STATEMENT OF WORK FOR RESEARCH FIRM/ORGANIZATION TO CONDUCT A BASELINE STUDY FOR USAID'S ADOLESCENT REPRODUCTIVE HEALTH (ARH) PROGRAM

1. Introduction

Cooperative for Assistance and Relief Everywhere (CARE) started its operations in Nepal in 1978 and is one of the first international aid agencies to work in the country. During the last four decades, CARE Nepal has been working with the most vulnerable communities of Nepal to address the issues of poverty and social injustice, along with challenging harmful social practices, building capacities, and empowering livelihoods. Today, CARE Nepal works to address systemic and structural causes of poverty and social injustice such as discrimination based on gender, caste, class, ethnicity, or geography. CARE supports humanitarian actions to address vulnerabilities from climate change and natural disasters. CARE works with marginalized women and adolescent girls and boys to ensure their health and reproductive health rights, empowerment, well-being, and dignity through social transformation and access to quality social and economic services.

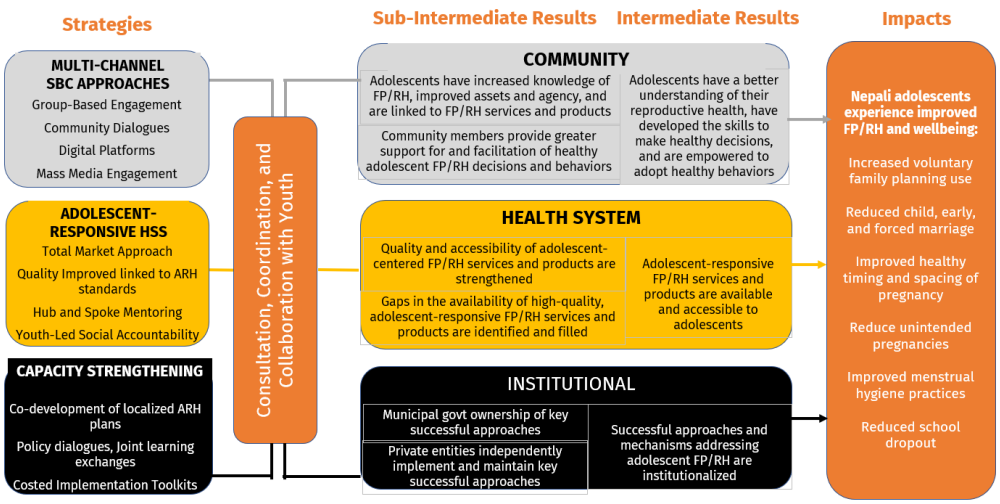
Adolescent Reproductive Health (ARH) is a five-year program supported by the United States Agency for International Development (USAID). Led by CARE Nepal and in partnership with the Howard Delafield International (HDI), Jhpiego, Nepal CRS Company and Association of Youth Organizations Nepal (AYON), is an adolescent co-led initiative to empower girls and boys of 10-19 years and including the most marginalized, to attain their adolescent reproductive health (ARH) rights. The primary goal of the USAID ARH program 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. The USAID ARH project will contribute to a healthy, resilient, well-nourished population in Nepal.

The purpose of this Statement of Work is to engage a local research firm having expertise in mixed-methods research to perform a baseline survey intended to establish the benchmark value of the USAID ARH program performance indicators. The research firm is expected to interview adolescent population 10-19 years, their parents and community people, municipality officials, public and private health facilities, etc. with a goal to understand the adolescent's healthy reproductive behaviors, current social norms, availability and accessibility of quality FP/RH services, access and utilization of adolescent-friendly services and products and key gaps in current services and systems.

2. USAID's ARH Program Background

USAID/Nepal's ARH program 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 behaviors. This program will work in coordination with the Government of Nepal 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 Province Health Directorate, Province Health Training Centers, ARH Civil Society Organizations (CSOs), private sector organizations, and professional associations. The primary goal of the USAID ARH program 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.

