipality, Mahottari, Madhesh Province

Other social norms prevalent are drying of cotton cloths (absorbent for menstruation) in dark areas where no one can see them for fear that someone would steal it and curse them so that the girl would not become pregnant later. The society also has misconceptions around the use of sanitary pads - if a girl uses sanitary pads then she would have problem in her fertility.

"I will not take pad said one adolescent girl, I was surprised and asked why she said, she mentioned, My mother told me that the use of pads make my vagina swollen."- School Health Nurse, Madhesh Province

Mobility restrictions for girls is also a social norm which limits the access of girls to health seeking practices. While boys are allowed to go anywhere anytime, girls are considered undisciplined and are not trusted by parents to travel alone or come home late. Health workers validated the findings about the restriction of girls' mobility and the necessity to ask a parent's permission to go out of the house. These restrictions limit the utilization of FP/RH services among adolescent girls. Likewise, teachers consulted from different study *palikas* also confirmed this finding of forbidding girls to stay for long periods outside the home.

"Girls are asked hundreds of questions if she comes home late. They are not allowed to travel alone. Someone from her family or close friends have to accompany her. This is the reason the girls might not be able to access FP/RH services." Mothers from HMG, Salyan, Karnali Province

Mobility restrictions in the Muslim community is rooted in the social norm that girls are perceived negatively for talking with boys. Their parents and community members don't accept unmarried girls talking to boys other than within their close circle of relatives. The belief is that if girls are allowed to travel alone, then there is a chance that they would talk to unfamiliar boys and have an affair with them and ultimately elope with the boy.

> ***My parents won't allow me to enter my house if they see me talking to boys"- An unmarried OOS adolescent girl from Banke, Lumbini Province***

Decision-making on use of FP devices rests on either husband, mother-in-law, or other family members. Females do not have a say on seeking services, having sex, bearing children and using contraception. They are forced to follow whatever the husband or family member decides for them. The norm around this practice limits the woman's role in decision-making and claiming their reproductive health rights. This finding is validated by other stakeholders consulted. The health service provider of public health facilities, health coordinators of municipalities and FCHVs collectively reflected during their interview that women did not have the ability to make decisions or even if they have the ability, they are not empowered enough to have their say within their family members for seeking RH services.

> ***"Women in our hospital usually come with their mother-in-law for counselling. They usually leave the facility saying they will ask their husband on the choice of family planning devices." -A public health services provider, Sharada Municipality, Salyan, Karnali Province***

4.1.2 Discussion about FP/RH in the community

The study witnessed that unmarried adolescents are forbidden to talk about FP openly. Open discussion about FP/RH is often taken negatively, and community members claim that adolescents who do talk about it are undisciplined. Some adolescents feel shy to talk about issues of FP/RH in the community, others fear that the community will perceive them as undignified. Their family will not approve of talking about these issues openly as it is linked with family prestige and blaming parents of bad parenting.

> ***"Talking about RH is tabooed in the community, people say that she is a bad girl if she goes around talking about these things in the open. They say she does not even feel shy. They complain what type of culture her parents have given to her, people say they don't need to know about these things at this age" - Adolescent 15-19, Shamsi Rural Municipality, Mahottari, Madhesh Province***

The community feels that conversations about family planning should be limited to married adolescents. Adolescents don't need to know and talk about family planning unless they are married. Once they are married, they will know about family planning. Talking about family planning among unmarried adolescents would lead to suspect that the adolescent is into bad behavior.

> ***"Unmarried adolescents aren't acceptable talking or using family planning. People think they have lost their dignity." OOS adolescent girls, Khajura Rural Municipality, Banke, Lumbini Province***

> ***"If we are found talking about condoms, community people say that we will end up going to gulf countries in future. They mean that we have to focus on studies rather than discussing family planning. Going to gulf is taken as last resort of earning for youth." -Adolescent boys from Sharada Municipality, Salyan, Karnali Province***

The health workers confirm that conversations around family planning and reproductive health problems are usually kept within the home and only shared with friends, especially in the *Madhesh* Province. Additionally, social norms like mobility restrictions hinder married adolescent from visiting the health facility for health problems. Adolescent girls only visit the health facility for their problem when it is too late.

> ***"Generally, girls talk with mothers or sisters and boys with friends for any health problem. Girls reach to a health facility for services at very late stage". Health coordinator, Madhesh Province***

4.1.3 Community perception about adolescents using FP

Parents were negative about unmarried adolescents using contraception. Parents thought that unmarried adolescents should not engage in sexual activity and not even be allowed to talk about family planning before marriage. If parents find out that their adolescent girls are having an affair, then they would marry them off. Parents also felt that unmarried adolescents do not need any RH services (except for MHM for girls). They highlighted that, unmarried adolescents "should not use" contraception which meant that adolescents should not be engaging in sexual activity. Using FP was not a problem among married adolescents with a child. This perception is again linked with the honor/reputation of the family where parents fear that the community will raise hundreds of questions if their children are found using contraception.

> ***"If community people find a boy using an FP device or even talking about contraception, they say that he is acting as if he has grown up sooner, he will surely bring a girl" - Adolescent boys, Sharada Municipality, Salyan, Karnali Province***

Moreover, they think that married girls need to bear children as soon as possible (preferably within a year or two of getting married) only then they can use contraception. This perception prevailed throughout all the provinces. If the married adolescent doesn't deliver a child within 2-3 years after marriage, then she will face many allegations. Also, the relationship between husband and wife is considered healthy if they bear a child soon after marriage while they will have doubts about fertility if the pregnancy is delayed.

> ***"The community says one should have a child after marriage then use FP. If we don't have a child within a few years then they say "BANJI" (infertile) - Adolescent girls, 15-19, Shamsi Rural Municipality, Mahotari, Madhesh Province***

> ***"I had asked my daughter (who eloped at the age of 15 years) not to bear a child soon. However, her family members (in-laws) constantly pressured her not to use any contraception as in doing so, she might not get pregnant ever. And so, she is currently pregnant at the age of 16." - A mother, Bangadh Municipality, Salyan, Karnali Province***

The fact that community people accept adolescents using contraception once they are married and deliver at least one child clearly shows that, for community people, it is not a matter of health risk associated with early sex, but a matter of perceived prestige. Community people perceive that being sexually active or being pregnant before marriage and disclosing the matter in the community poses a serious threat to the honor of the whole family. The community blames parents not disciplining their children and "letting them" be involved in such activity. There is the perception that adolescent girls and boys must remain

virgins until their marriage and sex is only acceptable after being formally married. Once married, they force the girls to get pregnant as early as possible without any concern of their age.

However, during interactions with adolescent boys and private health service providers, it was found that unmarried adolescents (mostly boys) visit health facilities (public and private) to seek family planning methods, mostly condoms and Emergency Contraceptive Pills (ECP).

> ***"The most common services sought by both married and unmarried adolescents are for ECP and pregnancy test kits". Private Health service provider, Sharada Municipality, Salyan, Karnali Province***

> ***"Some adolescents go to private facilities (pharmacy) to receive condoms and pills (ECP) "Adolescent boys, 10-14, Shamsi Rural Municipality, Mahottari, Madhesh Province***

Even the HMG members confirmed that the possibility of accessing FP/RH services should not be introduced to unmarried adolescents at all, however they agree that married adolescents should have knowledge of FP contraceptives and use services.

> ***"Communities think sex can only be done or FP contraceptives can be used only after marriage, if done before marriage it is not acceptable or perceived us as undisciplined/bad" -Adolescent girls, 15-19, Khajura Rural Municipality, Banke Lumbini Province***

Teachers, FCHV and LG representatives are positive about FP/RH service seeking practices among adolescents, however they have reservations about the use of FP among unmarried adolescents as they feel only married adolescents should be using contraception.

Against this backdrop, the research team suggests that the program needs to adopt mechanisms to analyze, discuss and challenge these social and gender norms to improve access of adolescents to reproductive health services and make healthy choices. Community dialogues with community leaders, religious leaders and parents through different approaches like Social Analysis and Action (SAA) could be valuable to change these norms.

4.2 Program Operating Context

4.2.1 Source of FP/RH information

The school-going adolescent has heard or known about reproductive health and family planning from school, teachers, book, friends, and digital platforms. Out-of-school adolescents have heard about FP/RH through sisters-in-law, mothers, and social media (Facebook and YouTube). Among married adolescents, they have received the information from health workers and FCHVs.

4.2.2 Currently available FP/RH services

All the visited hospitals in the study provinces provide all FP/RH services like FP contraceptives, post-partum and post abortion FP, delivery and HIV testing services including sterilization camp (except one of the provincial hospitals). While the FP/RH services were being provided by the hospitals to the married target groups, not all the hospitals provide services to unmarried adolescents due to unavailability of a private room within their premises, causing difficulty in providing quality services.

> ***We can start all these FP services making one staff responsible. Now it is already 6 months I am here, but FP services still closed (no MCH Clinic). If client asks, we give them depo, but we don't record in hospital register. HMIS register also not available. It is like zero reporting." Provincial hospital, Madhesh Province***

In terms of local health facilities (PHCC, HP), the health facilities are providing FP counselling services, short acting contraceptives like condoms, pills, injectables, and Long-Acting Reversible Contraceptives. When further explored, only a few of the health facilities visited were found to have provided services to unmarried adolescents. However, the health coordinator of one of the municipalities in *Banke* stated that the health facilities within his catchment area provided family planning services regardless of marital status to all adolescents seeking services. It should be noted here that this is the finding from only one municipality and hence can't be generalized across all study areas.

