Report

Midterm Review of the Adolescents 360 Program

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Submitted by Itad

In association with Avenir Health and London School of Hygiene and Tropical Medicine

Results in development

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Disclaimer

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Contents

List of acronyms

A360	Adolescents 360
ASRH	Adolescent sexual and reproductive health
AYSRH	Adolescent and youth sexual and reproductive health
CIFF	Children's Investment Fund Foundation
CEA	Cost-effectiveness analysis study
CYP	Couple-years of protection
FGD	Focus group discussion
FMOH	Federal Ministry of Health
FP	Family planning
HCD	Human-centered design
HEP	Health Extension Program
HEW	Health Extension Worker
IDI	In-depth interview
IPC	Interpersonal communication
KII	Key informant interview
LSHTM	London School of Hygiene and Tropical Medicine
LARC	Long Acting Reversible Contraceptive
mCPR	Modern contraceptive prevalence rate
MMA	Matasa Matan Arewa
MTR	Midterm review
MOH	Ministry of Health
M&E	Monitoring and evaluation
OE	Outcome evaluation
PAR	Participatory Action Research
PHC	Public Health Center
PE	Process evaluation
PSI	Population Services International
QA	Quality assurance
SFH	Society for Family Health
SRH	Sexual and reproductive health
TA	Technical assistance
ToC	Theory of Change
TWG	Technical Working Group
UCB	University of California, Berkeley
WDA	Women's Development Army

Glossary

- **A360 approach:** Interpreted by the evaluation team as the application of the six A360 disciplines to design a solution to improve the uptake of modern contraception among adolescent girls aged 15 to 19 years old.

- **A360 disciplines:** Human-centered design (HCD) (also referred to as user-centered design at the start of the program), public health, social marketing, adolescent developmental neuroscience, sociocultural anthropology and youth engagement (also referred to as youth-adult partnership at the start of the program).

- **Adoption**: Interpreted by the evaluation team as references to the use of the A360 approach or any components of it by the wider PSI organization, other implementing organizations and governments.

- **Assets:** The term used by IDEO.org to describe the suite of interventions and supportive materials that comprised the piloted solutions.

- **Blueprint for change:** An external programmatic communication tool for adopting A360.[1]

- **Design sprint:** A short, intense period of in-country IDEO.org support to a Population Services International (PSI) or Society for Family Help (SFH) country office, often to address a specific design challenge.

- **Interdisciplinary taskforce:** A taskforce comprising representatives of the A360 discipline experts and technical support from the wider PSI organization.

- **Minimum design standards:** Developed by A360, these were a set of standards on the application of each of the A360 disciplines, intended to guide design teams during prototyping.

- **Prototyping:** 'Prototyping is the stage of the human-centered design process where ideas come to life. Building prototypes is a low-cost and risk-averse way to get your ideas into the hands of the people you're trying to change.'[2]

- **Replication:** Is associated with the replication of the solutions/interventions or components of the solutions/interventions by PSI (with other funding sources) and by other organizations and governments.

- **Report cards**: A tool developed by the A360 Consortium to document and present the results of different design phases. This included the presentation of learning and results against desirability, feasibility, sustainability and scalability.

- **Solutions:** The country-level interventions produced through the HCD process. A360 has four solutions: Kuwa Mjanja in Tanzania, Smart Start in Ethiopia, 9ja Girls in Southern Nigeria, and Matasa Matan Arewa (MMA) in Northern Nigeria.

- **Young designer**: A young person engaged in designing the A360 solutions.

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[1] A360 Blueprint for Change: https://www.psi.org/wp-content/uploads/2018/08/BlueprintForRapidChange.pdf.

[2] Human-Centered Design 201: Prototyping: https://www.plusacumen.org/courses/prototyping

Executive Summary

Executive Summary

About A360

Adolescents 360 (A360) is a four-year, $30 million initiative (2016 – 2020) to increase adolescent girls' access to and demand for modern contraception in developing countries, beginning with Nigeria, Ethiopia and Tanzania. The program is implemented by a Population Services International (PSI)-led consortium, and co-funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation.

The A360 approach has drawn on six disciplines to develop country-specific adolescent and youth sexual and reproductive health (AYSRH) solutions: human-centered design (HCD), public health, adolescent developmental neuroscience, socio-cultural anthropology, youth engagement and marketing. Two years into the program, A360 has developed four solutions to increase uptake of modern contraception among girls aged 15 to 19 in Ethiopia, Northern and Southern Nigeria, and Tanzania.

A360 phases and timeline

| Inception | Inspiration | Ideation | Pilot | Optimization | Scale |
| JAN – AUG 2016 | SEPT – DEC 2016 | JAN – JUL 2017 | AUG - DEC 2017 | JAN - JUN 2018 | JULY 2018- 2020 |

About the evaluation

This midterm review (MTR) synthesizes evaluation findings from the design phase of A360 against key areas of interest for the A360 Consortium and the Foundations. It is based on data collected from Inception phase (August 2016) through to the beginning of Scale phase (September 2018), drawing together insights from:

- An ongoing process evaluation (PE) grounded in qualitative methods and the systematic review of A360 documentation and data. As of September 2018, around 300 interviews, 60 focus groups and 57 observations had been conducted across Ethiopia, Nigeria and Tanzania.
- A cost-effectiveness analysis (CEA) which seeks to understand the main cost drivers of the A360 approach.
- The baseline findings from an outcome evaluation (OE) aiming to assess the impact of A360 on the prevalence of voluntary use of modern contraception (mCPR), using a pre- and post-population-based cross-sectional survey design.

Key findings: the design of A360

The A360 approach is characterized by its six disciplines, which have had different levels of influence on the solutions. While the approach is now identified by A360 as transdisciplinary, HCD was regarded as the driving force of the design process, with the other disciplines feeding in through report cards, an Interdisciplinary Taskforce and minimum design standards. While all the disciplines are felt to have added value, their level of influence on the solutions differs based on the level of effort and resources allocated to each discipline representative or organization. Staff consider HCD

and youth engagement the most influential of the disciplines, although there have been some tensions, including:

- The formative research and prototyping processes were driven by HCD tools and language over the other disciplines. There were some concerns that the insights developed favored breath over depth, and had not sufficiently considered existing evidence. HCD also emphasized 'putting the adolescent girl at the center', which led to a focus on desirability of prototypes to adolescent girls over other considerations – while this has been widely valued, it raised some concerns about the feasibility and scalability of the prototypes being tested. It also meant that A360 did not design for solution implementers (e.g. service providers), who are fundamental to the success of the program. In Ethiopia and Nigeria, additional work has been required in the Optimization phase to develop a more in-depth understanding of service providers' perspectives.

- Youth engagement is hailed by A360 as one of the successes of the approach. However, there are some questions over how meaningful it has been in all cases.

Despite these challenges, **A360 has created a cadre of implementers with the capacity to work in a new way** through their exposure to new ways of thinking about program design, increasing their empathy towards young people and their capacity to design programs with users at the center.

Solidifying partnership with other implementing organizations for scaling the solutions has been a challenge throughout the design process. This appears in part due to the competitive environment of sexual and reproductive health (SRH) programming, and in part due to the challenges of pursuing partnership while also undergoing an intensive design process and promoting adoption and replication.

In total, $9.9 million was spent designing and implementing A360 up to and including the end of the pilot phase. This includes an estimated $2-3.5 million spent creating the A360 approach, $5-6.5 million spent implementing the A360 solutions, and $1-1.5 million spent on activities to promote the replication of the A360 solutions and adoption of the A360 approach. The CEA suggests that if the A360 approach was being applied in a similar fashion again, $800,000 could potentially be saved across these categories.

Key findings: the A360 solutions

Monitoring data suggests that A360 is on track to meet its target of 244,738 adopters by the end of the program. As of August 2018, 120,443 adolescent girls had attended A360 events, and 65,971 of these had adopted a modern contraceptive method – representing a cumulative conversion rate of 70% in northern Nigeria, 61% in Tanzania, 62% in Ethiopia and 42% in southern Nigeria. These results compare favorably against benchmarks from similar programs.

Linking contraception to aspirations has been key to achieving these results. In all contexts, solutions seek to position contraception as relevant and valuable through aspirational messaging about achieving one's dreams, autonomy, the value of self-worth, financial planning and caring for a family. Even at this relatively early stage of implementation, this appears to be one of the key successes to date.

A360 is also addressing the attitudes of service providers implementing the solutions. This is particularly apparent in Nigeria and Ethiopia, where engagement with public sector service providers is accompanied with training and on-the-job support and supervision. However, A360 has faced multiple obstacles that hinder service providers from actively counselling adolescent girls on all available methods, including weaknesses in health systems, and entrenched service provider bias towards and against particular methods. A360 is currently considering what more can be done to address these barriers as the solutions go to scale.

A360 is increasing girls' access to contraception through mechanisms that allow contraceptive services to 'fly under the radar.' However, this may bypass rather than address community myths,

misconceptions and stigma. The A360 solutions allow adolescent girls to access modern contraception 'under the radar,' helping them circumnavigate entrenched community stigma. This has been achieved through opt-out counselling moments, using aspirational brands which avoid direct reference to contraception, and employing 'hooks' such as entrepreneurship or vocational skills classes to encourage attendance at events. However, while evidence from monitoring data and the process evaluation suggests that this does work to increase uptake of contraception in the short term, it may be at the cost of actively addressing harmful community myths, misconceptions and stigma around contraception for adolescent girls.

A focus on achieving a minimal viable product, using adoption and conversion figures as benchmarks for success, has reduced incentives to implement aspects of the solutions that were designed to address some of the gender and social norms challenges. A360 aims to reach just under 250,000 girls with modern contraception – an ambitious target that has put significant pressure on implementing teams. This, along with a push to drive down costs to identify a 'minimum viable product' during the Optimization phase, has contributed to the decision to move away from some activities designed to address social norms or promote sustained engagement between girls and service providers, as country teams have focused on honing their solutions to emphasize elements that make an immediate difference to contraceptive uptake. This risks prioritizing short term results over efforts to establish a more supportive enabling environment for girls to access contraception in the longer term.

A360 has been actively promoting its approach and solutions to encourage others to adopt or replicate them. However, some of these promotion activities may have been premature, beginning before rigorous evidence on the effectiveness of solutions was available. Outcome indicators on replication and adoption have imposed pressure to communicate the successes of both the A360 approach and the solutions from early on in the program, before evidence became available on their effectiveness. While this has encouraged communication about learning and innovation – a welcome development in the competitive environment of SRH programming – there is a risk of declaring success too early, before solutions have been rigorously tested. Such a strong focus on adoption and replication from the outset has also taken substantial financial and human resources, adding to the already high workload of implementation teams during the early stages of the program.

Key Findings: the context

A360 is operating in complex policy environments, with health system limitations and entrenched social norms governing the acceptability of contraception for adolescent girls. A360 has engaged Ministries of Health (MOH) from the start of the program, which has enhanced national-level buy-in although this yet to translate into full ownership of the solutions. A360 is also faced with the challenges of ambiguous MOH policies around adolescents accessing modern contraception, linked to age of consent. This is acutely felt in Nigeria as a barrier to uptake of long acting reversible contraceptives (LARCs). In Tanzania, the political environment and national conversations around contraception are becoming increasingly conservative, which has presented implementation challenges and may continue to do so in the future. In all contexts, there are entrenched myths, misconceptions and stigma associated with contraception and the adolescent girls who use it, although there is also some sense of pragmatism from community members who wish to help girls avoid the grave consequences of pregnancy out of wedlock. While 'flying under the radar' helps to circumnavigate community stigma, it also may leave service providers, mobilizers and adolescent girls exposed to backlash.

The organizations and people behind A360 are critical to its success to date. However, the large consortium has required significant management oversight and communication, which has not always been adequately resourced. The A360 team have demonstrated commitment, passion and motivation to generate innovative solutions for adolescent girls, which has been a key force driving

A360 forward. However, in doing so, teams have put themselves as risk of burnout through an extremely demanding process and high workload. Despite a strong feeling of partnership and support, pressures on staff have been acute – a consequence of small country teams, intense periods of field work, and requirements to conduct MOH advocacy, pursue partnership, and promote replication and adoption while also meeting targets and going to scale.

Recommendations for A360 as it progresses to scale

- Ensure a focus on meeting targets does not detract from building enabling environments, resourcing quality programming, and promoting sustained contraceptive use. This could be aided by revisiting the Theory of Change and using it as a tool for decision making alongside considerations of cost, adoption and conversion, in order to ensure that key drivers such as social norms are not sidelined as solutions continue to adapt and go to scale.

- Focus on producing and sharing the right evidence at the right time, ensuring the effectiveness of solutions is sufficiently understood before A360 is promoted as best practice.

- Increase understanding around key aspects of the solutions and approach – for example, understanding how A360 is shifting service providers' attitudes towards serving adolescent girls.

Recommendations for future programs

Implementing organizations should:

- Use the inception phase to 'storm and norm', enabling design teams to commence inspiration with joint expectations, rather than navigating relationships simultaneous to implementation.

- Design for national ownership and shared delivery from the outset and maintain that focus, ideally building on a solid understanding of national political economy considerations and drivers of change.

- Balance pressures for rapid scale up with a focus on maintaining design quality and fidelity.

- Consider the potential of aspirational messaging**.** Tapping into adolescent girls' and couples' aspirations has resonated in the four distinct A360 implementation contexts, for both married and unmarried adolescents.

Donors should:

- Balance target-setting with flexibility. Setting targets and implementation geographies in the absence of a defined solution may create an unnecessary tension. Putting in place agreed parameters around the design challenge, rather than strict targets, may serve to keep to design team headed in the direction of success, without placing the solutions under pressure to deliver certain targets.

- Prioritize implementation over communication during the early stage of a program: Give the program time and space to implement both the approach and resulting solutions without the pressure of communicating success in parallel.

- Partner according to areas of strength: Donors play an important role in helping to identify and connect partners with complementary implementation strengths (e.g. community sensitization and family planning services) and incentivizing them to work together, potentially through an appropriate contract model with joint milestones.