The ARH theory of change is based in the socioecological framework, which recognizes the need to address individual agency, family and community relations, and formal and informal structures for meaningful change in key behaviors. USAID ARH Program Theory of Change (TOC) posits that **IF we increase assets and agency** of adolescents through **social and behavior change (SBC) interventions** as well as **transform social and gender norms** of parents, teachers and service providers and, **IF we increase quality and accessibility of existing ARH services** by strengthening capacity and accountability of providers, **create linkages to services as well as expand availability**



of services by increasing the role of private sector in service provision and, IF we **institutionalize provision of quality ARH services** by supporting municipalities to contextualize, operationalize and budget for ARH policies as well as strengthen accountability structures and measures, **THEN adolescents will be supported and empowered to make healthier ARH decisions** leading to increased use of health services, delay in marriage, childbearing and reduced number of school dropout. The meaningful engagement of adolescents in co-creation and program implementation is foundational to our TOC and cuts across all objectives.

Program Objectives

- Provide accurate, relevant FP/RH information and behavior change support to adolescents; and educate their parents, teachers, and communities, addressing current social norms for adoption of healthy reproductive health behaviors.
- Improve availability and accessibility of quality FP/RH services for adolescents by identifying and addressing key gaps in current services and in systems that determine effective access and utilization of adolescent-friendly services and products
- Institutionalize successful data-driven approaches and mechanisms addressing adolescent reproductive health through the public and private sectors by improving health system governance.

Program Approaches

- Social and Behavior Change evidence-based interventions including group-based approaches, school-based approaches, platforms for out-of-school youth, youth-led activism, digital platforms, social media
- Social franchising and referrals to ARH service providers linked to Social and Behavior Change interventions
- Critical dialogue and reflection to address social norms building on formative research and participatory methods
- Integration of ARH quality standards and ARH quality improvement process
- Female Community Health Volunteer (FCHV) outreach and group engagement for married and/or pregnant adolescents
- Localized strategies for ARH at municipal levels including budgeting and planning
- Private sector engagement and partnerships for ARH services and products

Key Results

USAID ARH is expected to build on the successes of past USAID programs. ARH will contribute the Government of Nepal to achieve the following results: Please see project ToC, Result and Indicator in Annex-1.

- Adolescents have increased understanding of their reproductive health, life skills to make healthy decisions, and are supported to adopt healthy behaviors
- Community members provide greater support to adolescents for healthy ARH services and products
- Adolescent-responsive RH services and products are available and accessible to adolescents
- Local/Municipal governments fund and manage independently for key successful ARH approaches
- Private entities implement and maintain key successful ARH approaches
- Adolescents experienced improved reproductive health and wellbeing

Geographic Location

The Program will cover 60 municipalities (15 rural, 45 urban) in total. In Madesh Province 41 municipalities (415 wards) of 6 districts, in Lumbini Province 12 municipalities (94 wards) of 3 districts, and in Karnali Province 7 municipalities (87 wards) of 2 districts). Of total, 596 wards, the program will reach 360 wards directly and 236 other wards indirectly across these 60 municipalities. CARE Nepal will share details about the district, municipalities' names, during the discussion/inception phase.

3. Purpose

The overall purpose of the baseline study is to measure the current status of the 29 performance indicators, and set target/milestone. to track the effect of the program over time. The baseline data will also be used to design tailor-made interventions.

4. Study Design

A sequential mixed method study design will be used for this survey. Quantitative data collection will be done to assess the socio-demographic status, behavior and FP and RH understanding and healthy behavior of adolescent and community people. For this HHs level survey will be carried out with the adolescent age 10-19 and their parent's/guardians. A qualitative study will be conducted to understand social norms and behavior related to RH and FP; availability, access, gaps of quality RH and FP services in public and private health facilities. Focus group discussion will be conducted with FCHVs, other adult people from the community not having adolescent age 10-19 age population in HHS beneficiaries. Similarly, Key Informant Interviews and In-depth Interview will be conducted with District, Municipality and Province level stakeholders/Officials, Public and Private Health facility health workers, FCHVs, school head teacher/School Health and Nutrition focal teacher and local NGOs/CSOs representatives.

4.1 Study site

For the HHs level survey, data will be collected in 3 provinces11 program districts and 60 municipalities.

Table No 1: Distribution of Urban and Rural Municipalities

Province/District	Total URBAN Municipality	Total Rural Municipality
KARNALI PROVINCE	**7**	**0**
Salyan	3	0
Surkhet	4	0
LUMBINI PROVINCE	**3**	**9**

Banke	0	4
Rolpa	1	2
Pyuthan	2	3
MADESH PROVICE	**35**	**6**
Bara	4	1
Dhanusha	8	0
Mahottari	6	2
Parsa	3	1
Rautahat	8	0
Sarlahi	6	2
Total	**45**	**15**

4.2. Study participants

HH survey: adolescent girls and boys (age 10-19) regardless of marital status, and their parents/guardians.