> ***"In my catchment area, I have circulated a notice to serve anyone coming to the health facility seeking FP/RH services regardless of their marital status." Municipality health coordinator, Banke, Lumbini Province***

Health facilities including provincial hospitals have been using data for planning, especially for forecasting FP commodities and other materials required. However, in *Madhesh* province, due to a lack of complete logistic data, the forecasting is done on a need basis. Some of the health providers also complained that they don't have a computer or regular internet services for timely reporting.

4.2.2.1 Adolescent friendly health facility

Among the six public health facilities that were visited during data collection, none of the health facilities were providing adolescent friendly services. There was currently no mechanism to ensure that adolescent needs are addressed and some of the health workers were themselves not aware of any adolescent friendly health facility. The health workers shared that there is no separate budget for adolescents and no focal person has been appointed for the adolescent program. The main problem with providing adolescent friendly services was lack of confidence and clarity among health workers on the proper/standard of care. Additionally, the facilities also lacked trained human resources, communication/counselling materials for adolescent and the informed choice poster.

> ***"There is no mechanism to ensure adolescent needs are addressed. We don't know about Adolescent Friendly Health Facility and this facility is not an Adolescent Friendly Health Facility"- Public Health Facility, Madhesh Province***

Some of the municipalities however have initiated the process of certifying the health facility as adolescent friendly and await the approval process in the municipal council.

The study team concluded that the health needs of adolescents are not met and urge upgrading the health facility as adolescent friendly health facilities to ensure that service providers are specially trained to communicate with adolescents in a friendly manner without being judgmental, respecting their confidentiality and privacy.

4.2.2.2 Availability and quality of FP/RH services

Family planning and reproductive health services are available for all populations including for adolescents. However, there are disparities in the quality of services provided across the health facilities visited.

Adolescent boys (both married and unmarried) have witnessed their friends visiting health facilities or have gone themselves to receive FP contraceptives, especially condoms. Unmarried adolescents go to both public and private facilities for general services, however, they prefer private facilities to receive family planning services as no one inquires about their age in private facilities. School girls have seen/heard of married adolescent girls accessing services from public health facilities. They are aware that there are public and private health facilities where they can access the services, if they want to, however they have never been to the facilities themselves to get those services.

Health Facility in Banke with a separate room for family planning counselling

"They go to both public and private facilities to get condoms but prefer private facilities as there is inquiry about the boys' age in public health facilities" OOS Adolescent boys, Shamsi Rural Municipality, Mahottari, Madhesh Province

Likewise, for *Madhesh* Province, unmarried adolescents rarely go to health facilities for FP/RH services but they have seen their sisters-in-law, mothers, sisters visiting facilities to receive FP/RH services. Everyone however agreed that married adolescents visits health facilities to seek FP/RH services once they get pregnant. Adolescents get psychosocial support from parents (for girls) and from friends (for boys). They understand the changes they go through (menstruation, puberty) as a normal process and do not seek any information regarding this.

"Most girls don't go to health facilities. During periods, we have cramps we stay at home, don't do anything, tolerate the pain". OOS adolescent, Gaushala Municipality, Mahottari , Madhesh Province

OOS girls go to private health facilities (pharmacies) to buy pads. They haven't ever visited HF/private sector to get other FP/RH services for themselves. They haven't seen/met anyone of their age who are unmarried, going to HF to receive FP/RH services.

Public and private health service providers mentioned that a considerable number of both married and unmarried adolescent boys visit their HF to receive services. In public health facilities, since condom boxes are placed in accessible areas and clients are allowed to take as many as one wants free of cost, adolescent boys are seen taking a substantial quantity of condoms. However, no records of the actual quantity of condoms distributed are generated. In private health facilities, many adolescent boys are seen asking for condoms and Emergency Contraceptive Pills (ECP). They have a code word "*72 ghante"* for ECP because of their hesitation and shyness to ask directly for them.. While they are readily providing the ECP for those who ask, providers discouraged the use of ECP as a regular FP method.

"Majority of people visiting for FP services is for ECP and which I think should not be encouraged rather managed in a proper way"-private health service provider, Salyan, Karnali Province

Concerning the FCHVs, none of the FCHVs consulted witnessed unmarried adolescent girls or boys approaching them for FP counselling or commodities like condoms and pills. They felt this was for fear of being questioned and breaching their confidentiality. This finding was validated by one FCHV stating that although the FCHVs do not talk about these confidential issues to other community members, she shares

this with her family members and thus breaks the confidentiality of the adolescents. Though this notion was only from one FCHV, the study team perceived this as an issue to be addressed for programmatic implications. As for married adolescent girls, FCHVs claimed both male and female come for counselling and FP services.

> ***"I don't talk about them (unmarried adolescents) to the community people but I talk to my husband if they come to receive FP services" -FCHV, Shamsi Rural Municipality, Mahottari, Madhesh Province***

FCHVs usually initiate discussions by themselves and counsel on bearing children by married adolescents. However, due to the deeply rooted societal norms of bearing children within a few years of marriage, they have not seen married adolescent girls using FP methods prior to giving birth to at least one child. This finding was true for all the study areas. In this regard, even though the married girls could have easily accessed the services from FCHVs, the rigid social norms prevent them from utilizing the services. Hence, in this regard, the program needs to focus on challenging these social norms around the use of FP/RH services by married adolescent girls.

In terms of quality of services provided, most of the adolescents mentioned that private health facilities provide better quality services as compared to public health facilities. The reason they choose private health facilities for FP services (if they want to access) is because of the confidentiality, the behavior of the service provider, and quick service. Most of the adolescents also had reservations on visiting public health facilities for any services except for counselling services, given the long waiting time, lack of confidentiality, behavior of the service provider, need to bribe the providers to receive services, perception that the medicine provided by the public health facility is of poor quality, and health workers inquire about the age of the boys who ask for condoms and ECP.

> ***"There is good medicine at the private facilities, while at government facilities they don't give good medicine. We have heard that good medicine they take home and bad medicine they keep at the health facility." OOS adolescent, Gaushala Municipality, Mahottari, Madhesh Province***

> ***"If we provide 100 rupees only then will the health worker listen to us otherwise they don't even listen to us so we prefer to go to private facilities than public." Adolescent girl 15-19, Shamsi Rural Municipality, Mahottari, Madhesh Province***

This notion was also validated by the health coordinator of the municipality who discussed that the service provider at the public health facility knows most of the people they serve and thus the adolescents have the feeling that they are readily recognized by the provider and that the provider would disclose this information to other members of the society. In this regard, the health coordinator also felt the necessity to focus on maintaining compliance to the standard protocols and guidelines while providing FP/RH services.

Additionally, lack of trained staff, unavailability of private space, lack of complete capacity in ARH, and interrupted supply of FP commodities are some of the challenges to provide quality services to adolescents in public health facilities. The health service provider highlighted that support for necessary equipment, trained providers as well as standard guidelines and protocols are some of the areas where the ARH program can collaborate with the municipality and health facilities. In addition, the need for responsive Health Facility Operation and Management Committees (HFOMC) was reiterated as an important part for improving the quality of services provided.

As evidenced in the study, the quality of the services provided is severely compromised as there is a lack of minimum requirements for services provided to adolescents, mostly in the public health facilities. The findings advise the need for adopting minimum service standards and adopting quality improvement models to overcome system level barriers.

4.2.2.3 Communication materials

Health communication includes verbal and written strategies to influence and empower individuals, populations, and communities to make healthier choices. The availability of health communication materials supports the provision of effective counselling services. Among the visited health facilities, most mentioned having communication materials for FP/RH developed and provided by the federal government. However, during observation, no communication materials specific to FP services (informed choice poster, flip chart, etc.) were found in the facilities. Additionally, there was no availability of the ASRH booklets or any other communication materials catering to the needs of adolescents. None of the municipalities have taken initiatives to develop any FP/RH related communication materials addressing the adolescent population. Adolescents from all study areas preferred Nepali language for written Behavior Change Communication (BCC) materials and local language (Nepali, *Maithali, Bhojpuri, Awadhi*) for any audio-visual aids.

4.2.2.4 Accessible, disability-friendly health facilities

Girls with disability interacting during a FGD

All the health facilities including the private facilities and hospitals unanimously agreed that the facility is not accessible to people with disabilities and have no mechanism to ensure that the needs of adolescents with disabilities are addressed. Some of the service providers of public health facilities stated that there is a waiver for waiting in line for people with disabilities when they visit a health facility. However, this does not necessarily mean that they are providing disability friendly services. The main reason for the health facility not being disability friendly was stated to be lack of infrastructure like ramp, handrails, accessible toilet and so on. In addition to that, there were not trained providers who could communicate with people with a hearing disability or verbal disability or developmental disability or any other form of disability that demands special training for communication. The discussion with various stakeholders led to a conclusion that adolescents with disabilities usually visit district hospitals accompanied by their parents to seek health services while there was no evidence of adolescents with disabilities using FP/RH services. The program will need to work closely with adolescents with disabilities as well as providers in order to meet this populations FP/RH needs.