- Support activities aiming to influence gender and social norms as well as more tangible adoption and conversion metrics, recognizing that these will increase cost per user and may not demonstrate immediate results in the short term.

Introduction

Adolescents 360 (A360) is a four-year initiative (2016 – 2020) to increase adolescent girls' access to and demand for modern contraception in developing countries, beginning with Nigeria, Ethiopia and Tanzania. Announced at the 2016 International Conference on Family Planning, A360 is a $30 million program, jointly funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF), hereinafter referred as the Foundations. The program is implemented by a Population Services International (PSI)-led consortium, in partnership with IDEO.org, the Center on the Developing Adolescent at University of California, Berkeley (UCB) and the Society for Family Health (SFH) Nigeria.

Itad is working in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) and Avenir Health to monitor, evaluate, and develop learning from the A360 program. This midterm review (MTR) synthesizes and reflects on evaluation findings from the design phase of the Adolescents 360 (A360) program. It identifies key lessons from the evaluation to date, drawing out learning for A360 and other programs.

Overview of A360

A360 uses an approach that merges six disciplines: public health, HCD, adolescent developmental neuroscience, socio-cultural anthropology, youth engagement and marketing to yield country-specific AYSRH solutions. From development to implementation, A360 aims to engage adolescents as equal program partners in driving AYSRH interventions, designed for girls, by girls. The program hypothesis is that this fusion of disciplines, including meaningful engagement of young people in all phases of the program, will catalyze novel approaches to AYSRH that can be replicated by partners around the world.

In addition to inception, A360 is being implemented in six phases, largely aligning with IDEO.org's HCD approach (see Figure 1). This report discusses the experience of A360 from inception through to the end of its Pilot phase, along with some insights from the Optimization phase in early 2018.

Figure 1 A360 timeline

Inception	Inspiration	Ideation	Pilot	Optimization	Scale
JAN – AUG 2016	SEPT – DEC 2016	JAN – JUL 2017	AUG - DEC 2017	JAN - JUN 2018	JULY 2018- 2020

Bridging Activites

National and country level advocacy, monitoring and evaluation, application of design standards for decision-making, and learning and capacity-building.

The A360 solutions

In Ethiopia, Smart Start uses financial planning as an entry point to discuss contraception with newly married couples. It leverages the nationwide Health Extension Worker (HEW) network, augmented by a PSI-recruited Smart Start team, and existing community structures such as the Women's Development Army. HEWs and Smart Start Navigators are trained to host conversations and provide services in an approachable way for rural, married adolescent girls and their husbands, using a visual discussion guide. [3]

In Nigeria, 9ja Girls provides branded safe spaces in public health clinics for girls. Walk-in 1-1 counseling is provided alongside Saturday sessions on Life, Love, Health. The curriculum features vocational skills, future-planning exercises, and discussions about love, sex and dating. The aim is to make contraceptives relevant by helping girls tap into their aspirations and see contraception as a tool to reach their goals. The program is delivered through a youth-friendly provider network, leveraging partnerships with the Ministry of Health (MOH) to train health service providers. [4]

In Northern Nigeria, Matasa Matan Arewa (MMA) targets married adolescent girls and their husbands using maternal and child health as an entry point. Male Interpersonal Communicators (IPCs) discuss contraception with husbands, using the health of the baby and mother as an entry point to encourage husbands to refer their adolescent wives to a female mentor or to a clinic for counseling. Female mentors also directly mobilize married adolescent girls. Girls are then mentored through four Love, Life and Family (LLF) classes in a setting identified by them, and receive one-on-one counseling with a provider and a vocational skills class. MMA also works with religious leaders and communities, to emphasize the benefits of child spacing.[5]

In Tanzania, Kuwa Mjanja delivers life and entrepreneurial skills training alongside opt-out, youth-friendly contraceptive counseling sessions and on-site service provision. These activities are united under the girl-centric Kuwa Mjanja ('Be Smart') brand. In-clinic and out-of-clinic pop up events aim to provide a safe space for girls, with targeted messaging intended to make contraception relevant depending on their stage in life, lifestyle and priorities. A digital component (Mjanja Connect) is under development with funding from the Vodafone Foundation, aimed at supporting community health workers to interact with and refer adolescent girls for services.[6]

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[3] Read more about Smart Start: https://www.a360learninghub.org/ethiopia

[4] Read more about 9ja Girls: https://www.a360learninghub.org/cause/southern-nigeria/

[5] Read more about MMA; https://www.a360learninghub.org/cause/northern-nigeria/

[6] Read more about Kuwa Mjanja: https://www.a360learninghub.org/cause/tanzania/

Overview of the report

The report is structured into the following sections:

The **Methodology** section describes the overall evaluation and the MTR approach.

Findings are presented in three sections:

1. **Design:** Focuses on the phases of A360, the influence of the disciplines and the cost of designing the solutions.

2. **Solutions**: Presents the baseline OE findings and results from PSI monitoring data, and discusses how the solutions are addressing the A360 Theory of Change (ToC).

3. **Context:** Highlights contextual and consortium factors that have enabled and inhibited the success of A360.

The last section, **Looking Forward**, concludes, and reflects on the emerging value and tensions of the A360 approach. It also provides recommendations for A360 as it goes to scale and for future programs. This section concludes with an outline on next steps for the evaluation.

Icons are used to support the navigation of this report and highlight key areas:

Inspiration phase

Ideation phase

Pilot phase

Optimization phase

Spotlights: Issues that emerged as strong themes have been drawn out through Spotlight sections:

Spotlight 1. Lessons from evaluating A360

Spotlight 2. The A360 experience of HCD

Spotlight 3. Meaningful youth engagement in A360

Spotlight 4. Service providers – the battle to serve

Critical success factors: Consideration has also been given to the critical success factors for A360 to date:

Critical success factor 1. Linking aspirations with contraception

Critical success factor 2. Shifting service providers' views

Critical success factor 3. The people behind the A360 approach

Methodology

This MTR report synthesizes data collected through the A360 evaluation, from inception to September 2018. This section first outlines the overall evaluation methodology, and then details the approach taken to synthesize this data for the MTR.

Evaluation methodology

Itad is working in collaboration with the LSHTM and Avenir Health to independently evaluate and distil lessons from the A360 program. The evaluation has been commissioned to:

- Provide timely evaluation data to course correct the program during implementation as necessary, and to maximize the effectiveness and impact of efforts.

- Assess the impact of the program in reducing the number of unintended pregnancies among adolescent girls.

- Provide a robust evidence base on what does and does not work to reach adolescent girls at scale, cost-effectively and to what extent the program is replicable.

Figure 2: Evaluation Components

The evaluation comprises three core components: an outcome evaluation, a cost effectiveness study and a process evaluation (see Figure 2). These are described further below.

Outcome evaluation

The Outcome Evaluation (OE) is led by LSHTM. Its primary objective is to assess the impact of A360 on the modern contraceptive prevalence rate (mCPR) among sexually active girls aged 15 to 19 years (married girls in Northern Nigeria and Ethiopia, unmarried girls in Southern Nigeria, and both married and unmarried girls in Tanzania). The secondary objectives include evaluating the impact of A360 on fertility rates, age at first birth, unmet need for modern contraception, and girls' knowledge of modern contraceptives, agency to use them and attitudes towards them.

The OE uses a pre-and-post-population-based, cross-sectional survey design, which includes a comparison group in Nigeria. A two-stage sampling design is applied in all three countries. The baseline survey was conducted in late 2017 before the start of the main A360 implementation phase, and the endline will be conducted in early-mid 2020. Further information on the OE methodology is available here.

Cost-effectiveness analysis

The Cost-effectiveness analysis (CEA) is led by Avenir Health. This component examines the main cost drivers of the A360 approach and investigates the cost-effectiveness of A360 in relation to other methods of solution design. The CEA provides information on what it costs A360 to achieve increases in use of modern contraception and associated measures of program effectiveness, including couple-years of protection (CYPs) and disability-adjusted life years averted. Measurement of costs and effectiveness focus

on the outcome evaluation study geographies, and effectiveness is measured using indicators developed for the outcome evaluation – primarily mCPR.

Process evaluation

The process evaluation (PE) is led by Itad. It is designed to complement the outcome evaluation through providing information on the context and mechanisms of A360. It aims to:

1. Provide analysis and learning to support adaptive management and course correction.
2. Evaluate how the A360 approach has played out in implementation.
3. Investigate how A360 has interfaced with the different contexts in which it has been implemented.
4. Evaluate the experience of A360 among adolescents and community members and how it affects perceptions and opinions about adolescent use of contraception.
5. Investigate how solutions have been operationalized and their feasibility for scale-up and replication.

Since Inspiration, the PE has undertaken four to five rounds of country-level data collection aligned with the phases of A360 (Inspiration, Ideation, Pilot and the beginning of Scale phase[7]), along with three rounds of global data collection.[8] Data sources include key informant interviews (KIIs), focus group discussions (FGDs), structured observations of A360 activities, and document reviews of A360 program documents. In 2018 the PE also introduced a participatory action research (PAR) component, which allows A360 country teams to identify specific areas for in-depth review, and which also allow for a faster turnaround of findings. These include areas of challenge or areas of success where a deeper understanding is beneficial to the program, with evaluation questions and implications from the research developed collaboratively between A360 implementers and the evaluation team. In 2018, the PE conducted a PAR in Ethiopia and Nigeria.

Table 1. Process Evaluation data collected at Inspiration, Ideation, Pilot, Optimization and Scale phases as of September 2018[9]

Data	Ethiopia	Nigeria	Tanzania	Global	Total
Key informant interviews (KII)	**77**	**82**	**103**	**56**	**318**
PSI/SFH (includes youth designers)	32	31	54		
Community implementers *Including service providers, mobilizers, and skills facilitators*	27	38	24		
Government	9	6	9		
External ASRH stakeholders	9	7	16		
Participatory youth research	**12**		**15**		**27**
Adolescent girls	12		15		
Focus group discussions (FGDs)	**15**	**23**	**26**		**64**
Adolescent girls	8	11	12		31
Community members *Including adolescent boys / husbands, and male and female community members*	7	12	14		33
Observations	**13**	**24**	**20**		**57**
A360 documents	**27**	**27**	**53**	**20**	**127**

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[7] At the time of the MTR the PE had only undertaken a full round of data collection for the Scale phase in Tanzania (in July 2018).

[8] Global data collection refers to interviews with A360 Consortium members who are not based in a PSI/SFH country office and the Foundations.

[9] Data was collected for Inspiration phase between August and December 2016, Ideation phase between February and August 2017, and Pilot phase between October and December 2017. Data collection for Optimization and Scale phases began in April 2018 and is ongoing.

Spotlight 1:

Lessons from evaluating A360

The HCD-led design process posed challenges to the evaluation in both design and implementation. Two years into the evaluation process, we reflect on the lessons learned, and issues for other evaluators, implementers and commissioners to consider:

- **Think about the timing of study designs:** Key pieces of information about the intervention were unclear and changed during the period when the OE and CEA protocols were being developed. Evolutions occurred in the interventions themselves, the study populations and the timeline for implementation. This resulted in resources being expended on multiple study designs before the final intervention was known.

- **Engage a flexible process evaluation team:** A program like A360 is fast paced and adjusts workplans frequently. This requires a flexible and resilient PE team, who can adapt and align closely with implementation workplans.

- **Adapt to respond to the intervention:** When evaluating an iterative HCD process, an adaptive PE approach is required. In A360, the process evaluation paused after the pilot phase to revise the approach and evaluation questions, in order to respond to the needs of A360 and ensure the right questions were being asked as the solutions scaled.

- **Mitigate limited documentation and fast pace with direct observation:** Direct observations through the process evaluation have been key to capturing the depth of the fast-paced, highly-iterative HCD process, which is often undocumented.

- **Be aware of the potential for research fatigue during the design phase:** Evaluators need to balance the importance of capturing the views of community members with the potential for research fatigue through participation in both the HCD process and evaluation.

- **Adapt to the needs of implementers to help evaluation findings feed into implementation:** Due to the intense pace of A360 and high levels of demand on country teams, there was initially limited scope for implementers to consider and apply process evaluation findings. In 2018, the process evaluation introduced 'sounding workshops' (facilitated workshops with implementation teams to engage with evaluation findings shortly after analysis was completed) and Participatory Action Research (PAR) case studies (described above) alongside its existing activities.

Future programs using HCD may wish to consider a **phased evaluation approach:**

1. Lead with a process evaluation, with predefined feedback loops, aligned to key decision moments for the program.

2. Wait until the intervention's details are finalized (e.g. following the pilot phase) before designing outcome evaluation and cost effectiveness components

However, the advantages of a phased approach need to be balanced against the disadvantages of delaying the outcome evaluation baseline.

Midterm review approach and methodology

The MTR has been developed in close consultation with representatives from both the Gates Foundation and CIFF, and with representatives from the PSI global team. Its aim is to synthesize existing data collected by the evaluation team to date in relation to the following questions:

Design

1. How did the A360 design phase unfold (up to and including Optimization)?

2. How much has it cost to develop the A360 approach, design the prototypes, and promote the A360 approach and solutions to others? What costs were critical, and what costs could be reduced or dropped if A360 was replicated?

Solutions

3. What progress has A360 made to date?

   What are the baseline OE findings?

   What progress is A360 making against its primary outcome areas?

4. How are the A360 solutions addressing the ToC?

Context

5. What have been the main enablers and challenges for A360?

   What are the contextual enablers and barriers to adolescent contraceptive uptake?

   What are the organizational and consortium enablers and inhibiters to success?

Looking forward

6. **Conclusion:** What is the emerging added value of the A360 approach?

7. **Recommendations**

   How might A360 need to adapt as it progresses to scale?

   What are the implications for future programs?

Data sources

The MTR is a synthesis report, summarizing existing data collected by the evaluation team to date.

- **PE:** All previous PE analysis and deliverables have been reviewed.