Focus Group Discussion (FGD) and Key Informant Interview (KII): FCHVs, adult people from the communities not having adolescent age 10-19 age population in HHS, district, municipality and province level stakeholders/officials, public and private health facility health workers, school head teacher/ school health and nutrition focal teacher and local NGOs/CSOs representatives.

4.3. Proposed Sampling Technique

For the quantitative survey, cluster sampling is proposed. Multistage cluster sampling will be used. Probability Proportionate to size sampling approach will be used to select the clusters within the strata. Each of the 11 districts will be divided into Urban Municipalities and Rural Municipalities clusters. And the sample will be allocated to the municipalities so that the sample drawn is representative of the rural municipalities and urban municipalities of the working municipalities. In each selected municipality the required sample size will be computed according to the proportion of HHs size and adolescent population. In total data collection will be done in 8,060 HHs of the working municipality.

Sample Size Calculation

For key indicators, the baseline value is estimated based on the secondary baseline information and preset target; then, the required sample size is calculated using the formula,

$$n \geq DEFT \frac{\left[Z_{\alpha/2}\sqrt{2P(1-P)} + Z_{\beta}\sqrt{P_2(1-P_2)+P_1(1-P_1)}\right]^2}{(P_2-P_1)^2}$$

Where,

n is sample size
DEFT =1
Power= 0.80
α = Type I Error
β= Type II Error

Required Sample Size= 8060

One Adolescent boy or girl aged 10-19 from the HHS will be selected randomly for the survey even the more than one Adolescent is in the sampled HHS. The team will ensure interviewing 60% of Adolescent girls and 40% of Adolescent boys from the total required sample size considering the program focused on FP, RH and social norms change. Similarly, interviews with parents/guardians will be conducted only with 25% of the sampled HHs. The interview with parents will be focused on social norms change with others.

Table 2: Sample Size for Qualitative Study

For qualitative study, purposive sampling techniques will be used using a well-defined criterion.

Study participants	Qualitative tools	Sample size
Public health facility and private health facility staffs	KII	15 to 20
FCHV (urban 4-5) (Rural 4-5)	FGD	8 to 10
Relevant government officials at the province (Palika Coordinator)	KII	6 to 8
Relevant government officials at the municipality level	KII	6 to 10
School Teacher	FGD	8 to 11
FGD with Community People (not covered by HHs survey)	FGD	5-10
Local NGOs/CBOs representatives	KII	4 to 6

5. Scope of Work

The overall scope of the assignment is to support CARE and its consortium partners to undertake a baseline survey in line with the program result framework and its performance indicators with socio-economic background and contextual information. The research organization will be responsible for managing and undertaking the baseline survey by designing the overall methodology including the survey tools and data collection methods, providing training to the enumerators, data collection and quality assurance, data analysis, and writing the report. CARE Nepal with its consortium partners, will provide an overall supervisor for the baseline study including sharing relevant globally used study tools, guidelines, and framework.

The work responsibility/task of research firm/organization is described below,

I. Baseline Design and Preparation

- Understand the program, and baseline statement of work, and prepare an inception report. The inception report should have i. Introduction, ii. Methodology & sample size, iii. Quality assurance mechanism, iv. Ethical consideration, v. Data collection tools/instrument, vi. Work plan etc. section.
- Submit inception report to CARE and its consortium partner organizations for feedback.
- Jointly with CARE Nepal, prepare baseline study/research protocol and submit National Health Research Council for Ethical Review Board (ERB) approval
- Jointly, design sampling framework considering the population proportion to size considering the working 60 Municipalities (HHs, Adolescent population, working area population, public and private health facilities) as a sampling unit. Data need to disaggregate based on Age group, Caste/Ethnicity, Geography (Rural and Urban Municipality), and district, public and private health facility and other categories as relevant