> ***"No differently abled people have come for FP/RH services and we have taken no steps to ensure disabled friendly services" -Public Health Facility, Madhesh Province***

4.2.3 Enabling environment

4.2.3.1 Priority for adolescent FP/RH

Adolescents are not one of the priority target populations while planning health programs at the local level. There is no separate budget for adolescents (except a budget specific to sports for youth) nor are

youth involved during annual work planning and budgeting activities. However, one of the local government stakeholders mentioned that they have additional funds which can be utilized for adolescent programs if necessary. A Mayor in one of the municipalities in *Madhesh* Province, who is also a medical professional, mentioned that one of the priority programs for the municipality is reproductive health and they are working on making RH services free for adolescent girls in that municipality. Likewise, one health coordinator in *Lumbini* province shared that they are planning to include married adolescent girls in health mothers' groups and train the FCHVs for effectively delivering health related topics in the group.

> ***"Adolescent health has been taken in high consideration and a budget is required for addressing health needs of adolescents We will propose and submit the budget in Poush 2079 " – Local Government. Madhesh Province***

The majority of municipalities and health facilities had not prioritized any specific FP/RH interventions for the adolescent population. The only programs that are focused on adolescents are menstrual pad distribution in school, school health nurse programs (in limited schools), and IFA supplementation focusing on school-going adolescent girls (through Federal government), and calcium distribution to schoolgirls. In *Madhesh* Province, there was minimal budget available for an adolescent program for peer education (*sathi sikshya*), adolescent friendly centers and an ASRH program as shared by the local representative.

> ***"Frankly speaking, we have not prioritized adolescent health in our planning and budgeting. Our thinking has only been limited to their education and sports' needs. Now that you reminded me, I think, this should be a priority area for us". -Local Representative, Bangadh Municipality, Salyan, Karnali Province***

Nevertheless, various stakeholders beyond the government sector are working in the provinces to strengthen and improve adolescent health such as UNFPA, Save the Children, *Surakshit Matritwo sanjal*, Aasaman Nepal, UNICEF. The project will have the opportunity to collaborate with these stakeholders for improved adolescent health outcomes.

4.2.3.2 Gender Based Violence /Gender Equality and Social Inclusion policy

: Adolescent girls during FGD at Bara

Even though the cases of Gender Based Violence (GBV) are not often officially reported, the key stakeholders consulted highlighted that they have heard of many GBV cases happening in their community. One of the health workers in *Lumbini* province highlighted that they have heard of many cases, however they are never reported through formal channels which makes it difficult to address the issue. While GBV cases were present in the community, unfortunately, none of the municipalities had GBV policies in place and only claimed to celebrate the 16 days' campaign on GBV. A few mentioned that although they don't have a GBV policy they do have a Gender Equality and Social Inclusion (GESI) policy but are facing challenges in implementing the policy due to many cultural issues related to GESI. The evidence suggests that there is a need to map the municipalities without the GBV and GESI policies and provide technical assistance to the local government in developing these

policies. In municipalities where the policies are already available the program can support the local government in implementing these policies across the program areas.

> ***Our Municipality has been responding immediately to any cases of GBV, but we do not have any GBV policy as such. I think we need to have a policy which helps in prevention of cases rather than addressing afterwards. Municipality representative, Khajura Rural Municipality, Banke, Lumbini Province***

> ***"We have a GESI policy formed but have not implemented it as so many things are related to culture, though we try to implement the policy we are unable to do so" Local Government, Mahottari, Madhesh Province***

4.2.3.3 FP/RH coordination committee

There was no existing FP/RH coordination committee at the municipal level in the study municipalities. However, there was a felt need that the formation and regularization of these committees would support discussing FP/RH issues. Nevertheless, some of the municipalities expressed challenges for the regular functionality of these committees. The findings suggest that the establishment and operationalization of such committees would provide avenues to prioritize adolescents and allow discussion of adolescent issues through these platforms.

> ***"There is no FP/RH coordination committee at palika level. We can formulate such platforms, but their functionality is a challenge. Because most of the time, members of such committees ask for allowances, thus a budget is required for such platforms. There is one committee for the health sector, but it is almost non-functional" - Health coordinator, Madhesh Province***

> ***"We have a municipality executive committee and issues of health are addressed by the same committee on a need basis. The committee does not explicitly talk about health all the time."-Health Coordinator, Banke, Lumbini Province***

4.2.3.4 Adolescent participation in Health Mothers' Groups (HMG)

Health Mothers Groups (HMG) are community groups intended for women of reproductive age (15–49 year). They meet on a monthly basis to discuss and promote health, hygiene and other relevant topics. Most of the adolescent girls in *Madhesh* Province have not heard about health mothers' groups, unlike those in *Banke* and *Salyan* where adolescent girls have heard about mothers' groups but do not know details about the group, although some married adolescents take part in these groups. In one municipality of *Madhesh* Province, 2 unmarried adolescents take part as well in addition to the married members. In general, adolescents would be interested to be part of these groups but were unsure if they would fit in and could open up within the group. In addition, the members of HMGs do not have appropriate/complete knowledge on ARH which limits their scope of discussing the issues that would interest adolescent girls.

Likewise, married adolescents do not want to be a part of HMGs because of the fear of being exposed about child marriage to the wider group. Hence, these girls would prefer one-on-one counselling sessions for getting informed about FP/RH issues.

> ***"I would never go to the HMG unless I am 20 years old. What if someone complains to the police about my marriage before the legal age of marriage?"-An adolescent girl from Salyan, Karnali Province***

Female Community Health volunteers (FCHV), who lead the mothers' groups, did not have confidence on delivering the contents of ARH in the group and highlighted the need of training to not only FCHVs but also some active members of the HMG.

> ***"We have been told that we need to focus on raising awareness among the adolescent girls for their improved reproductive health. However, we do not know what to do and how to talk about those topics with the adolescent girls. It would be good if you could train us on this area."- A FCHV from a mothers' group in Banke, Lumbini Province***

The study also found that in reporting, there are HMGs operating but they are only limited to collecting money for saving and giving credit among group members. The fact that most of the mothers' groups are limited to collecting and saving money and providing loans to the members provides one major reason why adolescents would feel excluded as adolescents have very little access to cash. One of the health focal persons of the municipality mentioned that they have prioritized inclusion and engagement of adolescents in their Health Mothers groups. They are also planning to train FCHV and members of HMGs on conducting HMGs effectively.

> ***"We are planning to make "capable FCHV" who can effectively conduct the HMG and disseminate the FP/RH information in the HMG meeting. We have allocated budget for this in this fiscal year and will keep on scaling this up in coming years."- Health Coordinator, Banke, Lumbini Province***

Likewise, the prevailing social norm within HMGs that unmarried girls should not be talking about FP/RH topics might limit the active participation of adolescents in the group. Even though HMGs are mainly frequented by married women, married adolescents are very infrequent members., USAID ARH will explore how the HMG platform can better engage married adolescents as well. However, the findings suggest that the program needs to first focus on changing the way the HMG operates, change the attitude of married women (existing members of HMG) and then seek ways to include married adolescents and eventually unmarried adolescents as well. Additionally, the program could use other approaches in the program, like adolescent group sessions and near peer mentors to engage adolescents (both married and unmarried) and inform them about FP/RH topics. The training of FCHV modular package should be utilized to significantly increase the participation of adolescents in the HMGs.

> ***"One of the challenges of including adolescent girls in HMG is the practice of collecting money (savings groups). Since adolescents cannot contribute, it is difficult for us to include them in the HMG." - FCHV from Salyan, Karnali Province***

4.2.4 School Health Program

In order to reduce absenteeism among girl students during menstruation, the Nepal government has launched a free menstrual pad distribution campaign at community schools targeting all girl students across the country. The menstrual pad distribution has significantly reduced absenteeism in school during menstruation as reported by teachers from *Lumbini* and *Karnali* Province. On the contrary, most of the girls in *Madhesh* Province only come for admission and to attend examinations. The rest of the time, they do not attend school regularly whether during their period or not. Due to their frequent absenteeism, the teachers are unable to confirm whether their absenteeism is because of menstruation or not. Some

of the teachers in *Madhesh* Province mentioned that although there is a regular supply of menstrual pads, girls still miss school due to of the absence of a room to rest.

> ***"There is regular availability of sanitary pads in the school however there is no provision of a separate room for students to rest during menstruation, therefore girls still miss classes during their period because they prefer to go home and rest. "School Teacher, Madhesh Province***

> ***"The school distributed sanitary pads, but we don't prefer them as they are of poor quality." 10-14 adolescent girls, Salyan, Karnali Province***

Sanitary pads have been provided in secondary school and above, however there are children age 12 menstruating in primary level school (up to grade 5), however there is no mechanism to provide pads to these children in the policy. Likewise, the out-of-school adolescents who are usually from a lower socioeconomic background cannot avail themselves of free menstrual pads from any source. The study team suggests a policy must be put in place to make menstrual pads available to OOS girls either through health facilities or from FCHVs.

All of the schools have separate toilets for girls and boys with most having a special dustbin for the disposal of menstrual pads. However, there were no incinerators available for disposing of the pads. All the schools had a disposal pit where they burn all waste collected at school. Schools also had a handwashing station, however one of the schools in *Madhesh* Province mentioned there is no water supply even though a hand washing station is available. The local government of *Madhesh* Province recognized the necessity to include boys in the conversation around menstruation to break the taboos in society.