- **CEA:** For the MTR, a new cost-effectiveness analysis was conducted to better understand how spending (through piloting[10]) breaks down into three categories: costs associated with creating the A360 approach; costs associated with designing and implementing the interventions at country level; and costs associated with promoting adoption and replication of A360.

- **OE:** The baseline outcome evaluation findings have been summarized and incorporated into the MTR report.

- **MTR survey**. A small online survey of A360 staff, donors and some external stakeholders was conducted in June 2018 which was designed to explore specific areas of interest for the MTR and triangulate findings from the PE. See Annex 1 for more detail.
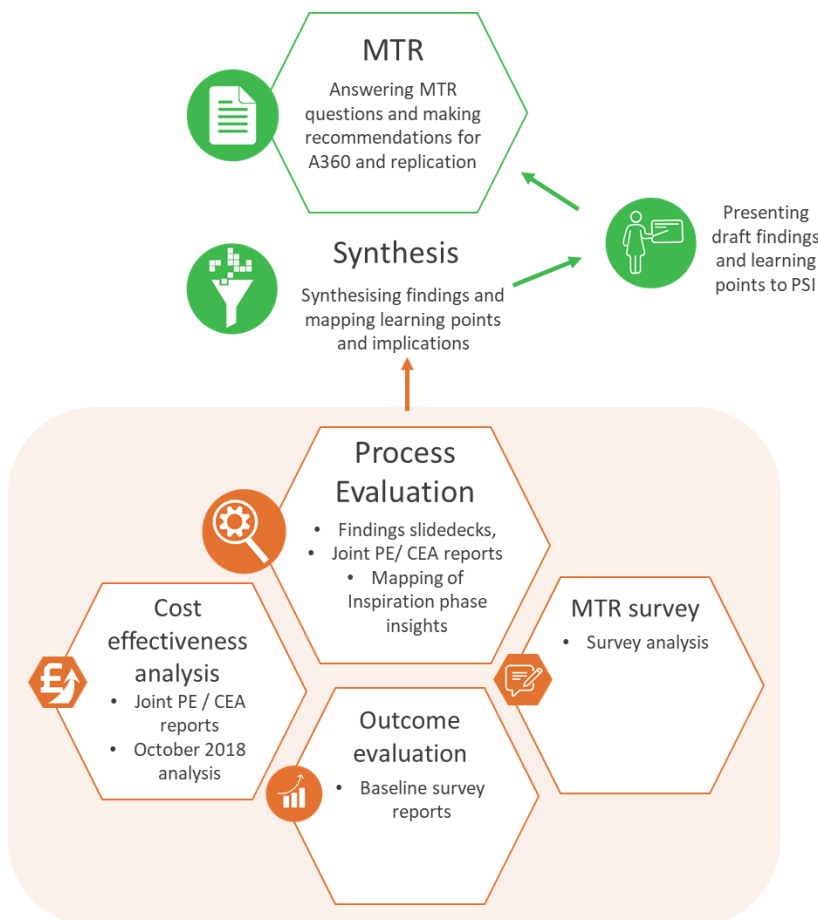
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[10] These costs do not capture the Optimization phase which followed piloting.

Data analysis

The synthesis was undertaken by four members of the PE core team. Documents listed in Figure 3 were systematically reviewed and data extracted against each of the eight areas of focus for the MTR. Common themes were drawn out into a narrative document, tracking relative weight of findings. In particular, implications identified during previous rounds of analysis were mapped and key learning points and observations identified. These were used to help identify implications emerging which have particular relevance for A360 moving forward and/or for replication of the A360 approach, which in turn feed into a set of overarching conclusions. Draft findings were presented to members of the global PSI team, for validation and clarification, before finalizing this report.

References are provided throughout the MTR where the report has drawn on a specific external document or source.

Figure 3. Data sources for the MTR

MTR
Answering MTR questions and making recommendations for A360 and replication

Synthesis
Synthesising findings and mapping learning points and implications

Presenting draft findings and learning points to PSI

Process Evaluation
- Findings slidedecks,
- Joint PE/ CEA reports
- Mapping of Inspiration phase insights

Cost effectiveness analysis
- Joint PE / CEA reports
- October 2018 analysis

Outcome evaluation
- Baseline survey reports

MTR survey
- Survey analysis

Challenges and limitations of the MTR

- The MTR is a synthesis of existing data and is therefore primarily focused on the design phase of A360. The review is therefore limited in how much it can say about the latest iteration of the solutions or how the solutions are performing at scale.

- Due to a number of factors, the timeframe for the MTR shifted, leading to challenges with aligning the process with the most effective point for the A360 program to consider the findings and feed any resulting programmatic revisions into scheduled planning opportunities.

- A360's progress to date, discussed in Section 3, draws largely on program monitoring data. It is not within the evaluation team's remit to conduct data verification or quality checks on this data.

Findings: Design

Summary of findings

The A360 approach is characterized by the six disciplines it has brought together to guide the design of the solutions. HCD was regarded as the driving force of the design process, with the other disciplines feeding in. While it took A360 some time to master this process, by Ideation phase there were several mechanisms to ensure the input of each discipline – although they have had varying degrees of influence on the development of the solutions.

In the **Inspiration phase,** with HCD providing the tools and language, the A360 approach was defined, and modalities for collaboration across the A360 Consortium established. Despite this, there were concerns over the generalizability of the insights generated in this phase and the 'ownership' of the insights.

The **Ideation phase** focused on putting the A360 approach into practice, with HCD continuing to guide the approach but with a public health lens playing a more significant role. With the desirability of the prototypes to adolescent girls at the heart of this phase, there were concerns about feasibility and scalability.

The **Pilot phase** was characterized by a shift from a design mindset to implementation. It was shorter than originally anticipated (only six weeks in each country), to make up for delays in the Inspiration phase. This – combined with gaps in the monitoring and evaluation (M&E) system – meant that the Pilot phase did not provide adequate time or space for learning and refining the solutions.

The **Optimization phase**, a departure from the prescribed HCD phases, was arguably a way to extend the Pilot phase to allow for further testing of the solutions to reach a minimal viable product.

Despite significant investment in trying to promote **partnerships** across all the phases, this continued to be a challenge for A360, with little in the way of tangible commitment.

In total, **$9.9 million** was spent designing and implementing A360 up to and including the end of the Pilot phase.

- An estimated $2-3.5 million was spent creating the A360 approach
- An estimated $5-6.5 million was spent implementing A360.
- An estimated $1-1.5 million was spent on activities to promote the replication of the A360 solutions and adoption of the A360 approach.

In consultation with the A360 Consortium, it is estimated that if the A360 approach was being applied in a similar fashion again, a saving of $800,000 could be made in terms of investment on creating and implementing the approach.

1   How was A360 designed?

The A360 phases

This section describes how A360 was designed and implemented through its Inspiration, Ideation, Pilot and Optimization phases. It also discusses the experience of HCD in A360, the influence of the various disciplines on the development of the solutions, and how the language around the A360 approach has shifted from multidisciplinary to transdisciplinary.

The design phase of A360 commenced in earnest in September 2016 for Ethiopia and Nigeria. It ended in December 2017 for Tanzania,[11] Ethiopia and Southern Nigeria (Northern Nigeria was staggered and ended in April 2018). Box 1 presents the composition of the A360 Consortium, while Figure 4 offers a summary of some of the key activities that took place during this time, further explored below.

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[11] A360 in Tanzania built on a year of funding and design support from Pam Scott, a member of the Maverick Collection. Therefore, the application of the design phases varied in comparison to Ethiopia and Nigeria. Due to some in-house capacity, they did not receive the same level of support from IDEO.org as PSI Ethiopia and SFH, instead receiving support for two short design sprints.

Figure 4 Summary of key activities in each design phase
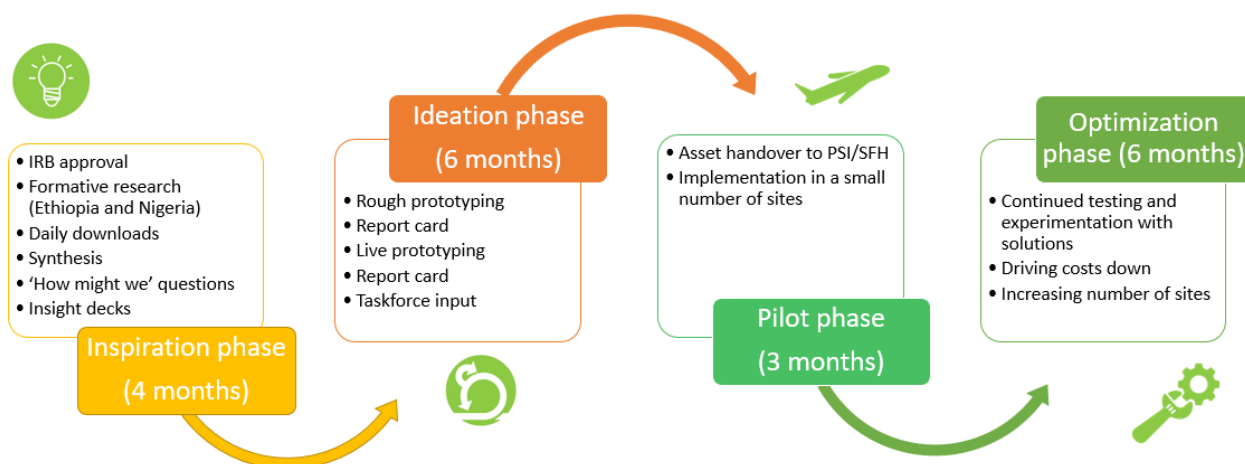
Inspiration

What did the Inspiration phase involve?

During the Inspiration phase, A360 conducted formative research to develop and synthesize sets of 'insights' for each country, which served as a springboard for the design of prototypes in the Ideation phase to follow.

Over the course of three to four months in Ethiopia and Southern Nigeria, research teams made up of A360 staff, IDEO.org designers, young people and discipline experts collected data from adolescent girls, male partners, mothers, fathers, health workers and community leaders. In Northern Nigeria, based on learning in the South, research was led by SFH with support from PSI Tanzania.

During the Inspiration phase, the A360 approach was defined, and modalities for collaboration across the A360 Consortium established. The A360 approach is grounded in six interconnected disciplines, presented by A360 as a Venn diagram (Figure 5).[12] These are the foundations from which A360 designed solutions for adolescent girls. During the Inspiration phase, experts in each of the disciplines came together to conduct formative research and deliver insights that would be taken forward to inspire prototypes in the Ideation phase.

Box 1: The A360 Consortium partners
- **PSI:** Dedicated teams in Washington, Ethiopia and Tanzania level, as well as wider technical and senior management support as needed.
- **SFH**: The implementing organization in Nigeria, with a dedicated team and support from SFH at state level as required.
- **IDEO.org**: Dedicated HCD support for Ethiopia and S. Nigeria, ad hoc support for Tanzania (including two design sprints) and light touch and remote support for N. Nigeria during the Inspiration phase.
- **UCB**, represented by one to two people depending on the phase, UCB represented adolescent developmental neuroscience and supported youth engagement.
- A socio-cultural **anthropologist** hired as a consultant. Supported all countries but played a distinct role in Nigeria, performing additional data collection.
- **Triggerise** played a role in inspiration and to a lesser extent in Ideation.
- **Ogilvy & Mather** played a role in the Inception phase.

HCD was considered the driving force of the Inspiration phase. It provided the language, framework and tools for Inspiration. While HCD was considered novel and exciting by country teams, various challenges were raised with the insights generated:[13]

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[12] PSI. (2016) What is A360?

[13] See Annex 2 for the A360 summary of dominant insights across countries. Full insights can be found on the A360 Learning Hub: https://www.a360learninghub.org/

- **The insights favored breadth over depth and did not adequately reflect demographic and regional differences.** It was felt that the insights developed did not provide sufficiently in-depth or representative insights, favoring breadth over depth. Insights also did not adequately reflect demographic and regional differences, despite broad variation within country contexts. Only in Nigeria were insights differentiated between the north and the south. In Ethiopia, there was little emphasis on demographic differences pertaining to marriage and child bearing, or on cultural tensions.

- **Insights were not systematically triangulated with existing evidence.** Despite literature reviews, stakeholder mapping and gender analysis conducted during the early Inspiration phase, as well as studies by other stakeholders, there was no systematical triangulation with the insights coming from data collection. While Demographic and Health Survey (DHS) statistics were presented in all insight decks, only the Ethiopia deck draws on other sources of evidence from the Guttmacher Institute and PMA2020.

- **The insight generation process was arguably insufficiently 'owned' by country teams.** With three to five international design experts supporting data collection and synthesis in Ethiopia and Southern Nigeria, PSI and SFH country teams grappled with the process of learning HCD while 'doing' HCD. Conversely, the international design teams were faced with the challenge of building the capacity of the country teams, while also trying to push forward the process. This was compounded with teams based in San Francisco working on insight synthesis and the development of the insight decks, while the country teams worked in parallel in other locations and time-zones, attempting to feed the country perspective. This resulted in the country teams not being truly involved in co-generating insights. This led to questions about who really 'owned' the insights that were developed during Inspiration.