- Propose a robust methodology to estimate the findings that is representative of the working municipality. The research firm will work closely with the program team later to finalize the methodology.
- Develop baseline data collection instrument i.e., survey questionnaire, FGD, and KII guide, and other tools to accumulate information based on the ARH performance indicator
- Finalize the baseline survey design and tools jointly with CARE and its consortium partners.
- Pre-test the qualitative and quantitative tools to check its validity and reliability and adjust based on the pre-test findings.
- Build quantitative questionnaire checklist in digital data collection platform to collect data using tablets/smartphone
- Prepare an overall plan for fieldwork in collaboration with CARE and its consortium partner organizations
- Take informed consent and accent from parents/ adolescents below 18 years and consent from adolescents 18 years and above before taking part in the survey.
- Hire a separate team of local enumerators for HHs survey and FGD and KII having a composition of boys/male and girls/female, from different geographic locations, understand and speak local language fluently, and train them on basic concepts of issues covered by data collection tools (I.e. ASRH, gender, norms), tools, respondent identification process, human research ethics and consent taking procedure, gender-based violence (GBV) risk mitigation and management process, code of conduct, data privacy, and field level data collection work itinerary.
- Select an appropriate location for training of the local enumerators that is accessible to all the 11 districts.

II. Baseline Execution

- Liaise with CARE and its consortium partner's staff to manage stakeholder engagement and communication
- Manage data collection work as per agreed field level itinerary.
- Conduct surveys using structured questionnaire with adolescent girls and boys regardless of marital status and their parents/guardians.
- Conduct FGD and KII with FCHVs, adult people for the communities not having adolescent age 10-19 age population in HHs, district, municipality and province level stakeholders/officials, public and private health facility health worker, school head teacher/school health and nutrition focal teacher and local NGO/CSOs representatives.
- Collect required follow-up information from respondent if needed through post interview communications and data gathering
- Periodically review the data into digital platform and paper base form to check its consistency and data quality.
- Set up a data quality assurance mechanism during the tool design, data collection, and after data is shared to the server from mobile/tablet by assigning a data quality assurance focal point. Similarly, conduct random verification on a sample basis to check the reliability of the data.
- Report any issues that require CARE Nepal or USAID attentions during the field work.

III. Baseline Report Preparation and Sharing

- Prepare dummy data analysis framework, output tables based on the instrument and agreed with CARE and its consortium partner organizations to use for final analysis
- Analyze quantitative and qualitative data and interpret findings to align with performance indicators with appropriate output tables. The baseline values should be presented in such a way that they can be used for target setting (as applicable), and tracked over time.

- Submit all quantitative data forms and qualitative data (raw data, including transcripts and translations, as necessary) to the CARE Nepal team.
- All the personally identifiable data in the raw data set need to be coded with pseudo names before sharing with CARE Nepal considering the data privacy.
- Provide additional interview notes collected which can help inform the understanding of the material in the reporting templates
  Develop and submit comprehensive and summary baseline survey report
- Present key summary findings

6. Expected Deliverables

The expected deliverables from research firm/organization are described below

- Inception report (understanding of assignment, methodology, sampling framework, data collection instrument, data quality assurance plan, execution plan)
- Baseline study/research protocol and ERB approval from NHRC
- Consent and assent forms, interview notes, transcripts and translations, clean and raw version dataset
- Draft version of baseline survey report
- Final baseline survey report- detail and summary report
- Present key summary findings in dissemination workshop
- Research manuscript based on baseline data-at least one manuscript

7. Reporting Line

The research firm/organization focal point will report to the assigned USAID ARH program/M&E team.

8. Expected Timeframe

The timetable shows only the main phases and stages. Once dates and a broad approach are agreed, a more detailed timetable will be developed during the inception phase. The expected starting date is November 21, 2022, and the End date is March 20, 2023.

Table No 4: Time Frame

Task	Period/Time	Location/Venue	Responsible
I. Design Phase			
Program sharing and preparatory meeting	1 day	USAID ARH Program Office	ARH Program Team
Document review and analysis	5 days	USAID ARH Program Office	Research Organization
Inception report and baseline study protocol preparation and sharing	10 days	Research Organization Office	Research Organization
Discussion and finalize inception report, baseline study protocol, proposed methodology, instrument, sampling framework and fieldwork itinerary	3 days	USAID ARH Program Office	ARH Program Team
Ethical Review Boards (IERBs) approval-NHRC	(25 days)		Research Organization
Pre-test the survey instrument	3 days	Adjoining Program District	Research Organization
Adjustment in the survey instrument based on a pre-test	2 days	-	Research Organization
Coordination and getting approval from municipality and province office for data collection work	-	From Respective Municipality Office	ARH Field Office Team
II. Execution Phase			

Training and field practice for local enumerators (Quant and Quall team)	5 days	Program Field Office	ARH Team and Research Organization
Data collection	35 days	Program Area	Research Organization
Data cleaning, processing, and analysis	7 days		Research Organization
Regular ongoing review of data into the server and hard copies and data quality assurance through random verification	Regular data collection work	Research Organization	
Prepare and share a draft report for review	15 days	Research Organization Office	Research Organization
Review and share inputs on a draft report	(15 days)		ARH Team
Incorporate relevant input and share the final version report	5 days		Research Organization
Presentation and sharing of finding	1 day	USAID ARH Office	Research Organization
Expected Total Working Days	**92 Days**		

9. Evaluation Criteria

All applications will be objectively evaluated by a procurement committee using the following criteria and based on a total score of 100.