> ***"I also visit schools and I was recently invited to mark menstruation day at school where I reinforced to include boys as well. Not only mothers should know about menstruation but also fathers and brothers should know. Men should know about menstruation now. They are the one who generally go to market to buy things like salt, oil, vegetables… why not to buy sanitary pads."-Local Government, Madhesh Province***

Most of the school teachers iterated that coordination exists between schools and municipalities for pad distribution, COVID vaccinations and lymphatic filariasis.

There is a provision in the local curriculum where the local government can develop their own modules based on the needs of the municipality. However, there is no inclusion of an RH module by the municipality and an English subject has been included in its place in most of *Madhesh* Province. Nevertheless, one of the municipalities in *Madhesh* Province has initiated the process of developing an RH module and there is felt need among the local government stakeholders that the development of such a module along with communication materials on ASRH would be helpful for teachers and students.

> ***"We are adopting a local curriculum but have not completed it. We are speeding up this task in this municipality and we will include ASRH in the local curriculum" Local Government, Madhesh Province***

> ***"The education section of our Municipality is taking a lead in incorporating RH topics in school curriculum."- Local government representative, Salyan, Karnali Province***

The findings suggest that there are opportunities for the program to work closely with the local government to develop local modules, if not already available for schools, focusing on reproductive health information, services available and reproductive health rights for adolescents.

4.2.4.1 School Health Nurse Program

The government has started a school health nurse program in selected schools to ensure regular attendance of children and regular health check-ups. The overall responsibility of the school health nurse is to take care of the health of the students on a daily basis, provide health services to students, motivate students to create a clean environment, work on community health awareness through students, and assist in monitoring and treating various problems seen in female students. In the study areas, the school health nurse program is available in one of the municipalities of the *Madhesh* and *Karnali* Province. Some activities conducted by the school health nurse are physical examinations of students, provision of first aid, offer classes on health topics ranging from nutrition to general health to RH topics, and distribute sanitary pads. However, the school health nurse shared that there is no separate program or teaching schedule for the school health nurse's program. Some of the challenges faced by the school health nurse were a lack of specific training on FP/RH (i.e. the school health nurse thinks that only marriage under the age of 18 is child marriage, need to change sanitary pads every 2 hours) and lack of teaching aids for students. When asked about necessary support, they expressed a need for training, session plans and teaching aids including posters, pamphlets, and videos for teaching adolescents. The school health nurse refers the children to a nearby health facility if required. The local representative also agreed that there is regular coordination between the Municipality and School Health Nurse. They have monthly meetings and the priorities for school health are discussed at that time.

> ***"SHN is being effectively implemented in our Municipality and there is regular coordination with the health section. The new HMIS has a provision for reporting certain services delivered by SHN which has helped us monitor this program more efficiently."- Local Representative, Sharada Municipality, Karnali Province***

However, the consulted head teachers had concerns on not being able to effectively mobilize the nurses in the absence of proper guidelines and scope of work for the school health nurse. Likewise, there were also concerns on the sustainability of the program in the absence of an internal school budget mobilizing the school health nurse program. There were also issues between the school health nurse and adolescent boys as adolescent boys felt ashamed to talk with the school health nurse (who is a woman) even if they wanted to ask about what was concerning them. As shared by the school health nurse, they are not able to provide proper care to the adolescent girls and boys as there are large number of students for one nurse to look after. Among the schools where the school health nurse program was not functional but had heard about the program, respondents felt the need for such a program to improve the reproductive health behavior among school going adolescents.

Adolescent boys interacting during a FGD in Banke

USAID ARH could advocate with the federal, provincial and local government to scale up school health nurse programs and thereby support adolescents to improve their reproductive health behaviors.

However, the program might need to think of alternatives to the school health nurse for discussing RH issues among adolescent boys as schoolboys were not very comfortable with school health nurses as suggested by the study. The team also recommends capacity building of these school health nurses in the adolescent health package as they are the first contact point for school going adolescent girls.

4.3 Program Approaches and Adaptation

4.3.1 Dreams and aspirations

The most important persons for adolescent girls and boys are their parents. More specifically, mothers are the most important person for them. A few spelled out that their friends (of same age) and their brothers (for boys) and sister-in-law (for girls) are the most important people in their life.

> ***"Mother is important to me because I feel like she understands every problem of mine. Since she has already been through all the stages I am currently experiencing, she is better positioned to advise me"-An adolescent girl with a disability, Salyan, Karnali Province***

In this milieu, the program might need to think about whom to include for the parental engagement activities. Since, most of the adolescents seem to be close to their mothers, it might be a good idea to engage with mothers more frequently than other members of the family. While for girls, since their sister-in-law appeared to be closer to them, they should not be neglected while designing parental engagement activities.

Adolescent girls and boys aspire to be doctors, engineers, nurses, police officers and also to obtain foreign employment (for out-of-school boys) in the future. Most adolescents want to become financially independent before getting married. When asked at what age they would get married, most of the girls said after they are 20 years old, and they plan to have children 2-3 years after marriage. However, when probed they said that if their parents ask them to marry earlier than that, they will have to get married as they cannot oppose their parents. This is true especially for girls from *Terai* region and Muslim girls in *Lumbini* province.

> ***"My parents are the most important people in my life. But I share my secrets with my best friend because it is easy to open up to her and she seems to understand my problems"- Adolescent girl, 15-19 years, Bara, Madhesh Province***

For adolescents with disabilities, fathers and mothers were the most important people in their life but they spend more time with their own friends with whom they share more about family, home life and what they are thinking. They aspire to learn more and be engaged in the teaching profession. Regarding marriage, they are aware of the age of marriage, and they prefer to get married after the age of 20.

The findings clearly depict that even though girls/boys are aware of the legal age of marriage and have prioritized their independence over marriage, they usually cannot deny their parents if asked to marry. Even the parents are aware of the legal age of marriage but in practice still prefer to marry early due to many social and gender norms. The program needs to design interventions to address these social and gender norms to delay early marriage.

4.3.2 School drop out

Girls from the hilly region have a tendency to drop out and get married on their own accord. The reason for these girls to drop out is because of a lack of interest in their studies. On the other hand, the out-of-school girls from the Muslim community in *Banke* said that they are forced to drop out of school (by their parents) and get married early as they are "too old to attend school". Adolescents in *Madhesh* Province left school due to poverty, unemployment, poor quality of education and the school environment not being good (boys make too much noise). Some out-of-school adolescents wanted to rejoin school if the school tuition and books were free.

"I have seen girls get married immediately after dropping out-of-school while boys migrate to India for work after leaving school." -A Teacher from Salyan, Karnali Province

However, some of the adolescent girls iterated they are too old to rejoin school and want to marry. Instead, they want to attend vocational training (beautician, tailoring) instead of returning to school which would allow them to earn some money. OOS adolescent boys mostly preferred vocational training (plumbing, electrician, mechanic, mobile repair) compared to rejoining school as most were from poor families and earning money from vocational training was a better option for them. However, there were OOS boys that showed interest in returning to school. The local government validated the findings where they shared that OOS boys might join the community learning centers but will leave once they get foreign employment, so skill based training is a better choice for OOS boys in *Madhesh* Province. The local government think most adolescent girls and wives are rejoining schools since male members are working abroad. The USAID ARH might need to consider married adolescent for UDAAN session.

With this backdrop, the program needs to segregate the adolescents willing to rejoin school or join vocational training. The program can establish linkages of these out-of-school adolescents into the available vocational training programs.

4.3.3 Group engagement

4.3.3.1 Adolescent Groups

Some groups like child clubs, youth clubs, and saving and credit groups were found in the study areas, some of which were functional while others were not functional anymore. When asked if adolescent girls and boys would like to be a part of some kind of group, all of them unanimously agreed to be part of the anticipated group. There was mixed response on having a heterogeneous group, however most preferred a homogeneous group (of either boys or girls) if they have to choose one, which was true in all Provinces. While with friends, they usually talk about their studies, future plans, and sometimes they talk about social issues. Boys sometimes talk about RH topics like family planning contraceptives however, for girls, the topic on menstruation was felt to be more relevant than any other topic.

For girls/boys group sessions the adolescent preferred to have a group in school, during weekends so that their studies are not hampered. The parents mentioned that having a group in school is safer for the girls and therefore they can send their girls for discussion without any hesitation. There was a mixed response from parents on having a heterogeneous or homogenous group. Some argued that since the adolescent girls and boys are learning together in school, there is nothing wrong in having a mixed group while others suspected that exposing girls in a mixed group with boys makes them more vulnerable to harassment and assault. Parents especially in the *Madhesh* Province did not want a heterogeneous group. Most of the girls

wanted sessions during snack breaks in school or immediately after classes are over, however, for *Madhesh* Province they preferred girls group sessions during the weekend.

OOS adolescents are busy in HH chores during the morning up to 10 am. They are open to being part of the program any time of the day after that. OOS girls wanted to have discussions in open places (*chautara*), as long as there are no outsiders present.

Girls during a FGD in Banke

Adolescent boys, girls and parents all agreed on having the group sessions weekly, fortnightly or monthly.

When asked about inclusion of boys/girls with disabilities in the group, all of the respondents agreed on including such adolescents in the same group. When adolescent girls and boys with disabilities were asked the same question, they also concurred on being included in the mixed group rather than having a separate group.

> ***"We feel good when we are included in the group of other boys and girls. We also get an opportunity to learn from them and get to know their perspective." An adolescent girl with a disability, Salyan, Karnali Province***

As for married adolescent girls, they prefer not being in a group with unmarried girls as they do not feel comfortable talking unmarried girls about FP/RH issues.