Inputs from the other disciplines were fed into the design of A360 solutions by discipline experts - through orientation sessions, remote support, and direct support to data collection. Notable contributions included:

Figure 5: The A360 disciplines
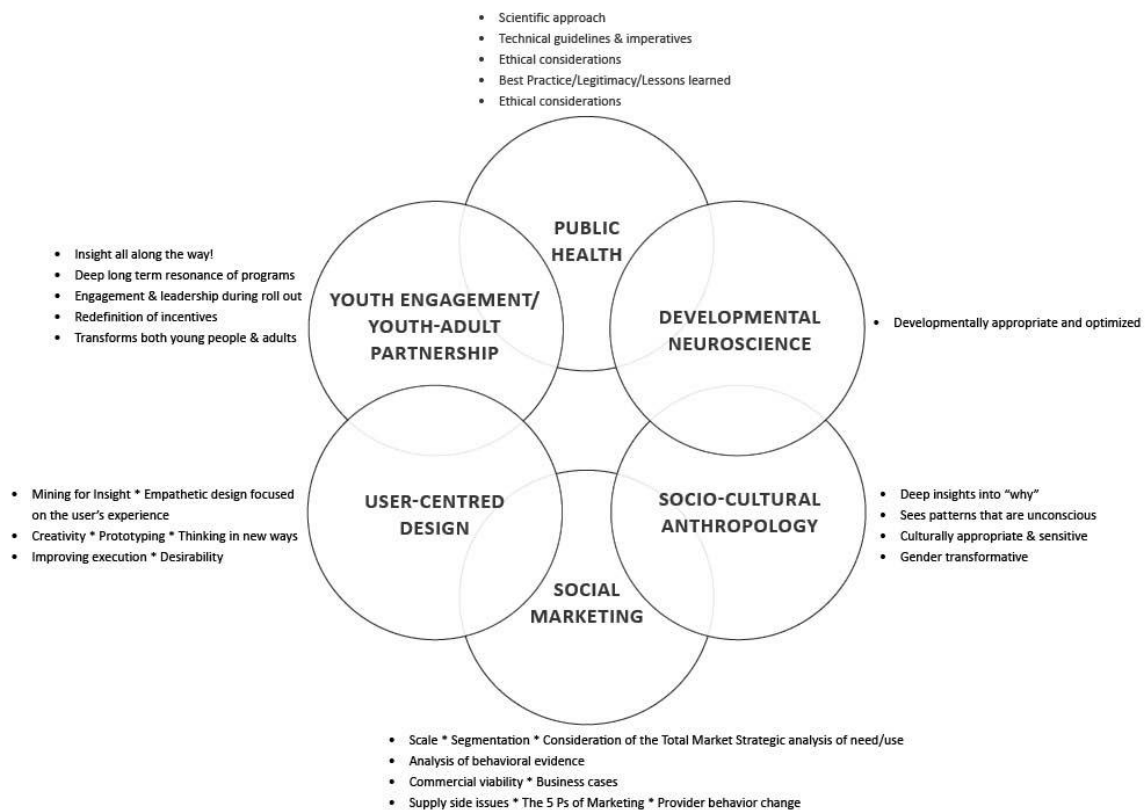
- **The introduction of 'trajectory moments' and 'inflection points' from developmental neuroscience**. These concepts presented novel entry points for widening the discussion around adolescent lives, sexual relationships, and acceptable childbearing/contraceptive practices, adapted to each local context.

- **The engagement of young designers as 'cultural interpreters', supporting data collection and analysis, from the youth engagement discipline.** This resulted in an appetite from the A360 Consortium to maintain youth engagement throughout A360.

- **Efforts to employ the ChANGES model[14] from social marketing to understand drivers and barriers for different 'segments' (groups) of girls.** This behavioural segmentation model moves beyond descriptive groupings (e.g. around age or life stage) to consider behavior change drivers (including goals, agency, culture and social norms). The model was used to inform the formative research in Ethiopia and Nigeria during the Inspiration phase. However, its utility was questioned as teams grappled with developing insights by segments – for example, researchers did not always manage to recruit girls from all relevant segments, in some cases found it difficult to identify which groups respondents fell into during interviews, and time and resource constraints limited how far it was possible to conduct analysis by segment.

"A360 continues to struggle with [segmentation] across the board. We know who the target girls are in each country but there isn't much data on them, where are they? How hard to reach are they here vs here? That marketing data has been elusive." A360 respondent

Despite a delayed start while teams waited for ethical clearance to conduct formative research in Nigeria and Ethiopia, investment in planning, coordination, data collection and synthesis over different geographies and time zones culminated in an insight generation process that engaged country teams, young people and the wider consortium. However, this may not be characterized as full 'co-creation' as originally envisaged by the A360 approach.

In parallel to this process, there were ongoing efforts to engage respective MOHs and other ASRH stakeholders at country level. PSI Ethiopia team invested efforts in establishing a 'champions group' of interested stakeholders and FMOH, while PSI Tanzania leveraged their role as secretariat of the ASRH technical working group to communicate about A360 and SFH focused on onboarding the FMOH through active engagement in A360 workshops and data collection. Across contexts, stakeholders were intrigued but not always clear on A360 the approach.

Ideation

What did the Ideation phase involve?

'Here you'll make sense of everything that you've heard, generate tons of ideas, identify opportunities for design, and test and refine your solutions.'[15]

The ideation phase moved from insights to tangible solutions which could be piloted and iteratively refined. In A360, the Ideation phase comprised two distinct rounds: rough prototyping and live prototyping.

The Ideation phase focused on putting the A360 approach into practice, with HCD continuing to guide the approach but public health playing a more significant role. During this stage, A360 developed clear mechanisms to ensure the input of disciplines into the prototyping process (see Box 2), as well as the documentation of key activities.

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[14] The ChANGES model aims to identify drivers that matter for outcomes in a segment, in relation to: Culture and habit, Agency, Knowledge, Goals, Environment, Social influence.

[15] IDEO.org. (2015) The Field Guide to Human-Centered Design.

With HCD continuing to drive the process in Ethiopia and Southern Nigeria, these attempts to standardize the input of the disciplines were welcomed. Public health was increasingly prominent during Ideation, layered into prototypes through feasibility and contextual considerations. The country teams were perceived as driving this, based on their understanding of the context, clinical requirements and the evidence base. At this stage, the broader AYSRH evidence base was drawn upon and considered. For example, based on evidence that standalone youth centers are not effective, the PSI team in Tanzania focused on leveraging existing spaces and systems for skills and service sessions.

Desirability for adolescent girls lay at the heart of rough and live prototyping, while issues around feasibility, scalability and sustainability also started to come to the fore. During this phase, brands were *'landed',* and groups of prototypes were tested individually and as systems. From this, nascent solutions were formed which contained multiple components, reliant on several moving parts. As described below in Section 4, all solutions have a component linking contraception to aspirations, and this was found to resonate with those adolescent girls exposed to the prototypes and solutions. Behavior 'pathways to change' were mapped for each of the solutions (see Annex 3) and were reflected in the A360 ToC, creating a common framework for understanding emergent solutions.

> **Box 2. Managing discipline inputs**
>
> 1. **Report cards:** These were used to document and present the results and learnings of different phases, considering desirability, feasibility, sustainability and scalability. They were used retrospectively as a 'sense check' and communication tool between country teams, consortium members and the Foundations
>
> 2. **Interdisciplinary Taskforce:** Made up of A360 discipline experts and other PSI technical experts, the taskforce was a systematic way to coordinate comments on the prototypes, as well link the country teams and IDEO.org with existing evidence, literature and materials pertinent to the developing prototypes.
>
> 3. **Minimum design standards:** This was a set of guidelines to ensure disciplines were influencing the design phase, describing 'ideal', 'must do', 'minimum' and 'below standard' considerations for each A360 discipline.

As this phase came to an end, there were operational and structural concerns, with implications for feasibility and scalability. Concerns largely stemmed from choice of service delivery platform, particularly in Ethiopia and Nigeria, where the public sector was the designated service channel for the solution developed. In both contexts, the public health system faces challenges in relation to commodity and consumables supplies, human resources for health and infrastructure, and management and leadership capacity. Tensions between what was ideal and what was practical were palpable, for example, in Nigeria, despite concern about cost and availability outside of Lagos, a standalone 9ja Girl-only facility in vacant government facilities was included as part of the design.

A360 continued to make concerted efforts to engage external partners at country and global level, leveraging global interest in HCD and family planning commitments but struggled to get tangible buy-in. Global communication efforts increased in this phase of A360, including the launch of the online A360 learning hub, engagement through conferences like the London Family Planning Conference and exchanges with other projects, such as the Dutch-funded Ignite Project. Although efforts were made to deepen partnerships at a global and country level, external stakeholders viewed solutions as vague and did not see not see a clear role for themselves. While Tanzania and Nigeria were making some progress sub-contracting locally-based organizations to support with the implementation of some solution components, they faced challenges maintaining implementation quality.

🛫 Pilot

What did the Pilot phase involve?

'Now is your chance to bring your solution to life. You'll figure out how to get your idea to market and how to maximize its impact in the world.'[16]

The Pilot phase was intended to provide opportunity for A360 to test the prototypes developed in the Ideation phase. At the beginning of this phase, branded and packaged solutions were formally handed over by IDEO.org to PSI and SFH country teams for piloting

The Pilot phase was characterized by a shift from a design mind-set to implementation, which created various challenges. Country teams adjusted for implementation, launching recruitment, enlisting field operations staff and in the case of Tanzania, moving innovation staff to implementation roles. Time, workload and capacity constraints created challenges in balancing the emphasis on learning and iterating through the Pilot, with the need to meet A360 targets for the first time. It also proved challenging to ensure that meaningful youth engagement carried through to implementation – in many cases youth engagement became equated with employing former young designers in mobilization and data collection roles, (discussed in Spotlight 3) reflecting the absence of a clear strategy for this discipline.

While the aim of the Pilot was to test solutions in 'live conditions', this was compromised by its short duration and delays in establishing the M&E system. The Pilot phase aimed to ensure that the solutions selected for scale-up were relevant and effective. Under pressure from the Foundations to make up for time lost in the Inspiration phase, the Pilot phase was shortened from an originally envisaged six months to three months in total, just six weeks per country. With M&E systems that were still forming due to issues with staffing the lead M&E position, it was largely viewed that the duration of the Pilot phase was inadequate to rigorously test the solutions in real world settings and feed data and learning back into the solutions to course correct.

Partnering with other international ASRH stakeholders continued to elude A360 at this point. While there was clear evidence of the influence of buy-in to the HCD aspect of A360 internally in PSI, as touched on in Box 3, explicit external partner commitment remained a challenge for the program at country level.

⚙️ Optimization

What did the Optimization phase involve?

The aim of the Optimization phase was '*to further improve interventions, and [establish] a strategic priority for each country,'[17]* and to define 'minimal viable solutions' at scale.[18]

Ethiopia focused on generating strong evidence to promote the integration of Smart Start into the government owned Health Extension Program. Nigeria narrowed its geographic focus while working on improving conversion rates through an improved intervention. Tanzania prioritized getting to speed and volume at low cost, while creating pathways to partnership which ensured the longevity of interventions.

The Optimization phase was introduced after Pilot, as a means of moving to scale. This phase is not a standard part of IDEO.org's HCD approach and was arguably added to compensate for the short Pilot phase. Led by PSI and SFH, the focus was on building the business case for each solution. This was accomplished by developing a detailed understanding of the data coming out of the M&E systems (particularly method mix), adoption and conversion rates, and understanding the most cost-effective way to implement the solutions while retaining fidelity to the design. This saw some components or roles reduced or dropped (e.g. Kuwa Mjanja clubs and mothers' clinic days in Tanzania and Smart Start

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[16] IDEO.org. (2015) The Field Guide to Human-Centered Design.

[17] A360 (2018). A360 Quarterly Narrative Report, Year 3, Quarter 1.

[18] A360 (2018). Optimization for Scale.

Navigators in Ethiopia). Different variations of 9ja Girls tested was Nigeria, with a reduced focus on branding and refurbishment of facilities as one aspect of experimentation around driving down cost. Optimization also saw a shift in geographic emphasis and corresponding budget allocation, with Tanzania primed for speed and scale, Ethiopia tasked with proof of concept across a smaller geographic area (e.g. selected woredas in four regions) and Northern Nigeria focused on state expansion (see discussion in Box 2 in Section 3).

During the Optimization phase, the PSI global team introduced an 'adaptive implementation' process, moving away from the language of HCD.[19] Depicted in Figure 6, this approach was introduced to facilitate continuous improvements '*to ensure interventions continued "fit" for the girls, and the health systems that own and sustain their implementation.*'[20] This approach has only been observed by the PE in Tanzania to date, where the implementation team undertook a weekly analysis of qualitative and quantitative monitoring data throughout the Optimization phase. It was viewed as a *'powerful process'* (albeit time intensive) by staff, allowing the team to identify, learn from and support outreach teams as the solution rapidly scaled,

Figure 6. A360's adaptive implementation process

identifying high and low performance in order to learn lessons and provide support where needed. The approach drove several adaptations in Tanzania during the Optimization phase – most notably the engagement of Youth Development Officers to support event mobilization and set up – however, most examples to date have been operational rather than more fundamental adaptation to address deeper challenges.

In Tanzania, a behavioral segmentation study used the ChANGES framework to identify which drivers matter most for different segments of girls. The study identified two priority segments to target: Faridas (younger sexually active girls) and Bahatis (mature sexually active girls). Different implementation models were targeted at the two archetypes, using distinct messaging to reach the two groups. However, during the Optimization phase one of the models (parent-girl clinics) was dropped, making it more difficult to ensure that segmented messages were being used in practice.

Speed and scope of scale-up contributed to various capacity challenges in Tanzania and posed risks to quality and sustainability – ultimately contributing to a decision to focus on fewer regions.[21] A focus on reaching targets played a key role in the decision to reallocate funding to Tanzania from Nigeria and Ethiopia, given that Tanzania had the greatest number of adopters. However, this pressure for speed and scale created incentives to sideline sustainability and sustained use. Achieving scale so quickly stretched the team's capacity and resulted in outreach teams operating with limited training on the Kuwa Mjanja solution and limited A360 supervision, thus creating risks for implementation quality. Encouragement to rapidly accelerate adoption and conversion rates created a disincentive to invest in activities that lacked direct translation in terms of numbers of girls reached, but which may be important for sustainability and sustained use (discussed further in Section 4). Following discussions with the Tanzanian MOH, towards the end of the Optimization phase, PSI made the decision to reduce its focus to fewer regions and are now

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[19] Although there is significant overlap, as iteration is considered an important aspect of implementation within HCD as per IDEO.org, 2015. Field Guide to HCD, Design Kit. IDEO.org, San Francisco, USA.

[20] A360 (2018). Pursuing Youth-Powered, Transdisciplinary Programming for Contraceptive Service Delivery across Three Countries: The Case of Kuwa Mjanja in Tanzania.