I. Technical proposal: Detailed and appropriate description of methodology how applicant will implement, manage, and monitor the quantitative surveys and qualitative interviews in each study population described in the RFP **(40 points)**

II. Team Composition: A right sized senior team with skill-mix and relevant experience to lead the design and implementation of the baseline. Proposed a right-sized team of data collectors with due considerations to age and sex for the quantitative and qualitative data collection. Demonstrated ability of the team to hire and manage field data collection teams with appropriate academic backgrounds and professional experience in conducting structure checklist-based enumeration, surveys, and qualitative interviews **(15 points)**

Additionally,

- Highly competitive team having a composition of expertise in mixed method research design, sampling framework, Gender and Social Inclusion, Social Norms, Social and Behavior Change Communication (SBCC), Adolescent Reproductive Health (ARH), Family Planning, and ARH-focused program in Nepal
- PhD preferable for the team lead having team management/mobilization expertise and previous experience on similar surveys/studies with at least two research articles published in Reproductive Health & Family Planning theme in a peer-review journal
- Team Leader should familiar with the structure and roles and responsibilities of officials within the MoHP, federal context and structure and Adolescent Reproductive Health and Family Planning programs and services in Nepal

III. Past performance: Experience conducting large surveys, quantitative and qualitative data collection, experience working with the adolescent population and in the ARH, FP, Gender, Social Norms and SBCC field **(15 points)**

Additionally,

- Demonstrated track records of high-quality quantitative and qualitative research work, and studies in Nepal. Examples of at least three similar completed assignments and outputs shall be shared during the discussion meeting.
- Familiarity with the integrated Health Management Information System (iHMIS)

IV. Budget: Proposed costs are reasonable, justifiable, and realistically comprehensive of all necessary team remuneration, supplies, materials, and other costs associated with baseline study implementation. Budget is clear and understandable **(30 points)**