From different interactions, the research team concluded that group engagement within the school setting would be better for in-school adolescents. In this regard, the "*sathi* corner" envisioned by the project could be one effective method to get adolescents engaged in the groups in the school. While for OOS adolescents, groups within their community need to be created to discuss FP/RH issues. For married adolescents, the peer approach or homogenous groups of married adolescents would best fit.

4.3.3.2 Peer Mentor

Adolescents have never heard about peer mentors and no peer mentors exist in their community/schools. Once they knew about the concept, they were interested and would want to become peer mentors themselves. Brothers, sisters and sister-in-laws are the preferred mentors, however in the *Madhesh* Province they preferred peer mentors who are part of the adolescent groups and someone of their age. They would prefer peer mentors to be the same gender, same age or a bit older, and from the same locality. In *Madhesh* Province, some of the adolescents didn't have reservations on the age of the peer mentor as long as they can openly discuss their problem and the mentor has the ability to teach them about FP/RH topics. Most of the adolescents would not want someone from another community as they might not understand their context. They want peer mentors to be someone who is more knowledgeable than they are, someone who respects their dignity and does not undermine them.

"The main problem with our parents is that they do not or pretend not to understand us. We need someone who can relate to our problems, listen to us and understand us. This could be someone similar to our age."- adolescent boys (15-19 years), Bangadh Municipality, Salyan, Karnali Province

"Peer facilitators should be female of any age group but should be more knowledgeable. If mentors talk with parents and family, they will easily allow us to take part in educational sessions. Our parents think mentors will take care of girls. I am not comfortable with a mixed session. There will be shame, bullying and harassment in mixed sessions." Adolescent girl 10-14 years, Gaushala Municipality, Mahottari, Madhesh Province

However, in *Madhesh* Province the peer mentors especially for adolescent girls are not perceived well by the community people. Adolescents sometimes have to face many allegations for being a mentor.

"Communities perceive that peer mentors are bad "if we become peer mentors and teach people in the community then we are bad, and we are spoiling other people as well. They say "Labari". - Adolescent girl,15-19 years, Shamshi Rural Municipality, Mahottari, Madhesh Province

The peer mentor approach envisioned by ARH would be an important intervention in the given context. Since adolescents feel themselves left out because of the lack of proper communication with their parents/family members, they seek out someone who would listen to them without being judgmental. Adolescents might not always be seeking suggestions like parents tend to provide. The tendency of adolescents is to follow whatever their friends suggest. Engaging youth and training them to be peer mentors will be a good approach for bringing positive change in the FP/RH behaviors.

Adolescent boys interacting during a FGD in Bara

4.3.3.3 Champions

Adolescents liked the idea of having a champion in their community who could advocate for adolescent issues. Some of the girls mentioned that FCHVs could be the champion for them while most of the other adolescent could not envision any person existing in their community who could be the champion among them. Some of the adolescents in *Madhesh* province mentioned that there are facilitators who are working under other projects, and they could envision a similar person as a champion for FP/RH. No one except FCHVs from their community has been trained in FP/RH, however as some of the FCHVs were newly appointed and have not received specific training on FP/RH it may be hard for them to be champions immediately.

4.3.3.4 Intergenerational dialogue

At present, adolescent girls and boys do not feel comfortable talking with parents or seniors especially about FP/RH issues except for girls talking about menstruation with their mother. Upon describing the concept of intergenerational dialogue, they agreed it was a good idea especially, the OOS girls. They are open to discuss the FP/RH matters with their parents and community members, however, they want their parents/community members to initiate the discussion. However, for *Madhesh* Province, talking about FP/RH with their parents was unacceptable in their society and they would feel uncomfortable talking about FP/RH with their parents except about menstruation. However, a handful of school going adolescents mentioned it is ok to discuss about FP/RH with their parents (who are also educated). Some

other alternatives for intergenerational dialogues might need to be explored for these dialogues in *Madhesh* Province.

In *Lumbini* and *Karnali* Province, the same concept was also liked by parents, FCHV, and members of health mothers' groups. They said they would like to talk about FP/RH topics, assuming that they know the appropriate methodology and content. Likewise, the health coordinator emphasized the need of intergenerational dialogue on addressing various social norms and a means of making adolescents aware of the expected behaviors of parents from their children which would ultimately bridge the gap. However, in *Madhesh* Province, the parents shared that adolescents are more comfortable talking about FP/RH with their friends and their sisters-in-law/brother and they don't talk about these issues with their parents.

> ***"Our children think we do not understand them, and we think they do not listen to us. In my opinion it's just the matter of communication between us and our children. So, if we could create an environment where both the generations can come together and have a dialogue, a lot of misunderstanding would be unlocked on its own."- A mother from HMG in Salyan, Karnali Province***

The study team concluded that while discussing the various group engagement approaches, adolescent girls, boys and parents were interested in joining some form of group session to learn and interact about various adolescent issues. Group formation should be done based on the priority of the adolescents and respecting their desires. While identifying and selecting peer mentors and champions, priorities should be given to locals with whom the adolescent can relate and learn.

4.3.4 Adopting Innovation

4.3.4.1 Digital Technology

Girls with disabilities during a FGD in Bara

Almost all of the adolescent girls who took part in the study in *Lumbini* and *Karnali* Province had access to a mobile phone (access here means either they own a phone or can use someone else's phone for a significant amount of time), however this was very unlikely in *Madhesh* Province, where only a handful of adolescent girls had access to a mobile phone and when they did, it was for a very limited time. However, for adolescent boys, access to mobile phones was not a problem. They might not own a smart phone, but they can have access to it from any member of the family. For in-school adolescents, they do not have much time to spend on mobiles, while for OOS adolescents they use phones for a longer span of time ranging from 2 to 6 hours a day. Adolescent girls in *Madhesh* Province have access to mobiles only for 10-30 min per day after they complete all the HH chores, and some were not even provided a mobile in the evening. Mostly, they use a phone for phone calls, internet browsing for studies, watching videos, TikTok, Facebook, and gaming. Girls mostly watched short clips of dance, serials, comedy on TikTok, and very few played mobile games while boys play games like Free fire, Ludo, PubG, candy crush and bubble shooter. TikTok was unanimously mentioned by all adolescent girls and boys and most watched TikTok videos.

Girls who had access to mobile phones and those who were actively surfing the web disclosed that they seek a variety of information through internet such as academic topics, menstrual health, beauty related tips and so on. They also shared the information with their friends which were found to be helpful.

> ***"I sought information about managing menstruation on YouTube. I have also guided my peers and given suggestions and made my own friend aware during menstruation."-An adolescent girl from Sharada Municipality, Salyan, Karnali Province***

When talking about Game of Choice (GoC), they could not conceptualize how this game would be and therefore had no preference on the content of the GoC. Adolescent boys in *Madhesh* Province preferred competitive games and would like to have some reward for winning. In *Madhesh* Province, the adolescent girls were interested to know about their bodily changes and menstruation through the GoC platform. They preferred offline games and would want interactive games where they could make friends, talk to friends and win points. In terms of language, they preferred local language.

> ***"At this age, we tend to do a lot of things and become interested in clothes others wear. Therefore, changing attire and appearances in the game would appeal better to users like us." -Adolescent girls (15-19 years), Salyan, Karnali Province***

The parents mentioned that they would allow phone access to their adolescents who complete grade 10. They also discussed that adolescents use phones anyway, so it would be better if we could provide information through mobiles. However, In *Madhesh* Province, access to mobile phones, especially for adolescent girls, is limited as they would be busy in school, HH chores, homework and taking care of their siblings. Moreover, some of the parents were also reluctant about the use of phones as information has been circulating about the negative impact of excessive engagement in social media and influencing adolescent girls and boys, especially for instigating self-initiated marriage and eloping. Communities have negative perceptions about adolescent girls using mobile phones especially in *Madhesh* Province.

> ***"The community doesn't perceive girls who are too much on mobile phones as "good". If people from the community, see us playing or using a phone they click our picture and post it in Facebook." An adolescent girl in Madhesh Province***

Among the girls who had access to mobile phones, most of them liked to have group chats. They would text their friends if they encounter any problems. This helps them instantly seek support from friends. With this backdrop, the program may also consider forming groups of adolescent girls on social media with the provision of admin (someone from their own community) who is trained in ARH and can provide suggestions on the issues raised or refer to appropriate places for seeking services.

For married adolescent girls, they use mobile phones for communicating with their husbands, most of whom were migrant workers. As mentioned above, neither do they do want to be the part of unmarried adolescent groups nor part of health mothers' groups as they exist today.

From the evidence generated through discussions with adolescent girls and other stakeholders, it can be concluded that adolescent girls married and unmarried, digital platforms and mobile games could be one of the choices for teaching and learning about FP/RH for them. However, in areas without or with limited accessibility to mobile phones, there is a need to identify strategies to improve their access to digital platforms (mobile/web). Girls group sessions and near peer mentors could be some of the platforms

where these games could be demonstrated and discussed by the mentors or facilitators where girls have limited access to phones.

4.3.4.2. Voucher and coupon approach

Private clinics currently do not have any voucher/coupon system; however, they provide discounts on services/commodities to their regular customers. When the research team asked private providers about the voucher and coupon approach, they could not readily conceptualize it. Once it was explained, they feel the voucher/coupon approach would help to increase the client flow and would support the program if such activities are implemented and they are strengthened in terms of their capacity.