[21] Note that at the time of the MTR, only one round of process evaluation had been undertaken (in Tanzania) since the introduction of the optimization strategy, and therefore it is not possible to generalize across A360 as a whole.

developing a 'saturation strategy.' This will involve stationing two to three outreach teams in a smaller number of regions, and running activities for several months until objectives for reaching girls and providers have been achieved. This will allow for deeper community and parental engagement and will allow the team to address capacity challenges.

With significant investment and senior management support, PSI Tanzania made a breakthrough in their partnership efforts. With significant human resources and commitment from country-level senior management and the A360 Project Director, PSI Tanzania made significant strides in this phase. The Kuwa Mjanja brand and materials was approved by the Tanzanian MOH, enabling PSI Tanzania is promote it as a national girl brand and they were in advanced discussions with Girl Effect on taking the brand forward. As previously mentioned, they were also successful in securing funds from the Vodafone Foundation to add a digital component to Kuwa Mjanja.

How did the A360 disciplines contribute to the design phase?

The disciplines of the A360 approach are considered interconnected, but have had different degrees of influence over the design of solutions. The PE and MTR survey have collected data on the perceived influence of the different A360 lenses over the course of the design phase (summarized in Figure 7 below):

Figure 7: Value and challenges of each discipline
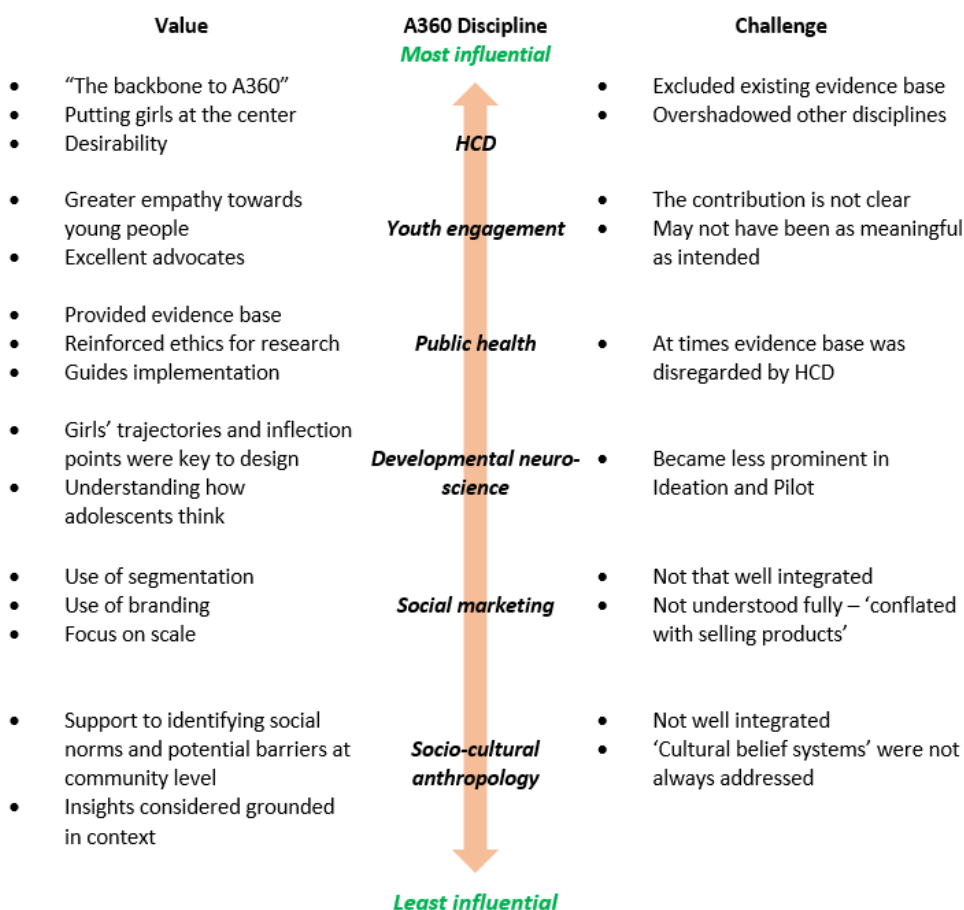
- Implementers view **HCD** as the core of the A360 approach, guiding the process itself, with the other lenses contributing through in-country design teams, community moments, country visits and remote consultation from sectoral experts (who formed part of the Interdisciplinary Taskforce), as well as reviewing report cards (see Box 1 above).

- **Youth engagement** was considered a key discipline, increasing the empathy of those exposed towards young people, although it was felt to be under resourced and may not have been as meaningful as intended.

- **Public health** underpins the implementation of the solutions, playing a key role in ensuring that data was collected in adherence to best practice, around ethics—although there were concerns in the earlier stages that existing evidence was not being taken into account as prototypes and content for solutions were being developed. The evaluation has also noted some ethical issues including around privacy, accuracy of information provided during mobilization and when discussing side effects, and risk of community backlash, discussed further in Section 4.

- **Adolescent developmental neuroscience** played an important role in the Inspiration phase, guiding research teams to apply thinking around girls' life trajectories and widen the discussion to consider how adolescents think about sexual relationships, childbearing and contraceptive practices.

- A360 drew on **social marketing** to develop girl-friendly brands in each country. However, its influence was often considered to be more implicit, and not fully understood by implementation teams. The branding and messaging developed in A360 was seen as a product of HCD, rather than social marketing. Efforts to employ adolescent segmentation models from social marketing have also had mixed success, as discussed above.

- **Socio-cultural anthropology** was considered the 'least influential' discipline by survey respondents, who felt that although insights from the design phase were grounded in context, the anthropologist was not engaged early enough in the process to inform research protocols, meaning that a socio-cultural perspective had in some cases not been well integrated, or cultural belief systems explicitly addressed. The anthropology expert's role was not always clearly defined or central to design teams, leading to lower engagement. This is reflected in some of the challenges A360 has faced in relation to meaningfully addressing cultural barriers and social norms, discussed further in Sections 4 and 5. However, some A360 staff also felt that this lens had provided some 'foundational' insights, for example around the importance of working with community structures (such as kebele leaders in Ethiopia) and building on natural life transitions.

These varying levels of influence are linked to budget allocations and the degree of influence of disciplinary experts within the A360 team. The disciplines have been represented by specific individual and organizational experts within the A360 team, each ensuring their discipline was promoted as the solutions were designed. As a result, the level of effort assigned to the disciplines is partly reflective of where these individuals sit on the spectrum of influence, which generally mirrors the resources allocated to them. Where disciplines did not have expert representation on the A360 team, or where budgets were smaller (as was the case with social marketing and socio-cultural anthropology) the influence of the discipline during the design phase was less strongly felt.

The A360 approach was described as 'interdisciplinary' and 'multidisciplinary' during the design process but the language has shifted to 'transdisciplinary' since Optimization.[22] Online survey respondents suggested that through the implementation of the A360 approach, the boundaries between the lenses have been 'dissolved', making it 'impossible' to attribute any specific developments to any lens. This may reflect the learning each consortium partner has reportedly undergone through working on A360. However, A360 and its solutions were not designed in a transdisciplinary way. It is too early to indicate if the Scale phase will reflect a transdisciplinary approach, and what benefits this may have for the program.

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[22] The latter is defined as *'…an integrative process in which researchers work jointly to develop and use a shared conceptual framework that synthesizes and extends discipline-specific theories, concepts, methods, or all three to create new models and language to address a common research problem.'* This discussion initiated through Ahna Sulieman from UCB (slide deck: Ahna Suleiman, A360 Transdisciplinary Science – Implications for evaluation team. Transdisciplinary definition from Stokols, D., Hall, K. L., Taylor, B. K., & Moser, R. P. (2008). The science of team science. American Journal of Preventive Medicine, 35(2), S77-S89.

Spotlight 2:

The A360 experience of HCD

Despite growing interest and investment in HCD, there are few rigorous evaluations of the impact of HCD interventions in public health.[23] Early evidence includes a theory-based evaluation of the Hewlett Foundation's strategy to apply HCD in family planning and sexual and reproductive health (SRH) in Sub-Saharan Africa. This concludes that interventions using HCD in Kenya and Zambia resulted increased access to SRH and family planning services for adolescent girls, although *found 'less evidence of its ability to design sustainable solutions quickly at scale.'*[24]

While it is too early for the A360 evaluation to determine the impact of the interventions developed using HCD, the approach has been widely valued for placing the adolescent girls at the center of design and shifting ways of working. There is some valuable learning from A360 for those applying HCD in other programs:

- **Engage Ministries of Health and external partners from the start to change mindsets and increase buy-in:** The evaluation has observed new ways of thinking about designing interventions and working with girls among those involved in the design process, including government officials. A360 actively facilitated the involvement of Ministry of Health representatives in the design process. Conversely, external stakeholders who were not involved found the HCD process confusing to follow.

- **Broaden the definition of 'user' during the design process – who will implement the solution?** In A360, service providers are fundamental to the delivery of the solutions but were not fully considered in the initial design phase. Both the Ethiopian and Nigerian country teams sought additional support during the Optimization phase to understand more about the service providers implementing the solutions.[25] In the words of one implementer: *'[I wish we had] … designed for health providers at the same time we designed for girls.'*

- **Consider the design parameters around feasibility and scalability from the start.** The desirability of solutions to users is a key aspect of HCD, but there were concerns about whether feasibility and scalability were considered early enough in the process. For example, in Ethiopia, the Inspiration phase was completed with data collected from both married and unmarried girls, before a decision was taken to focus on married adolescents. Human and financial resources could have been saved if this this decision was made earlier.

- **Consider time-zones and locations of the team.** In the earlier phases of A360, as relationships were still being formed and partners understood, there was a real tension around the design process taking place in San Francisco and a lack of clarity around the input of the country team. These complications were ironed out as the design process progressed but could have been avoided if design teams were based in-country from the outset.

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[23] Bazzano, A.N., Martin, J., Hicks, E., Faughnan, M., Murphy, L. (2017) Human-centred design in global health: A scoping review of applications and contexts. *PLoS One.* 12 (11).

[24] Calder, R., Shorten, T., Wallach, S., Cooper, J., Mulhern, E. (2017). *Evaluation of The Hewlett Foundation's Strategy to Apply Human-Centred Design to Improve Family Planning and Reproductive Health in Sub-Saharan Africa*. Itad.

[25] The PE evaluation team supported PAR in Ethiopia focused on the integration of Smart Start into the HEP. In Nigeria, it focused on potential service providers' bias towards providing adolescent girls with modern contraception.

- **Break down language barriers:** Those working in HCD and in public health use different language around program design and implementation. Getting on the same page is important to mitigate potential confusion as teams work together.

- **Build in time for relationship building.** Pairing country teams (with contextual, cultural and technical expertise) with design experts in A360 worked well but a productive dynamic took time to develop, with a notable improvement between Inspiration and Ideation.

- **Embrace ambiguity:** Embracing ambiguity was perceived as an exciting part of the process, although one that requires a mind shift from 'business as usual' in terms of entering into a design process that can be unclear.

- **Prepare to implement:** Shifting from a design mind set to thinking about implementation and scale-up was a challenge for some of the country teams. Ensuring that standard program cycle management and business processes are deliberately considered in the design phase as part of feasibility and scalability, could ensure that the solution and organization is better prepared for scale-up.

- **How much time do you have for design?** As much as HCD was appreciated as the guiding discipline in A360, it was apparent that a 'HCD light' or shorter design phase would be pursued by implementers if they were embarking on a process like this again.

Spotlight 3:

Meaningful youth engagement in A360

A core goal of A360 was to *'meaningfully collaborate and forge partnerships with adolescents and young people… in order to bring their expertise into the design and implementation phases of the project.'*[26] Young people were recruited as 'young designers,' supporting activities such as data collection, analysis, translation, prototyping, and monitoring and evaluation (M&E). By November 2018, A360 indicated that they had worked with over 280 young people.[27] Despite attempts to standardize youth engagement across A360 through strategies, in practice it evolved in different ways in the three country contexts:

- In **Ethiopia**, young designers played an important role in A360's Inspiration phase, with a large cohort of young people from different regions involved in formative research aided by training at a bootcamp on data collection skills, ethical research and the process of downloading findings. However, there were challenges in recruiting and retaining young people, and this was costly both financially and in terms of staff time. In the Ideation phase, 'young designers' were young graduates, who could support the prototyping of interventions through their professions, such as accounting and nursing. They were engaged on an ad hoc basis for rough and live prototyping, and were not always clear on their future in the program. A small number from Inspiration stayed with A360 and assumed an advocacy role, presenting A360 to the MOH, other development partners and in other external communication. In the Pilot phase, youth engagement was pursued through employing public health practitioners in their twenties as Smart Start staff, and working with youth champions to mobilize married adolescent peers.

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[26] A360 (2016) Youth Engagement Plan – PSI Ethiopia.

[27] A360 (2018). The Young Designers Driving Youth- Powered Healthcare Forward.

- In **Nigeria**, a much smaller cohort of young people were engaged and retained from the Inspiration phase to the Pilot phase. Young people changed roles as the program evolved, from data collectors and 'cultural interpreters' to supporting M&E efforts in implementation as A360 employees. This was described by staff as *'a symbiotic relationship – a win-win situation.'* However, in Nigeria, the age for young designers was 18 to 30 as there were challenges with recruiting staff under the age of 25.

- In **Tanzania**, PSI was already engaging young people as Innovation Officers to lead on prototyping and iterations prior to the launch of A360. PSI were also working with adolescent girls through Restless Development to identify adolescent friendly service providers. From Inspiration, youth engagement became more deliberate, with youth-adult partnership training rolled out to regional PSI staff and youth interns recruited at regional level to support piloting. Kuwa Mjanja Queens (girls aged 15-19 or slightly older) were also engaged to support mobilization. However, the process evaluation has raised concerns regarding the safeguarding of this group in the past, given potential community backlash and that some Kuwa Mjanja Queens reported lying about the nature of events to hide the fact that contraception is offered in order to get girls to attend (discussed further in Section 4 of the Mid Term Review).