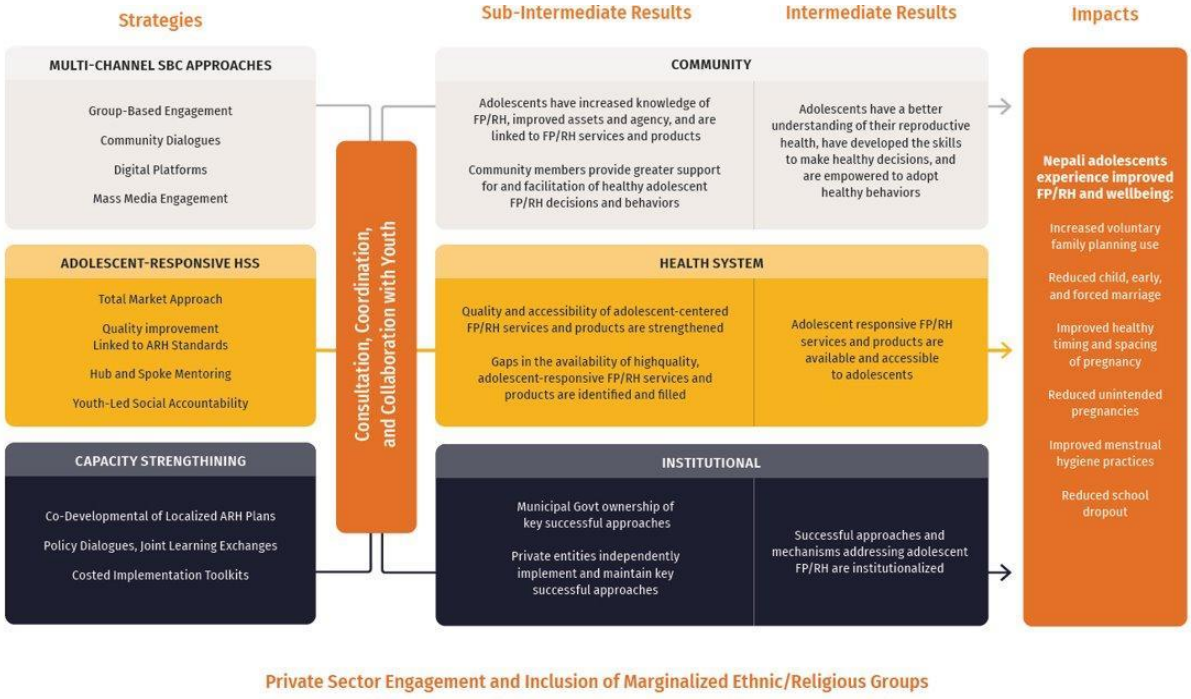
Additionally,

- Registration at the appropriate government authority
- Registration with Inland Revenue Office
- Latest audited financial statement and tax clearance certificate

10. Submission Guideline

Interested research firms, organization, who meet the above requirements should apply by submitting their Expression of Interest (EoI) with technical proposal (maximum 20 pages) that outlines the understanding of the proposed baseline study overview, methodology, sampling framework, targeted respondent reach approach, similar work experiences, brief technical description and capacity of team proposed, work plan, organizational profile highlighting relevant experience, and field work budget and budget narrative vie emailed to **npl.carenepal@care.org** with subject line **"Baseline Survey for USAID ARH** Program" or Hard copy can be submitted to the CARE Nepal office, Jhamsikhel Lalitpur. But, we preferred submission of e-copy. Interested consultancy firms/companies can send questions regarding the terms of reference to npl.carenepal@care.org by 19th October 2022 The closing date for application is **November 4, 2022**. Only short-listed applicants will be contacted for presentation, discussion and sharing.

Annex-1
Theory of Change (ToC) USAID Adolescent Reproductive Health in Nepal

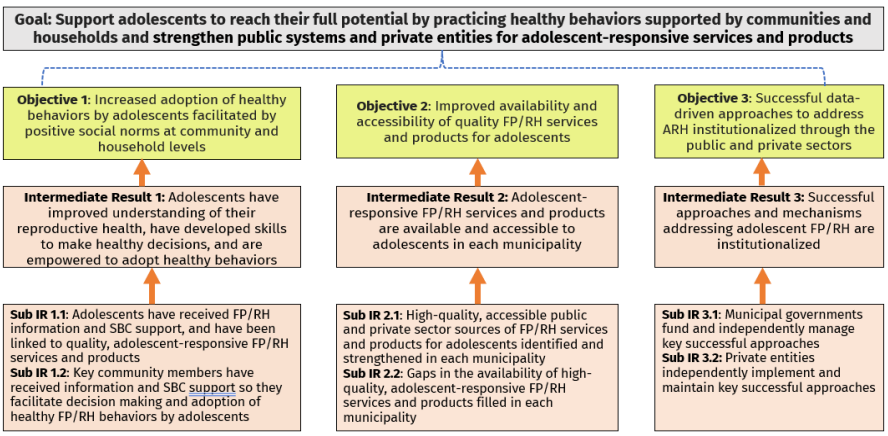


The ARH theory of change is based in the socioecological framework, which recognizes the need to address individual agency, family and community relations, and formal and informal structures for meaningful change in key behaviors. USAID ARH Program Theory of Change (TOC) posits that **IF we increase assets and agency** of adolescents through **social and behavior change (SBC) interventions** as well as **transform social and gender norms** of parents, teachers and service providers and, **IF we increase quality and accessibility of existing ARH services** by strengthening capacity and accountability of providers, **create linkages to services as well as expand availability of services** by increasing the role of private sector in service provision and, **IF we institutionalize provision of quality ARH services** by supporting municipalities to contextualize, operationalize and budget for ARH policies as well as strengthen accountability structures and measures, **THEN adolescents will be supported and empowered to make healthier ARH decisions leading to increased use of health services**, **delay in marriage, childbearing and reduced number of school dropout.** The meaningful engagement of adolescents in co-creation and program implementation is foundational to our TOC and cuts across all pathway. Key assumptions in this theory of change are that these results and impacts resonate with adolescents as the primary target group as outcomes of interest. Risks include misalignment of program theory of change with results and outcomes most relevant to adolescents. To avoid this risk, as part of startup ARH will hold sessions with adolescents to discuss the relevance of key results and outcomes and adapt the theory of change as needed as part of adaptive management and learning.