> ***"Vouchers will be an excellent idea for increasing clients. I will be very happy to apply such a system to my clinic. I will also offer discounts to support this type of voucher mechanism because it may increase the flow of clients into the clinic and allow me to share profits." Private Health Facility, Bara, Madhesh Province***

4.3.4.3 Coaching and mentoring

Health workers including those from private facilities believe that onsite coaching and mentoring is better equipped to provide hands on skill building to health workers. The health facilities in *Lumbini* and *Karnali* provinces received intensive mentoring and coaching from Strengthening Systems for Better Health (SSBH) activity. The onsite coaching had provided them the opportunity to correct neglected yet important behaviors for quality service provision.

> ***"The SBA trained staff knew that PPH management kits need to be made available during delivery. However, this was not practiced until we were told by team members of onsite monitoring and coaching. Following that particular visit of the team, we have always made sure that all the essential equipment is in place - Health service provider, Salyan, Karnali Province***

Many of the hospitals reported, post federalism, the health facilities including hospitals have been receiving supervision for general operations but not for specific services/programs. In fact, facilities have not received any onsite coaching and mentoring services including private facilities, mostly in *Madhesh* Province.

> ***"Onsite coaching is a good tool where we can learn while staying at the health facility." Public HF, Madhesh Province***

While onsite coaching was taken positively by all the health workers consulted, it was also mentioned that the health service provider would also require refresher training in specific topics when new guidelines or protocols are developed by the government and a common understanding is required among all the health workers across the Municipality.

A private health service provider iterated the need of both training and onsite coaching. While they insisted there's a need for training in new protocol/guidelines including record keeping and reporting, they also recognized the importance of onsite coaching.

> ***"Onsite coaching can be a good approach for improving service delivery. In addition to direct coaching and mentoring provided to us, we would also want to transfer our knowledge to our colleagues."-Private health service provider, Banke, Lumbini Province***

4.3.5 Collaboration and engagement with private sector

Some of the private facilities were registered in the Department of Drug Administration (DDA) while some were not. They provide services like pills, condoms, depo, counseling, Intrauterine Contraceptive Devices, and HIV testing services. Most unmarried adolescents come to private facilities for condoms and ECP as well as for pregnancy test kits, while married adolescents come for injectables. Private facilities want training and also want to coordinate with government service providers to better plan for providing services to adolescents. Regular supportive supervision/onsite coaching from the government entities is expected and welcomed, however, in reality is very limited.

Private Service Provider during a KII in Bara

Health coordinators welcome the private sector engagement activities. Nevertheless, none of the private health facilities in one of the program municipalities have been registered with the municipality. The reason for not registering as stated by the local government representative is that the private facilities did not agree to pay taxes to multiple authorities in order to register.

Some of the private facilities are already providing data to the local HF through the government record-keeping and reporting system, while some of the private facilities with access to DHIS2 do not. There were facilities which used to report the service data to district health offices however this practice was discontinued post-federalism. In addition, most of the private facilities usually do not record the service provided and do not report to local HF except for Malaria cases. The municipality is concerned of under/no reporting of the service provided by private health facilities and are planning to mainstream private clinics in their reporting system.

> ***"The government needs to develop a common record keeping and reporting tools applicable for private HFs too. It would be better if the private sector is also included in various trainings related to child health, FP, safe motherhood by the local government along with the record keeping and reporting of the services provided"- Private health service provider, Salyan, Karnali Province***

Some of the municipalities (*Lumbini* province) are also planning to provide specific training to the private sector for quality service delivery. Health coordinators are open to joint planning with the private sector which is only possible after the private sector provides the report on service coverage.

All of the health coordinators and health service providers (both public and private) emphasized the need to mainstream the private sector in the Health Management Information System (HMIS) reporting by providing them access to DHIS2 by the government. While the public service providers and health coordinators also would like to collect records from private health facilities and report in the government DHIS2 platform, the study team suggests building the capacity of the private sector in recording and reporting information in the government information management system and possibly providing access to the DHIS2 platform or reporting through the local health facility.

4.3.6 Governance and accountability mechanism

4.3.6.1 Health Facility Operation Management Committee (HFOMC)

Health Facility Operation and Management Committees (HFOMC) are the local health governance bodies responsible for functionality of the peripheral health facility (health post and the primary health care centers). The guideline lays down the composition of the committee, their responsibilities, objectives of providing effective health services and maintaining accountability and transparency in day-to-day management functions. Among the health facilities visited, all the health facilities had health facility operation and management committees and they were functional. In one of the health facilities in Salyan, it was found that the HFOMC was considerably active and supportive which is why the health facility even dissolved the Minimum Service Standard (MSS) committee as all the decisions related to service quality were made by HFOMC itself. The HFOMC had already identified potential adolescent members to be included in the committee in that municipality.

> ***"HFOMC of our health facility is a key body. It is very active and readily resolves any problem that our facility faces. I have no issues so far with the committee." -Service provider, public health facility, Salyan, Karnali Province***

However, in *Madhesh* Province, the HFOMC meeting is conducted only on a need basis and there are challenges around meeting allowances for attending regular meetings. The adolescent health agenda is not discussed in these committee meetings. All the health workers unanimously agreed that there is no involvement of adolescents in the management committee, however, the health workers agreed that involvement of adolescents in such committees would serve as a platform to discuss the issues that adolescents are facing and would also provide an opportunity to address the health and RH issues of the adolescent. Most of the health workers are aware of adolescents who could advocate on adolescent problems and could be a member of the HFOMC. The HFOMC in the health facilities visited are operating as per the new revised guidelines according to the health workers.

> ***"The HFOMC members asks for a meeting allowance while providing their signature during the health facility operation management committee meeting, therefore we only sit for the meeting as necessary"- Health Worker, Madhesh Province***

4.3.6.2 Community Score Card

The health workers in this study provided mixed evidence on availability of social accountability. The health workers valued the social accountability approach, however only public hearings as a tool for accountability were available in some of the health facilities. In the public hearing events, the health facilities disclose and discuss activities and budget with the HFOMC and general public who are the direct/indirect beneficiaries of the health services provided by the health facility. This is the platform where the general public can ask questions and the health facility staff along with the management committee are answerable and accountable. Some of the health facilities did not even have a citizens' charter, one of the basic requirements for accountability. The health workers are interested in collaborating with the program for developing accountability tools. When the research team further explored about the community score card, its use, and applicability, the health service providers of the public health facility in *Lumbini* and *Karnali* provinces mentioned that it would be a very helpful tool to reflect on the progress made by the health facility (They were already familiar with the Community Score Board). A health worker from *Karnali*

province further stressed the need of including private service providers in the interaction meeting so that the contribution of the private sector could also be discussed, and they could be encouraged to report to the health facility. When asked about what the possible indicators that could be included in the community score card, she mentioned antenatal check-ups, institutional delivery, postnatal care and family planning.

> ***"We can include indicators of public satisfaction as a measure to showcase our progress. Ultimately, the client should be satisfied to show our progress"- A health service provider from Salyan, Karnali Province***

4.3.6.3 Feedback and accountability mechanism

All the stakeholders consulted were positive about a Feedback and Accountability Mechanism (FAM). The different approaches mentioned were –thorough one-to-one physical meetings, group interactions, online web portal, messaging (through Viber, WhatsApp, Messenger) mobile apps, placing a suggestion box in opportune places and text messaging. Frequency of feedback collection varied among the participants. . They want their concerns to be addressed as soon as possible. However, the response would also depend upon the nature of the concerns raised. There were mixed responses regarding anonymizing the person raising concerns.

5. CONCLUSION

This formative research sought to assess the existing context of the districts within the USAID ARH program in terms of the social and behavioral norms, gaps/challenges in the current operating context and approaches for implementing the designed strategy for USAID ARH. This study revealed various social norms across the program areas hindering the FP/RH behaviors of adolescents. While all the social norms were not prevalent across all the geography and ethnic groups, nevertheless, these social norms should be dissected and analyzed while implementing adolescent FP/RH program. Social Analysis and Action, an evidence based reflective dialogue process, should be helpful to analyze and change these social norms and thereby contribute to improved gender-normative behaviors and improved family planning behaviors.

In Nepal, national policies and strategies suggest establishing adolescent-friendly health services and youth-friendly corners and many programs have adopted this approach. As evidence from this study emerges, not all health facilities in the study areas are adolescent friendly and most do not have a youth friendly corner. The quality of services for adolescents is deeply compromised as there is a sheer lack of trained health service providers, poor or no counselling, lack of confidentiality, and lack of communication materials. As a result, most adolescents prefer private facilities for FP/RH services because of these quality challenges. A quality improvement approach and onsite coaching and mentoring strategy adopted in the program could help to overcome these supply side barriers. Additionally, there is a need to establish or revitalize the various existing committees, which could serve as a potential platform to discuss adolescent issues and problems. None of the health facilities, including the hospitals were accessible to people with disabilities. The needs of adolescents with disabilities are not met and therefore integration of disability should be throughout adolescent policy documents and a planning process and mechanism has to be initiated to ensure a disabled friendly/responsive environment during program implementation for inclusiveness.

Local government holds the power to allocate budget for different target populations. Unfortunately, adolescents have not been among the priority target populations during program planning and budget allocation. To demonstrate the importance of adolescents, continuous advocacy and sensitization of the local leaders is necessary.