Across all three countries, there was a clear sense throughout the design process that young people added real value to A360 and shifted the mindset of the designers and implementers. However, there were concerns that the young designers engaged in Ideation and Pilot were not representative of the target populations, as they were more likely to be older and unmarried. Equally, the extent to which young people were always 'meaningfully' engaged in A360 was at times questioned. For example, one A360 staff member reflected: *'for youth engagement to be truly meaningful [young people] would need to have equal involvement in the process. However, for A360…the young designers were brought in at key moments, rather than being consistently involved.'*

In addition, metrics to measure and assess youth engagement were not put in place, meaning that the true impact of young people on the development of the A360 solutions cannot be fully understood. *'If you have a change – was it because the youth designers were there? There is no way of knowing. That is frustrating.'*[28] This also makes it difficult to understand the impact of engagement in A360 on young people themselves.

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[28] A360 Consortium respondent, Ideation phase.

2   How much did it cost to design and pilot the A360 solutions?

In total, $9.9 million was spent designing and implementing A360, from the start of the program up to and including the end of the Pilot phase.[29] This includes $726,700 of leveraged funding, outside the A360 budget. The total amount spent to the end of the Pilot phase has been subdivided into three broad 'buckets' of costs (see Figure 8):

- **Create: An estimated $2-3.5 million was spent creating the A360 approach**. This captures the costs associated with bringing together the different consortium partners and six disciplines. It includes most of the Inception phase (excluding some costs to promote replication and adoption), and a portion of the subsequent phases to account for continued efforts to develop and refine the A360 approach.

- **Implement: An estimated $5-6.5 million was spent implementing A360**. This includes designing and piloting solutions in the three countries.

- **Promote adoption and replication: An estimated $1-1.5 million was spent on activities to promote the adoption of the A360 approach and replication of the A360 solutions**. This includes developing materials for external audiences (e.g. the learning hub and content for it) and participation in key meetings and conferences.

Figure 8: Breakdown of the costs by bucket
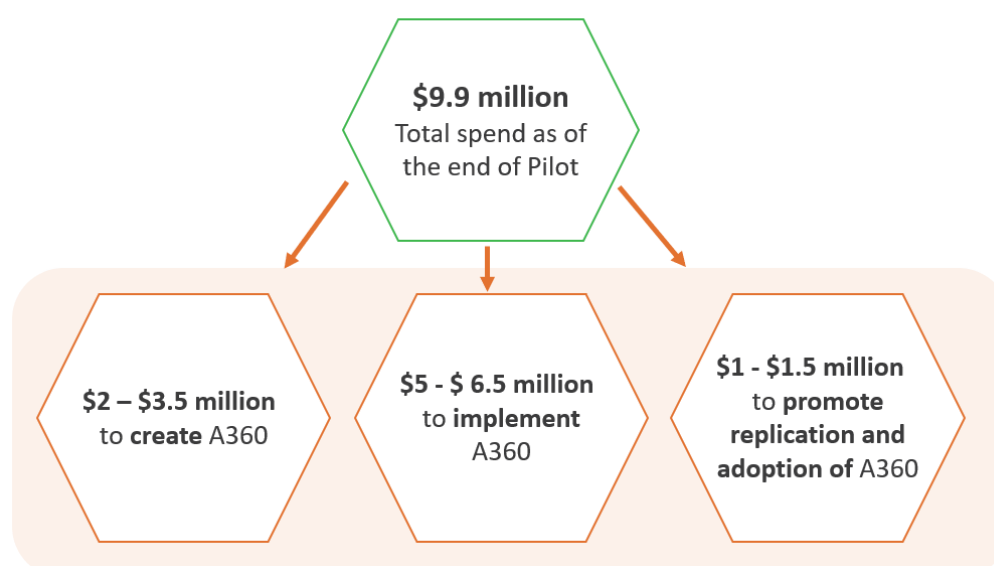
The evaluation sought to assess what changes, if any, stakeholders would suggest to the design process with the benefit of hindsight. An interactive activity was held with A360 implementers in February 2018, triangulated with online survey responses and PE findings. The below costs have been identified as key areas where more or fewer resources might be expended if the A360 Consortium was designing the program again.

Stakeholders felt that costs could be cut in relation to:

- **Applying HCD in full**: Stakeholders expressed some appetite for a design phase relying more heavily on local designers, which in some cases could be done in a shorter time period (HCD light or hybrid).

- **The international bootcamp:** PE and online survey data indicates that a country-specific bootcamp may have been more beneficial than bringing everyone together for a full week in one place, with the focus primarily on launching formative research in Ethiopia.

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[29] Pilot phase ran until December 2017; however, the costs include some Pilot spending in Nigeria in early 2018 due to a delay in the northern Nigeria pilot

- **The Inception phase**: There were significant delays due to lengthy IRB processes in Ethiopia and Nigeria. During this time, staff were already engaged and salaried. Some of these costs have been deducted.

While attrition and retention of staff may have added to costs for A360, these have not been deducted due to the natural turnover of staff in any program.

Stakeholders felt that A360 would have benefitted from additional expenditure on:

- **More intensive youth engagement:** The PE and online survey data indicated that youth engagement was a key aspect of A360, but felt it was under resourced. This costing attempts to address this by increasing costs associated with youth engagement.

- **A longer pilot:** Responding to the appetite for a longer Pilot phase the assessment has taken this into account.

- **Increased M&E support**: In recognition that there were gaps in this M&E leadership and a craving for more consistent support in this area.

- **A larger research team**: This was considered an area that was under resourced and there was a desire for more support from a research team around desk and literature reviews during the design phase.

With these adjustments, it would have cost an estimated $8 million to create and implement the A360 approach, compared to the approximately $8.8 million actually spent.[30][31] This does not represent a drastic change, as the activities that were removed were largely offset by increasing costs for other activities. When putting a range to this figure, the cost effectiveness study estimates that improved implementation could cost between $6.4m and $10m depending on how much was scaled back and how much was increased. [32]

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[30] The range of actual costs is $8.4m -$8.9m. Note, this figure does not include the costs associated with promoting replication and adoption.

[31] All changes were applied for the low, medium, and high scenarios but to different degrees. For activities that were agreed to be fully eliminated (e.g. the Bootcamp) the costs were removed from all three scenarios. For other activities, changes for the medium scenario were informed by consultation with PE colleagues; sensitivity testing for the low and high were done based on +/-25% to provide a range that accounts for uncertainty. For example, for 'a shorter Inception phase' inception costs were reduced by 30% for the medium scenario with a range from 15% to 45% for the high and low scenarios.

[32] This range is based on applying different levels of how much less or how much more each activity is done (with the exception of those where there was clear agreement to remove them completely).

Findings: Solutions

Summary of findings

The outcome evaluation baseline data collection established the 'starting point' for A360. It found that modern contraceptive prevalence rates (mCPR) for adolescent girls were higher in three of the four study geographies than initially estimated, which has implications for the power of the studies to detect an effect of the intervention.

A360 monitoring data is being used to measure the number of girls aged 15-19 who have become adopters of modern contraceptives, as well as the proportion of attendees at A360 events who adopt. This data suggests that the program is on track – based on current plans – to meet its target of 244,738 adopters by the end of the program. It is important to note that targets and implementation geographies have shifted significantly since the inception of A360, pointing to challenges in setting firm targets too early in an HCD process.

Each solution is attempting to meet a standardized pathway to behavior change, nested in the A360 ToC:

1. While the A360 solutions are all seeking to **create supportive environments for adolescent girls to access contraception**, this has been one of the most challenging areas for A360.

2. The solutions have been successful in **positioning contraception as relevant and valuable to adolescent girls and some influencers** through connecting aspirations to the uptake of contraception.

3. Building trust and credibility in methods has been challenging given entrenched myths and misconceptions associated with contraception, as well as the reality of implementation in the public sector.

4. Solutions have **increased the availability of service delivery points** through pop-up events (Tanzania), girl-specific clinic activities on Saturdays (Nigeria) and beginning to shift the attitudes of service providers working on the solutions.

5. At this point in implementation, it is too early to determine if continued relationships have been established between adolescent girls and the health system to **ensure sustained use of modern contraception.**

3   What is A360's progress to date?

3.1   What were the findings from the baseline Outcome Evaluation?

The OE baseline data established the 'starting point' for A360. It found that the mCPR for adolescent girls was higher in the three out of four study geographies than estimated. The OE primarily monitors mCPR among sexually active girls aged 15-19, along with a range of secondary outcomes including percentage of unmet need for contraception. Baseline evaluation findings are presented in Table 3, showing that the observed mCPR was higher than predicted in three of the four study geographies. In these cases, it is unclear whether there has been a general increase in mCPR over time or whether A360 and hence the outcome evaluation has selected areas where mCPR is higher (e.g. closer to urban centers).

Table 2. Outcome evaluation findings

		Ethiopia	Nigeria		Tanzania	
		Oromia	Nasarawa	Ogun	Illemela	
		Married girls	Married girls	Unmarried girls	Married girls	Unmarried girls
Outcome evaluation baseline*	*Predicted mCPR[33]*	*44.0%*	*3.0%*	*64.4%*	*16.2%*	*38.5%*
	mCPR (protocol definition)[34]	61.3% (50.8, 71.0)	14.4% (11.8, 17.6)	47.0% (44.1, 51.0)	28.5% (21.4, 36.8)	51.4% (48.4, 54.5)
	mCPR (DHS definition)[35]	47.2% (37.0, 57.7)	8.7% (7.1, 10.6)	45.4% (42.0, 48.8)	19.4% (13.4, 27.3)	48.7% (45.8, 51.5)
	Unmet need for modern contraception[36]	20.5% (16.4, 25.4)	21.9% (19.1, 25.0)	32.5% (29.3, 35.9)	40.3% (37.0, 43.8)	32.0% (25.4, 39.5)
DHS findings	mCPR (Ethiopia DHS 2016; Nigeria DHS 2013; Tanzania DHS 2015/16)	31.8%	1.2%	49.7%**	13.3%	33.1%**

*Analysis adjusts for cluster design
**DHS define 'sexually active girls' as those who report having sexual intercourse in the past 30 days. The OE used a slightly modified DHS definition for unmarried girls, including those who were sexually active in the past 12 months

The sample size calculations for the OE relied on several assumptions including baseline mCPR, design effect, and (in Tanzania), the proportion of 15-19-year-old girls who are married. Several of these assumptions had to be adjusted based on the baseline findings. For example, mCPR was higher than expected in some settings (see above), the proportion of girls married in Tanzania was much lower than expected,[37] and the design effects in Ethiopia and Nigeria were higher than expected. These changes have implications for the power of the studies to detect an effect of the intervention. In particular, the large design effect in Ethiopia and the higher than expected mCPR in Nasarawa mean that the outcome evaluation now has the power to detect only larger effect sizes. The evaluation team are exploring alternative analysis strategies that could be employed to improve the power of the study e.g. matched pair within cluster analysis in Ethiopia.

3.2 How has A360 influenced contraceptive use among adolescent girls?

Program monitoring data is being used to measure the number of girls aged 15-19 who have adopted modern contraceptives, as well as the proportion of attendees at A360 events who adopt. This data was collected and reported by PSI through routine monitoring, and has not been independently verified by the evaluation team. The outcome evaluation will complement this data by looking at population-level changes in mCPR and a range of secondary outcomes.

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[33] Predication made based on DHS estimates and other available data. Note that the DHS sample of 15-19-year olds was very small with significant regional variation.

[34] Defined as: Number of fecund sexually active 15-19-year-old girls reporting use of modern contraceptives at the time of the survey divided by the number of fecund sexually active 15-19-year-old girls. Sexually active girls are those who report having sexual intercourse in the last 12 months. Fecund girls are those who have started menstruating, are not pregnant, and do not report that they are infertile.

[35] Definition for married girls: number of married 15-19-year-old girls reporting use of modern contraceptives at the time of the survey divided by the number of married 15-19-year-old girls. Definition for unmarried girls: number of unmarried sexually active 15-19-year-old girls reporting use of modern contraceptives at the time of the survey divided by number of unmarried sexually active 15-19-year-old girls. Sexually active girls are those who report having sexual intercourse in the past 30 days.

[36] Defined as: sexually active and fecund adolescent girls aged 15–19 years who indicated that they either want no more children (limiters) or want to wait for two or more years before having a/another child (spacers) but are not using modern contraception.

[37] Married girls made up a smaller proportion of all girls aged 15–19 years than expected (baseline survey 5.7% vs. PSI estimate 21.7%).