How do we bring change at Community Level, Health System Level and Institutional level

Community Level
USAID ARH leverages gender-transformative approaches to address social norms and practices affecting ARH in tandem. These approaches are mutually supportive, facilitating sustainable behavior change

through reflective (knowledge, norms) and reflexive (habit) drivers that support motivation and meaning for target groups. Social Behavior Change (SBC) and transformative norms approach will use multiple channels with group-based interventions as the foundation. Group-based interventions are an evidence-based mechanism for building knowledge, skills, and empowerment and providing links to service providers. Girls' group sessions will include interactive exercises and reflective dialogue to explore RH information (fertility awareness, HIV and other STIs, menstrual hygiene management). Girls will also gain skills in negotiation (peer pressure, cross-generational relationships), leadership, risk perception, decision making, and financial literacy as well as building their capacity to safely challenge gender norms and child and early forced marriage (CEFM). Group-based interventions will be amplified and reinforced through cutting-edge digital media, the online portal (games, videos, chat box), social media, and radio ensuring broad coverage. The SBC content for adolescents will be aligned with content developed for adults to support normative change work with parents, teachers, religious leaders, and service providers. The program will engage parents, teachers, religious leaders, and others in the community who may act as barriers to adolescents' agencies and their access to ARH services. Adolescent mothers will be engaged through FCHV-led structures.



Health System Level

Health service providers are a key target audience. Underpinned by the Total Market Approach, USAID ARH will leverage existing government standards for quality health care services for adolescents to ensure quality FP/RH service delivery for adolescents. The program will build the capacity of public and private sector providers as well as implement a comprehensive Quality Assurance (QA)/QI program through a hub-spoke mentoring model. A hub-and-spoke mentoring model will be employed, whereby district hospitals serve as the "hubs" to provide municipal health facilities low dose, high-frequency technical assistance, and supportive supervision related to their ARH capacity. Given public sector constraints and adolescent preference for private sector health providers, the ARH Program will increase private sector engagement in ARH. Product availability will be expanded through the Game of Choice (GOC) social franchise network. The ARH Program will also address ARH service delivery gaps in rural and remote areas through co-creating and implementing a strategy with private sector providers to incentivize them to expand the availability of ARH services and products in these areas where they already have a large presence. Community Scorecard (CSC) results in local youth-led governance and accountability structures support identifying the quality of health services, identifying bottlenecks, assigning responsibilities and implementing service improvements.

Institutional Level

USAID ARH will build the investment case for municipal governments and private sector providers to prioritize, integrate and finance ARH ensuring scale-up and institutionalization of evidence-based approaches. Key interventions include supporting municipalities and the private sector to contextualize ARH policy, activating provincial level reproductive health operational committees (RHOCs), demonstrating evidence for USAID ARH approaches and informing prioritization of ARH interventions

as well as developing and building capacity on the use of costed implementation toolkits to facilitate the municipal budgeting for ARH. USAID ARH will target private sector professional associations to ensure scale-up, institutionalization, and sustainability of key interventions including the social franchise program using data to demonstrate the viability of the program. To build learning and ownership of USAID ARH approaches, we will convene stakeholders across the government, private sector, professional associations, and adolescent and community groups to advance dialogue and social accountability during and beyond the program. These forums will strengthen the collaboration between provincial/municipal health offices and the private sector, from increasing government knowledge of the private sector to strengthening data sharing, and jointly identifying challenges and solutions.

Change Measurement Indicator and Mapping with ToC

This table maps the key indicators aligned with each result in the ARH Theory of Change (Result 1: Community, Result 2: Health Systems; Result 3: Institutional level). Five indicators below are at the overall impact level, with 9 indicators to measure the community-level pathway, 10 indicators to measure system pathway, and 7 indicators to support measure institutional pathway.