Adolescent boys, girls and parents showed interest to join group engagement sessions. As planned, group sessions should be an effective strategy for behavior change. Mobile access was more common in *Lumbini* and *Karnali* Province and less likely among adolescent girls in the *Madhesh* Province. Peer facilitators, peer mentors, FCHVs and school health nurses could be established to improve access to digital games among adolescent girls in *Madhesh* Province. Vouchers and coupons could be explored in the program as the private health service providers were interested in adopting this innovative model. Capacity building through onsite coaching and mentoring was widely accepted by all the health service providers. However, they preferred training for new protocols and guidelines, leaving onsite coaching and mentoring to support and improve on-going programs and services.

The HFOMC is active and functional with exceptions in some facilities in *Madhesh* Province. The findings suggest involvement of adolescents in these discussions could benefit in addressing adolescent health problems. While other health accountability tools are missing except the social audit mechanism, the community health score card was recognized as an effective accountability tool to track the progress of the health facility.

6. RECOMMENDATIONS

Drawing upon the findings, the study team has identified some areas for USAID ARH to consider for better programming. Below are recommendations and the rationale for them. The last column indicates whether the program's initial planned approaches and activities need to be radically changed, slightly changed or not changed at all.

	Major changes required to initial planned program activity		Minor changes required (could be context specific and a slight modification) to initial planned program activity		No changes required (Initial idea of project addresses the program needs)

SN	Recommendation	Rationale	RYG Rating
1	Social analysis and action (SAA) is necessary to transform the social norm.	Numerous social norms have been identified that affect adolescent reproductive health and family planning behavior. The formative research further explored that while some of the norms, like married adolescents are not allowed to use contraception unless they have at least one child, are straight forward others are rooted within and linked to other social norms (i.e. child marriage is deeply rooted in the practice of paying a dowry) and have an effect on different FP/RH practices related to adolescents. Hence, the study team strongly recommends using the SAA approach and developing the content addressing the norms identified in the study This activity has already been planned in the project.	
2	Advocate with the local level government on the importance of adolescent reproductive health being included in policy formulation including planning and budgeting.	The study witnessed low prioritization of adolescent health needs among the local government representatives. Adolescent needs should be recognized and prioritized by the local government. Advocacy at each level, but starting from the local government level, is imperative to help the government recognize the needs of adolescents. Continuous advocacy would sensitize the local government to understand the importance of adolescent health and leverage local resources to address the health needs of adolescents. Additionally, the project needs to ensure the participation of adolescents with disabilities in ARH policy formulation, planning budgeting and implementation to make it more GESI inclusive including development of modules in FP/RH to teach in school to support adolescents to adopt healthy behavior. Advocacy by adolescents was planned however the emphasis on disability was not explicit.	
3	A quality improvement approach to strengthen public health facilities and make them more	The research ascertained that adolescents preferred private facilities to public health facilities for seeking FP/RH services due to a lack of confidentiality and quality of services in the public sector. The program should develop interventions to enhance the capacity of	

	adolescent responsive is required.	public health service providers including FCHVs in adolescent responsive services. The onsite coaching and quality improvement approach planned by the project could help to overcome the system level barriers in the public health facility to make them more adolescent responsive.	
4	Capacity building including training, onsite coaching and mentoring are essential to ensure the quality of services offered by private providers. Additionally, the private sector needs to systematically report their data to the government through their management information system.	The private sector is the first choice for adolescents to access FP commodities like ECP and condoms. It was also found that private service providers are providing these services without proper counselling to the adolescent, especially in the use of ECP and its possible side effects. Hence, private service providers require capacity building/training, regular supervision and onsite coaching and mentoring to ensure that their services meet the government standards. The basic *Sangini* training and ASRH as envisioned in the program will enhance the capacity of the private providers in family planning methods including counselling among adolescents. The private sector needs to be able to access and enter data into the government management information system at the federal, province and local level and the project could support in enhancing the capacity of private providers to do so. All of these activities were planned as part of the program.	
5	Form and reactivate existing platforms to discuss adolescent health issues with meaningful participation of adolescents.	Various platforms exist in the health system like the HFOMC, RH committees, HMG. There is a need to form these groups/committees or reactivate them where they are not functional. These platforms could be a great entry point to initiate discussion on adolescent health needs and ensure adolescent representation to voice their problems. Additionally, ensuring participation of adolescents in these platforms would be beneficial to design adolescent responsive programming. This activity is already planned as part of the program.	
6	Adolescent girls/boys and parent group sessions will be an effective mechanism for behavior change.	Adolescent girls, boys and parents across the study areas showed interest to join the group engagement sessions (homogenous groups preferred) and could be one of the effective strategies for behavior change. School based groups for school going adolescents was preferred. Intergenerational dialogue needs to be cautiously implemented in *Madhesh* province considering the sensitivity of the topics discussed. These activities were planned as part of the program.	
7	An adapted approach to attract married adolescent girls should be envisioned for group formation.	Since married adolescent girls were not comfortable being in any of the groups envisioned by USAID ARH, different approaches like a peer-to-peer approach, or using peers as facilitators in married adolescent groups will be explored in order to effectively communicate FP/RH messages. The original activity envisioned using HMGs for married adolescents. This may still be possible however	

		some adaptations will need to be made to encourage married adolescents to attend.	
8	Design and implement more school-based activities to impart knowledge about FP/RH among adolescents.	The school-going adolescent identified school, teachers and books as a common source for receiving FP/RH information. Various interactions, group sessions and interpersonal activities could be conducted in the school. Similarly, since dropping out of school has been identified as linked to early marriage and early pregnancy, the program should also focus on motivating girls and boys to remain in school. Maximizing the use of the school health nurse (for adolescent girls) and male health teachers (for adolescent boys) to provide FP/RH information to school going adolescents will be considered. Although working with the school nurse was envisioned in the program originally, this recommendation suggests more extensive interactions at the school level.	
9	Advocacy for and collaboration with other agencies for referrals to vocational training for adolescent girls and boys.	One of the main reasons for dropping out of school was found to be a lack of interest in studying as the current teaching/learning methodology did not cater to the need for skills to secure future earning and sustenance for the family. Therefore, USAID ARH should link to skill-based training for adolescents (especially older adolescents 15-19 years). This can be done either by advocating to integrate vocational training in the local curriculum or linking with other vocational training agencies. This activity was not included in the planned program however will be extremely beneficial and not take too many resources as it will be added to our advocacy work and collaboration with other entities.	
10	Emphasize self-efficacy sessions for girls.	It was found that decision-making capacity for girls, regardless of their marital status, is low. Decisions about major life events ranging from dropping out of school to marriage to being pregnant or to using family planning/contraception largely rests on either parents, parents-in-law, or husbands. They have no say concerning their personal health matters. Hence, the project needs to work on improving the self-efficacy or boost the confidence of girls to be able to decide and communicate on the issues that directly affect her health. This issue was already taken into consideration within the SAA group sessions.	
11	Advocate for and facilitate the integration of the School Health Nurse Program in all schools of working Municipalities and implement capacity building exercises for school health nurses in ASRH.	School health nurses were found to be effective in imparting knowledge related to menstruation and RH among adolescent girls along with providing general examinations. Therefore, the ARH program will collaborate and facilitate strengthening the school health nurse program to improve the knowledge of adolescents. The program could think of approaches to maximize the use of this skilled cadre to improve the health of adolescents. Additionally, USAID ARH needs to advocate for the program with municipalities in schools where there are not already school health nurse programs. Although the program was always planning to work with	

		the existing school nurse program, it will be valuable to additionally advocate for and help initiate school health nurse programs where not already available.	
12	Adapt to local context communication materials for adolescents following NHEICC guidelines.	The ASRH (adolescent sexual reproductive health) booklet including other communication materials are largely unavailable in most of the health facilities. Additionally, there are no new communication materials being developed by the local government for adolescents. There is a huge opportunity to collaborate and support the local government to develop adolescent specific communication materials (digital and printed materials) as digital communication was the first choice for the adolescent. It is important to ensure the appropriate language while designing these digital and printed materials. Although the program will be developing some BCC materials/content, locally produced materials were not envisioned. The program will work with municipalities to develop materials and also will facilitate sharing between municipalities to learn from each other and adapt existing materials to be cost effective.	
13	Adapt context specific digital technology as a means of communication for adolescents.	Since access to mobile phones was different in *Madhesh* Province with very low access among girls as compared to *Lumbini* and *Karnali* Provinces, the digital technology envisioned by the project may need to be adapted. Different strategies like improving access of girls to mobile games through peer facilitators, peer mentors, FCHVs or school health nurses should be explored. In addition to the game itself, since girls were more interested in group chat, social media platforms could be added with support from champions as administrators of the group.	
14	Include capacity building activities for health care workers to offer services to adolescents living with disabilities.	The research findings have indicated that the health needs of adolescents with disabilities (or people with disabilities of any age) are not considered while planning health programs and offering health services. This comes mainly from a lack of awareness about the needs of people with disabilities and negative attitudes of the health workers/program planners at the local level. Hence the study team recommends designing awareness raising and capacity building activities for health care workers and planners. This specific activity was not originally envisioned in the program but can be easily integrated and is a necessity in order to offer inclusive programming.	
15	Provide technical support to the local government to develop and implement GESI and GBV policies/strategies.	The findings suggest that most of the local governments do not have GBV or GESI policies. Therefore, the program needs to map the local municipalities to identify the availability of GESI and GBV policies and provide technical assistance to develop and implement them.	