As of August 2018, 120,443 adolescent girls had attended A360 events,[38] and 65,971 of these had adopted a modern contraceptive method.[39] As seen in Figure 9, the cumulative conversion rate was 70% in northern Nigeria, 61% in Tanzania, 62% in Ethiopia and 42% in southern Nigeria.[40] As of August 2018, A360 conversion rates were improving and are higher than an identified benchmark of 51%.[41]

Figure 9: Cumulative adopter totals, A360 Results Framework Update (Oct 2018)
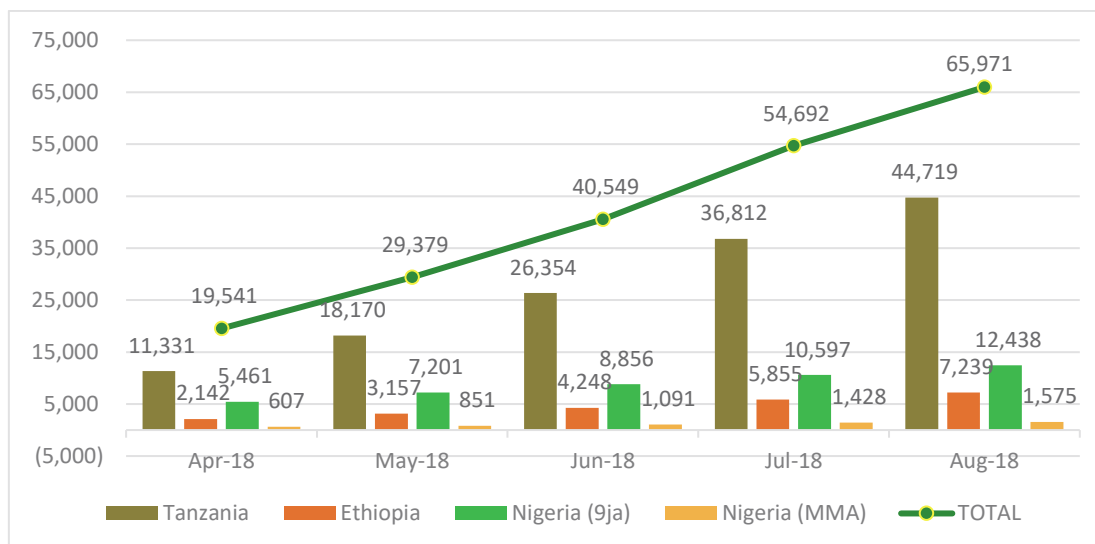
PSI projections indicated that A360 expects to achieve its goal of 244,738 adopters by the end of the program.[42] Projections were based on expanding geographies in Tanzania and partnering with the government in Ethiopia.[43] However, it should be noted that targets have been negotiated downwards since the Inception phase (see Box 3). As of August 2018, Northern Nigeria had seen the greatest improvement in conversion rates (from 59% to 70%) but the total number of adopters remained low at 1,575. Tanzania continued to contribute the largest number of adopters at 67.8% of the total number and an 8 percent point growth in conversion rates between April and August 2018. There have been some fluctuations in conversion rates reported by the program, which raise some questions regarding data quality.

Box 3: Shifting targets and geographies

In the Inception phase of A360, before solutions were designed, it was estimated that the program would reach over 300,000 15-19-year-old adolescent girls as new users of modern contraception, and country specific projections were made. As the solutions developed, these targets were reduced to approximately 280,000 adolescent girls and a program-wide approach to targets was adopted, rather than a country specific one. This reflects decisions made during the design phase. For example, in Ethiopia, the Smart Start solution is aimed at rural, married adolescents, who are significantly harder to access than those in an urban setting. Targets shifted again at the end of Optimization (October 2018) to a total of just under 250,000 adopters of modern contraception.

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[38] This includes attendance figures from the beginning of the pilot phase to August 2018.

[39] Adoption is defined as girls aged 15-19 who were not using contraception the day before or at last sex, and who take up a method at the event. The exception to this is in Tanzania: in the August 2018 Optimization Report, PSI proposes using a different definition from this point onwards: adolescent girls starting contraception for the first time. This definition can be more easily captured through government forms, improving ease of measurement, and represents 98% of PSI Tanzania's adopters (according to Q1 2018 data). In order to make up for the slight shortfall, Tanzania will also capture girls under 15 who adopt a method.

[40] Conversion rate is all adopters divided by attendance: Smart Start session in Ethiopia; 9ja Girls class/mentoring session, 1:1 counseling, or pop-up event in Nigeria; girl's clinic or pop-up event in Tanzania (A360 Optimization Report, June 2016).

[41] Benchmark figures derive from the Future Fab 2017 Impact Report. The relevance of the Future Fab benchmark is being assessed and other benchmarks are being evaluated (A360 Optimization Report, June 2016).

[42] By the end of August, a total of 65,971 adopters had been reached which represents 25.6% of the project's goal. A360 Midterm Program Review - Executive Summary (2018)

[43] However, discussions about Optimization were ongoing at the time of writing this report and a final plan had not yet been agreed upon.

	2016		2018
Ethiopia	124,620	$\longrightarrow$	17,738
Nigeria	136,177	$\longrightarrow$	67,000
Tanzania	66,751	$\longrightarrow$	160,000
Total	327,548	$\longrightarrow$	244,738

There has also been a significant decrease in the number of geographies in which the solutions are being scaled up, primarily related to the human and financial resources required to implement the solutions. Notably, PSI Tanzania rolled out Kuwa Mjanja in 18 regions but in mid-2018, a decision made with the MOH to reduce implementation in order to focus on saturating priority regions.

	2016		2018
Ethiopia	5 states; 2 cites	$\longrightarrow$	4 regions
Nigeria	10 states	$\longrightarrow$	5 states
Tanzania	10 regions	$\longrightarrow$	5 regions

Overall, the target has reduced by over 80,000 girls. In-country targets are widely different to those anticipated in the early stages of the program, and the target geographies have shifted substantially, highlighting the challenges in setting targets and implementation geographies too early in an HCD process.

As of June 2018, PSI monitoring data showed that LARCs (implants and IUDs) accounted for 51% of methods adopted program wide. Across all three countries, the reported method mix compares favorably to national DHS / PMA2020 figures. However, the method mix varies widely by country and intervention model, as detailed in Table 4. In particular, there have been some concerns over the method mix in Nigeria, given the high reported numbers of short-term methods, specifically condoms. Recent adaptations to 9ja Girls (such as the roll out of a new counseling algorithm) shows a promising shift in the method mix.

Table 3. Method mix per country, Optimization Report (August 2018)

|	Ethiopia		Southern Nigeria		Northern Nigeria		Tanzania	
	A360	Ethiopia DHS 2016[44]	A360	Nigeria PMA2020	A360	Nigeria PMA2020	A360	Tanzania DHS 2015-16[45]
Overall LARCs	**27%**	**18%**	**15%**	**3%**	**25%**	**15%**	**67%**	**20%**
IUD	0%	3%	0%	1%	0%	0%	16%	0%
Implant	27%	15%	15%	2%	25%	15%	51%	20%
Injection	67%	75%	21%	4%	33%	32%	7%	51%
Pill	8%	6%	13%	26%	23%	24%	12%	17%
Condom	0%	0%	51%	58%	18%	21%	9%	11%
EC	0%	N/A	0%	9%	0%	7%	4%	N/A

PSI data on the cost of solutions per CYP suggests that costs are lower than projected in Tanzania and Nigeria, although higher in Ethiopia, as detailed in Figure 9. It should be noted that this data was collected by PSI, following a different methodology to the independent cost-effectiveness component of the evaluation. PSI data suggests that cost per CYP is particularly low in Tanzania, where A360 has been able to leverage costs from the UK Department for International Development (DFID) and KfW (a German government-owned development bank) funded outreach teams when scaling up the Kuwa Mjanja solution.[46] Cost per CYP is higher in Ethiopia because overall costs are higher, due to an emphasis on

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[44] DHS 2016 estimates include married girls 15-19 years old who are currently using a modern method of contraception.

[45] DHS 2015-16 estimates include married girls 15-19 years old who are currently using a modern method of contraception.

[46] This includes leveraged costs funded by DFID (who covered 42% of total costs in June) and KFW (2% in June but 18% in May). A360 contributed 56% of funding in June. PSI (2018) Optimization Report Tanzania Data Slides, August.

Figure 10: Cost per CYP, projected and actual (A360 Optimization Report, August 2018)

Legend: ■ 2018 Projected ■ 2018 Q2 Actual
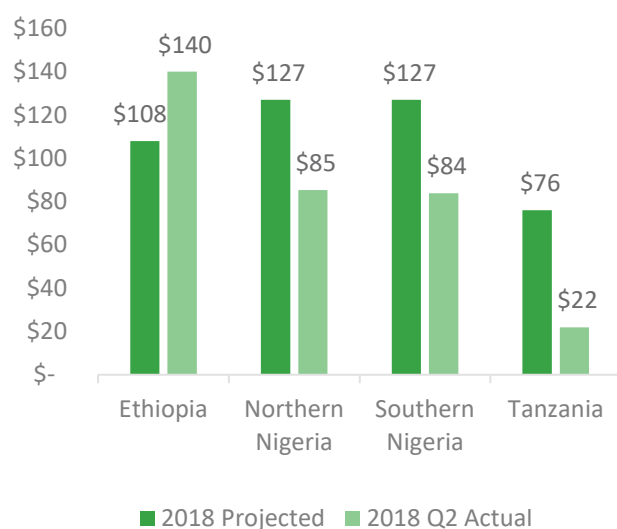
'going the last mile' and reaching more rural and isolated girls, and because LARCs are a lower proportion of methods than projected.[47] Figure 10 provides a summary of CYP, based on projected versus actual in quarter two of 2018.

3.3 How has A360 promoted adoption and replication of A360-inspired processes and solutions within and beyond intervention areas?

A360 seeks to promote adoption and replication of its approach and solutions by other projects, programs, organizations and governments.

'Adoption [of approach]' refers to A360 inspiring other interventions to adopt a similar approach, or any components of it. For example, including beneficiaries as designers, employing HCD, utilizing multi or transdisciplinary task forces, or using a stop/start design process.

'**Replication [of solutions**]' refers to A360 inspiring replication of specific solutions (or elements of them) within and beyond intervention areas, with other funding sources. For example, an opt-out counseling moment for adolescent girls, or components of the Smart Start, 9ja girls or Kuwa Mjanja curriculums.

There are various challenges with attempting to measure both adoption and replication within the lifetime of the A360 program. Firstly, as there is no clear definition of the A360 approach, it is difficult to monitor whether it or components of it have been adopted, as it isn't clear how much similarity is required for a particular example to count. Secondly, much has been written on the substantial gap between evidence, policy and practice in the health sector, suggesting it can take many years for lessons on effective practice to instrumentally influence policy and practice, including in ASRH.[48] Given that innovations often diffuse indirectly, there are also challenges with attributing any observed change specifically to A360 in a context where other actors are also actively generating and sharing learning on AYSRH.

PSI monitoring data reports early progress towards adoption and replication. To date, PSI reports leveraging $12.5 million in funding for projects building directly on or adopting aspects of the A360 approach, reflecting a good level of buy-in to HCD within PSI and SFH. An additional $90.3 million in funding has been won by PSI through proposals that referencing insights, learning and experience from A360. For example, PSI Ethiopia secured funding from the Maverick Collective to build a solution based on

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[47] A360 Optimization Report, August 2018.

[48] Chandra-Mouli, V., Lane, C. & Wong, S., 2015. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. *Global Health: Science and Practice*, 3(3), p.333 LP-340.

insights collected on unmarried girls during the A360 Inspiration phase. However, concrete examples of adoption and replication relate to PSI projects only so far.

A360 is investing significantly in communication efforts about the program and generating open access resources, including through the Learning Hub and high-profile conferences. A360 has invested significant time and resources to promote adoption and replication. For example, in quarters two and three of 2018, A360 developed five publications, including the A360 Blueprint for Change (see Section 4), a resource on Evidence-Based Adaptive Implementation, and a Smart Start High Level Intervention Kit.[49] During this period, A360 reports that its Learning Hub received 3,192 unique visitors and 7,264 page views. A360 also submitted 20 conference abstracts, for the International Conference of Family Planning and the Core Group Global Practitioners Conference. Two further publications are in development, including a peer-reviewed journal article.

Concerns have been expressed around balancing the timing of adoption and replication with developing the evidence-base for the effectiveness of the approach and solutions. In the Pilot phase, country-level respondents had some pragmatic concerns about promoting adoption and replication. There was some discomfort in promoting the solutions externally at a point where there was still limited evidence to demonstrate proof of concept – before it was possible to prove the solutions were effective. There is also a challenge in promoting adoption and replication in an environment where agencies compete for funding, offering a disincentive for others to adopt what is sometimes viewed as a competitor's model.

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[49] These resources are all available on the A360 Learning Hub: https://www.a360learninghub.org/replication-tools/

4   How are the A360 solutions addressing the Theory of Change?

Reflecting the iterative nature of the A360 program, the A360 ToC (Figure 11) has been updated frequently throughout the design process. This has included some significant modifications on how socio-cultural norms and adolescent agency featured. Initial versions of the ToC addressed the ChANGES model (discussed in Section 1) at the intermediate outcome level. At the end of Ideation phase, this was replaced with a standardized pathway to behavioral change (see Figure 12) at the output level. While this has remained static since then, in mid-2018, PSI published the Adolescent 360 Blueprint for Change[50], intended as a tool for replication. The Blueprint has characteristics of a ToC and it is unclear if this will be incorporated into the ToC moving forward.
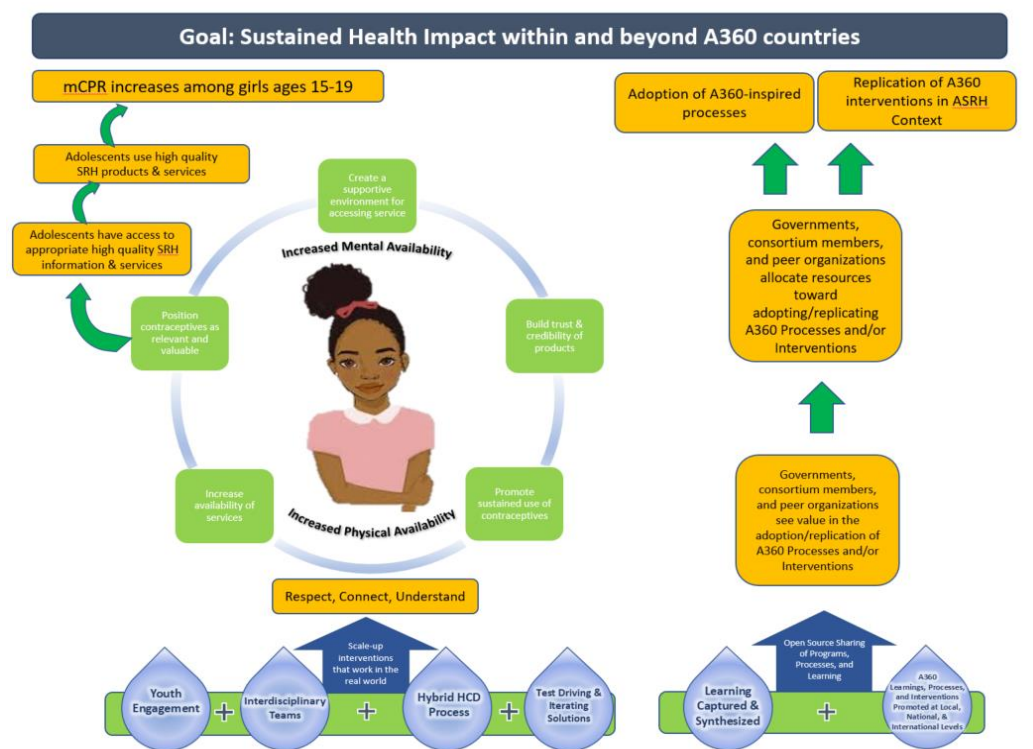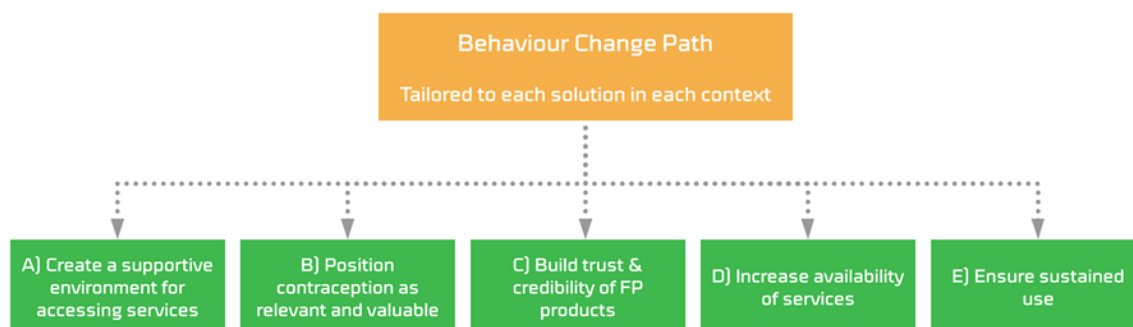
Figure 81. A360 Theory of Change