Result Statement and Indicator	**Indicator Type**	**Reporting Frequency**	**Indicator Link with ToC Pathway**
Goal: Support adolescents to reach their full potential by practicing healthy behaviors supported by communities and households and strengthen public systems and private entities for adolescent-responsive services and products			
Age at first marriage	Impact	Twice Y1 & Y5	All 3 pathways contribute to impact
Percent of girls dropping out of school (selected sentinel schools)	Impact	Twice Y1 &Y5	All 3 pathways contribute to impact
Percent of women aged 15-19 years with non-first births who had given birth with at least 33 months of birth spacing	Impact	Twice Y1 and Y5	All 3 pathways contribute to impact
IR 1: Adolescents improve RH understanding, develop skills, are empowered to adopt healthy behaviors			
Percent of currently married girls 15-19 years who reported making the decision to use contraception jointly with their husband or by themselves	Outcome	Annual	Community Pathway
Modern contraceptive prevalence rate among women aged 15-19 years	Impact	Twice Y1 & Y5	All 3 pathways contribute to impact
Sub IR 1.1. Adolescents have increased knowledge of FP/RH, improved assets and agency, are linked to FP/RH services and products			
Proportion of Adolescents (10-19) with basic knowledge on FP and RH	Outcome	Annual	Community Pathway
Number of individuals in the target population reporting exposure to FP messages through/on radio, electronic platforms, community group dialogue, interpersonal communication or in print. (**FP HL. 7.2-3)**	Output	Annual	Community Pathway
Percent of audience who recall hearing or seeing a specific USG-supported FP/RH message (**FP. HL. 7.2-1)**	Output	Annual	Community Pathway
% of digital platform users aged 10-19 years acting on in-game referrals for ARH services/products	Output	Annual	Community Pathway
Number of innovations supported through USG assistance **(STIR-10)**	Outcome	Annual	Institutional Pathway

Sub IR 1.2 Community members improve support for, facilitation of healthy adolescent FP/RH behaviors			
Percent of Community members describing positive changes in social norms for healthy RH behavior of adolescents in targeted municipality	Outcome	Annual	Community Pathway
% community members reporting high equity in gender norms (Gender-Equitable Men Scale)	Outcome	Annual	Community Pathway
Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations **GNDR-8**	Outcome	Annual	Community Pathway
Number of USG-assisted community health workers (CHWs) providing FP information, referrals, and/or services during the year **FP HL. 7.2-2**	Outcome	Annual	Health System Pathway
Percent of married adolescent 15-19 years who attended at least one Health Mother's Group in the last 6 months.	Outcome	Annual	Community Pathway
IR 2 Adolescent-responsive FP/RH services, products are available, accessible in each municipality			
Percent of health facilities with readiness for adolescent-responsive contraceptive services **USAID CDCS (2020-2025) indicator 3.1-3**	Impact	Annual	Health System Pathway
Couple Years (15-19) protection in USG supported programs (**FP. HL.7.1-1)**	Outcome	Annual	Health System Pathway
Number of FP client visits to the ARH- supported health facilities/SDPs	Outcome	Annual	Health System Pathway
Sub IR 2.1. Quality of FP/RH services, products for adolescents is strengthened			
Percent of adolescent FP clients who received rights-based/quality family planning counseling services	Output	Annual	Health System Pathway
Percentage of USG- assisted service delivery sites providing FP counselling and/or services (**FP-HL.7.1-2)**	Output	Annual	Health System Pathway
Average Percent improvement in Community Health Quality Score Card (CHQSC) scores	Output	Annual	Health System Pathway
Sub IR 2.2. Gaps in availability of high-quality, adolescent-responsive FP/RH services, products filled			
Percent of adolescents (age 15-19) reporting unmet need for family planning	Outcome	Annual	Health System Pathway
Average stock out rate of contraceptive commodities at FP service delivery points (**FP.HL.7.1-3)**	Outcome	Annual	Health System Pathway
IR 3: Successful approaches addressing adolescent FP/RH are institutionalized			
Number of innovations supported through USG assistance with demonstrated uptake by the public and/or private sector (**STIR-11)**	Outcome	Annual	Institutional Pathway
Percent of USG-assisted organizations with improved performance (**CBLD-9)**	Outcome	Annual	Institutional Pathway
Sub IR 3.1. Municipal governments exercise ownership of key successful ARH approaches			
Percent of municipality completing, endorsing a budgeted localized ARH plan	Output	Annual	Institutional Pathway
Number of municipalities allocating funding dedicated to ARH in annual work plan and budgets	Output	Annual	Institutional Pathway
Number of provinces with functional reproductive health coordination committees	Output	Annual	Institutional Pathway
Sub IR 3.2. Private entities independently implement/maintain successful approaches			
Percent of municipalities implementing monitoring and supervision of ARH quality standards among private providers/outlets	Output	Annual	Institutional Pathway

Note: There are a few 5-8 additional indicators that will be available during the discussion phase.