References

1. Sawyer SM, Afifi RA, Bearinger LH, et al. Adolescence: a foundation for future health. Lancet 2012; 379(9826): 1630-40. 3.
2. Central Bureau of Statistics. National population and housing census 2011. Kathmandu: Central Bureau of Statistics, National Planning Commission Secretariat, Government of Nepal, 2012.
3. Ministry of Health and Population. Nepal Adolescents and Youth Survey 2010/11. Kathmandu: Ministry of Health and Population, Government of Nepal, 2012.
4. Ministry of Health, Nepal; New ERA; and ICF. 2017. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.
5. Ministry of Health and Population, Nepal; New ERA; and ICF. 2022. Nepal Demographic and Health Survey 2022: Key Indicators Report. Kathmandu, Nepal: Ministry of Health and Population, Nepal.
6. Ministry of Health and Population, Nepal; WHO, 2017. Adolescent Sexual and Reproductive Health Programme to Address Equity, Social Determinants, Gender and Human Rights in Nepal, Report of the Pilot Project
7. Ministry of Health and Population, Nepal; UNFPA and UNICEF 2015, Assessing Supply Side Constraints Affecting the Quality of Adolescent Friendly Services (AFS) and the Barriers for Service Utilization.
8. Department of Health Services, Annual Report 2077/78, Kathmandu, Nepal
9. Napit, K., Shrestha, K.B., Magar, S.A. et al. Factors associated with utilization of adolescent-friendly services in Bhaktapur district, Nepal. J Health Popul Nutr 39, 2 (2020). https://doi.org/10.1186/s41043-020-0212-2

ANNEXES

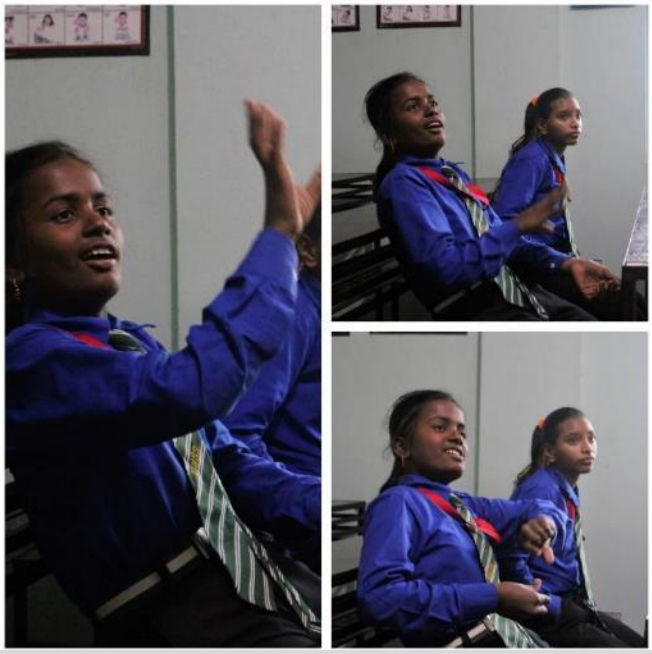
Annex 1: Stories in brief

1. Blank Slate: An opportunity to create social impact

Adolescent girls from *Shree Adarsha Secondary School, Khajura Rural Municipality in Banke district* and *Shree Durga Higher Secondary School, Kalaiya Municipality in Bara district* in Nepal prefer to share their secrets with their friends instead of their parents. This is a common trend among adolescents as they transition from relying on their parents to relying more heavily on their peers for guidance and support. Improved parent-child communication can help promote greater awareness and healthy behaviors, but cultural taboos and social norms often prevent parents from discussing sexual and reproductive health issues with their children. This can result in false information and risky behaviors among adolescents. To promote safer behaviors, it is necessary to approach sexual and reproductive health issues in an honest and age-appropriate manner.

Adolescent girls belonging to Muslim community answering RH related questions at Shree Durga Higher Secondary School in Bara district of Madhesh Province. Photo Credit: USAID ARH

2. Breaking the Silence: Same Opportunities for Disabled Adolescents



Hearing impaired adolescent girls from Shree Durga Namuna School in Bara district of Madhesh Province sharing their experiences. Photo Credit: USAID ARH

Hearing impaired adolescents attending *Shree Durga Higher Secondary School* in Bara district of *Madhesh* Province have limited knowledge about reproductive health and its significance. The teacher in-charge sees a pressing need for reproductive health education and services for these students. The community has a crucial role in helping disabled adolescents by offering social and financial support, educational opportunities, and advocating for accessibility and raising awareness. However, adolescents with disabilities often face specific difficulties in terms of their reproductive health, such as accessing health care due to physical or financial obstacles, experiencing stigma or discrimination, and needing to take into account specific medical requirements relating to their impairment. Therefore, it is crucial that health care professionals are aware of the needs and concerns of disabled adolescents and that they have access to comprehensive reproductive health education and services to ensure that adolescents with disabilities have the same opportunities as non-disabled adolescents to make informed decisions

Annex 2: Research Management-team division for the field work

USAID ARH plans to mobilize its internal project team for study purposes. Below table summarizes the responsibility of each of the team members.

People Involved	Primary Task	Time Engagement
Research and KM Manager Manisha Laxmi Shrestha	Develop research protocol and tools. Coordinate all the tasks to be performed and lead the process throughout, managing work plan, conducting data collection and analysis, generate results, write and submit report Coordinate debriefing while in the field and after the completion of the field data collection	45% of time
Director-Data Collection, Analytics and Use Mr. Bidur Bastola	Oversee major research related technical matters, design research tools and represent ARH in external dissemination activities, review final deliverables	30% of time
MEL Manager Ms. Sapana Koirala	Contribute while designing research tools, FGD and KII respondent's identification process. Technically supervise MIS specialist for maintaining the quality of the process Participate in data collection	10% of time
MIS Specialist Ms. Rabina Dhakal	Support Research and KM Manager throughout, managing work plan, design research tools Perform analysis and generate results	45% of time
Technical Advisor - Health System Strengthening and Governance Mr. Santa Dangol	Provide technical guidance related to ARH during research design and tools development phase Support in identifying the research sites Coordination with program teams as per work plan for mobilization of the program team	5% of time
Provincial MIS & M&E Specialist Bijendra Banjade and Santosh Aryal	Co-work with MIS Specialist (central level) to design research, develop tools, train the research team, data synthesis and analysis, and report writing	35% of time
Consortium partners staff (Nepal CRS	Jointly contribute in data collection and preparing transcripts	20% of time

Company, Jhpiego, HDI) and CARE field team Dan Bahadur Khadka Jukki Chaudhary Shankar Devkota Pramit Shah Anisha Karn Durga Rana Rakesh Yadav Karna Dhoj Chand Sudip Aryal Muna Khatri Kishor Bikram Sen Shikha Shahi Madhav Khanal Bhim Bahadur Saud Bandana Rana Paarash Jung Kandel Anish Bajracharya		

Annex 3: Study Area and Coverage

District	Municipality	FGD/KII
Mahottari	Samsi	Adolescent girls (15-19) Adolescent boys (10-14) Adolescent OOS boys Parents District Hospital Adolescents with disability Service provider (both public and private) Teacher School Health Nurse Health Coordinator FCHV
	Gaushala	Adolescent boys (15-19) Adolescent OOS girls Adolescent girls (10-14)

		Parents Private service provider Teacher School Health Nurse FCHV LG representative
Bara	Subarna	Adolescent girls (10-14) Adolescent OOS girls Adolescent boys (15-19) Adolescent OOS boys Health Mothers group Service provider (private) FCHVs Local government representatives
	Kalaiya	Adolescent girls (15-19) Adolescent boys (10-14) Health Mothers group Adolescents with Disability Service provider (public) Service provider (private) FCHVs Teachers School Health Nurse Local government representatives
Banke	Khajura	Adolescent girls (10-14) Adolescent boys (15-19) Adolescent OOS girls Health Mothers group District hospital (4 district) Service provider (private) FCHVs Health section coordinator from LG
	Narainapur	Adolescent girls (15-19) Adolescent boys (10-14) Adolescent OOS boys Parents Teachers Local government representatives

Salyan	Bangadh	Adolescent girls (10-14) Adolescent OOS girls Adolescent boys (15-19) Parents Service provider (public) Teachers Local government representatives
	Sarada	Adolescent girls (15-19) Adolescent boys (10-14) Adolescent OOS boys Health Mothers group Parents District hospital (4 district) Service provider (private) FCHVs Teachers Local government representatives

Annex 4: Research Schedule

	Activities/Months	Sept	Oct	Nov	Dec	Jan	Feb
1	Preparatory Phase						
1.1	Preparatory discussion with program team	x					
1.2	Desk review	x	x	x			
1.3	Finalize the research protocol		x	x			
1.4	Finalize research tools			x			
1.5	Take ethical approval from NHRC			x	x	x	
2	Execution Stage						
2.1	Training of research team					x	
2.2	Data collection					x	
2.3	Transcribing/translation of qualitative interviews (verbatim)					x	
2.4	Qualitative data analysis and visualization					x	
2.5	Preparation of draft report					x	
3	Finalization Stage						
3.1	Draft report circulation among internal team and feedback collection					x	
3.2	Preparation of final report					x	x
3.3	Final report submission to USAID						x

3.4	Response to USAID comments						x
3.4	Sharing of report findings						x

Annex 5: Data Collection Tools:

We will share tools with final version.