Figure 12: A360 pathway to behavior change

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[50] Available here: https://www.psi.org/wp-content/uploads/2018/08/BlueprintForRapidChange13.pdf.

The remainder of this section discusses each elements of the behavior change pathway in turn, and evidence to date on how effectively A360 is working in each area.

4.1 Are the A360 solutions creating supportive environments for accessing services?

In **Tanzania,** Kuwa Mjanja positions its outreach events as 'wellbeing' events rather than contraceptive events, providing girl-friendly safe spaces where contraceptive services are offered discreetly alongside life and entrepreneurial skills training. 'Opt-out' private moments are used, in which all girls receive 1-1 counseling unless they actively choose to opt out, to ensure that girls who want to adopt a method are not stigmatized. Kuwa Mjanja works with government and community leaders to organize and promote events, in order to ensure community buy-in. Parents sessions were also piloted but were dropped from the solution during the Optimization phase, as discussed in Section 1.

In **Nigeria,** 9ja Girls conducts sessions with mothers and community leaders to build community buy-in, while MMA engages husbands through male IPCs, and also runs sensitization activities with religious leaders. The solution also uses opt-out private moments.

In **Ethiopia,** Smart Start employs a 'quiet movement' to build community buy-in, using financial planning rather than contraception as an entry point to working in communities. It also engages husbands through offering counseling to young married couples.

While the A360 solutions are all seeking to create supportive environments for adolescent girls, this has been one of the most challenging areas for the program. Entry points for creating a supportive environment have focused on community influencers and interpersonal relationships (e.g. mothers and husbands), as well as normalizing counseling among adolescent girls themselves. There have been some key successes and challenges in the early stages of implementation:

- **The opt-out moment has generally proved successful and A360 is actively addressing challenges that may arise.** An opt-out approach to counseling has been adopted in both Tanzania and Nigeria, attempting to normalize the idea of one-on-one time with a service provider among groups of peers attending A360 group events. Uptake data suggests that this is effective, however, some challenges have arisen with this approach. Firstly, while opt-out moments emphasize privacy, some adolescent girls are concerned that if they spend too long with the service provider, their friends (waiting in a tent or space outside or near where counseling is taking place) will associate this with the uptake of a method. In some cases, this appears to skew girls' preference towards shorter-term methods. Secondly, at dedicated A360 events, service providers can feel rushed when counseling due to the number of girls waiting to be counseled, which may influence how they counsel the girls. In Nigeria, A360 is experimenting with ways of overcoming this, such as a more staggered approach to counseling throughout a session rather than at the end.

- **Creating supportive environments is resource intensive.** Activities to address environmental constraints have proven to be resource intensive in terms of staff time and logistics, as they need to be replicated in each new geography where the solutions are introduced. The ability to influence community members is constrained by the reach of specific influencers, within a girl's household or the community.

- **A 'flying under the radar' strategy is useful for reaching unmarried adolescents, but it has risks**. A360 activities targeting unmarried adolescents are not framed as being about contraception or family planning. Instead, they emphasize vocational skills and aspirations, to help increase the acceptability of solutions within communities, and reduce stigma for girls. While this has proved successful at improving access to services for girls, it needs to be managed to avoid risks of community backlash and ensure adolescent girls do not feel misled or tricked into attending the program (see Section 4.2).

- **It has proved challenging to engage men while also seeking to transform gender norms**. Husbands are explicitly targeted in Ethiopia and Northern Nigeria. However, there is some concern that their

inclusion may reinforce traditional gender norms, such as their primacy in decision making and the subservience of wives. Targeting mothers through mothers' sessions in Tanzania and Nigeria may also reinforce the gender norm that holds mothers responsible for pregnancy out-of-wedlock. In addition, the gendered content of sessions may reinforce biases of solution implementers, which may color their interactions with adolescents. In Tanzania and Southern Nigeria, the lack of male engagement has been highlighted as an issue by service providers and MOH representatives. A360 has defended this position, indicating that girls want a solution and brand that is explicitly for them. There has been increasing recognition of the role that men can play, outside of their filial role, in all contexts (e.g. village leaders in Ethiopia and Tanzania and religious leaders in Nigeria). However, it is unclear if these engagements have been scripted using an empowerment frame of reference.

'Take for instance, there is a man that told us about the unhygienic condition of their family bathroom but when his wife started to attend this program [MMA] she completely changed and always washes the bathroom, so you see he has also benefitted as a husband. So, I can say that A360 benefits every family member.'
Solution implementer, Nigeria, Pilot phase

4.2   Are the A360 solutions positioning contraception as relevant and valuable?

In **Tanzania**, Kuwa Mjanja uses body changes and 'achieving dreams' as an entry point to discussing contraception with adolescent girls, depending on their life stage. The Kuwa Mjanja brand and messaging aim to connect with girls using messages and imagery that are relevant to them. Vocational skills training activities aim to provide a 'hook' to attract girls and help them link contraception to achieving their dreams.

In **Nigeria**, 9ja Girls uses job skills and life planning as an entry point to discussing contraception, within 'Love, Life, Health' classes. Branded 9ja Girls spaces embedded in public health centers (PHCs) aim to create safe spaces for girls. MMA uses the health of the baby and mother as an entry point, mentoring girls through group sessions focusing on skills building, health, nutrition, maternal and child health and conflict resolution as an entry point to discussing contraception.

In **Ethiopia**, Smart Start uses financial planning as an entry point to discuss family planning with young couples through couples' counseling sessions, including a 'baby calculator' tool that helps link contraceptives with financial security.

The solutions have been successful in positioning contraception as relevant and valuable to adolescent girls and influencers. The increase in contraceptive uptake demonstrated through A360 monitoring data (see Section 3.2) is a good indication that the solutions are positioned as relevant and valuable for adolescent girls, and this is confirmed by PE findings to date. A number of factors have been consistently highlighted as contributing to this success:

'Communities are much more supportive and accepting of the life, dream, goal building events…community acceptance is high. And it's high because we're not going in saying we're holding contraceptive events for adolescents.'
A360 respondent, Tanzania, Optimization phase

- **Linking contraception with aspirations**: In all contexts, solutions seek to position contraception as relevant and valuable through aspirational messaging about achieving one's dreams, the values of autonomy and self-worth, financial planning and caring for a family. This not only resonates with adolescent girls and husbands, but also the service providers exposed to the solutions, many of whom now profess understanding the importance of serving adolescent girls or, in the case of Ethiopia, recognized that they had not previously considered married adolescent girls as clients for family planning.

'Kuwa Mjanja is a good project because it has improved our condition and taught us to have self-understanding and also provides us with employment. If for instance you master making soap, you can open up your firm.'
Adolescent Girl, Tanzania, Pilot phase

- **Using vocational or entrepreneurial skills training as a 'hook'**: In Tanzania and Nigeria, vocational or entrepreneurial skills training is

one of the most appealing aspects of the solutions for adolescent girls. However, taking this component to scale has been challenging, and there is some evidence of loss of quality in execution of the sessions in both countries, particularly when community-based organizations were subcontracted to deliver these sessions. There are also some ethical concerns about girls' expectations around the sessions, as girls often view them as a gateway to employment opportunities, when this is generally an unrealistic expectation from short, one off sessions with no follow-up support.

'If you decide to change the skills of life, love and health, girls will not like it because it's the skill acquisition that they are interested in. If you decide to change it then some won't come.'
Adolescent Girl, Nigeria, Ideation phase

- **Using financial planning as an entry point:** In Ethiopia, financial planning is viewed as a unique selling point of the Smart Start solution by external respondents. However, it was found that HEWs often revert to family planning messaging linked to child and maternal health when left to implement Smart Start on their own. PSI Ethiopia are looking at ways to iterate Smart Start so it becomes more accessible for HEWs to implement.

'We have learned to plan our future before we decided to have a child, we are advised to own property before having a baby. If we don't have money the baby will be malnourished. Then our husbands said the lesson is very useful."
Adolescent Girl, Ethiopia, Pilot phase

- **While the Kuwa Mjanja and 9ja Girls brands in Tanzania and Nigeria are considered key aspects of the design, they do not always translate to adolescent girls as intended.** In Tanzania, there are a variety of interpretations of the Kuwa Mjanja pineapple brand, some of which are closer to the intended empowering connotations than others – ranging from '*girls are as clever as a pineapple*' to '*girls should keep their value just like a pineapple fruit until someone comes and buys it and peels it for himself.*' In Nigeria, SFH has experimented with reducing the extent to which they 'brand' facilities in an effort to drive down costs. This experiment suggested that minimal branded spaces embedded in PHCs had the potential to deliver the same results as fully branded 9ja Girls spaces.

> **⚑ Critical success factor:** Unlocking aspirations
>
> Even at this relatively early stage of implementation, tapping into the aspirations of adolescent girls (and their husbands where relevant) appears to be one of the key factors in the success of the solutions to date. It is apparent that it is important to reach service providers with this message as well as girls, as service providers are important gatekeepers to uptake. Educating service providers about the role that contraception can play in ensuring girls can reach their goals and stay in education appears to be a key factor in their willingness to serve adolescents.

4.3   Are the A360 solutions building trust and credibility of FP products?

In **Tanzania** and **Nigeria**, A360 solutions use interactive counseling sessions with youth-friendly service providers identified by girls, to address fears, dispel myths and highlight the benefits of contraception.

In **Ethiopia**, services are provided by trusted HEWs who have been trained in youth-friendly service provision, through house-to-house visits or at health posts.

This aspect of the behavior change pathway has been challenging given entrenched myths and misconceptions associated with contraception, as well as the reality of implementing in the public sector. In all contexts, myths and misconceptions associated with contraception are deeply entrenched in the communities A360 is working in, including among service providers. The most common include beliefs that contraception will cause infertility, but there are also worries about contraceptive methods moving around the body, causing infection through stopping or altering monthly periods, weight gain, pain, bleeding or cancer. These beliefs contribute both to girls' fear of contraception, and parents' and service providers' reluctance to promote it to girls.

The solutions generally attempt to counter myths and misconceptions through interactive sessions run by youth-friendly providers, which aim to build trust in and the credibility of contraceptive methods. These sessions are considered novel by adolescent girls. Many girls profess hearing about certain methods for the first time during the A360 counseling and appreciate the ability to see and touch the methods. However, there have been challenges, particularly as the solutions go to scale:

- **In Nigeria and Tanzania, it has proved challenging to systematically identify youth-friendly service providers**. Adolescent girls initially played a role in identifying youth-friendly service providers in Tanzania, through a 'mystery client' process in which girls were trained to visit and rank the friendliness of service providers. However, as Kuwa Mjanja went to scale, service providers were generally identified by local government rather than girls. In Nigeria, facilities and service providers are selected in collaboration with the local government, with adolescent girls playing no role. In both countries, a criterion for selection of service providers is that they have undergone youth-friendly service provision training; but in reality, this has not been the case for all service providers implementing the solutions.

- **Adolescent girls sometimes feel lied to about the nature of A360 interventions, or about side effects**. In Tanzania, the PE found that mobilizers do not always inform girls that outreach events will offer contraception. The PE has also found that service providers do not always talk about side effects during counseling. Both omissions risk eroding trust, contributing to discontinuation, and reinforcing common myths and misconceptions, which are often closely linked to legitimate concerns about side effects (e.g. delays in return to fertility after receiving the injection).

- **Service providers are often biased toward or against particular methods.** The PE has found that service providers often have strong views and biases around which methods are more or less appropriate for girls, which often link to myths and misconceptions – for example, it is a common fear that injections may cause problems conceiving in future. This includes beliefs about adolescent eligibility to use certain methods (especially by younger adolescents, aged 15-17 years). This has been recognized as a challenge and A360 is investigating how to overcome it, with the support of the evaluation team.[51] In Nigeria, SFH is experimenting with introducing new content into training, and increasing support and supervision. More detail is provided in Spotlight 4.

'The availability of adolescent friendly services is still the challenge. They are there but not sufficient unless the project has an objective about it in training the providers so as to get many adolescent friendly providers. There should be many facilities so as to have many youths accessing the services.'
Government Respondent, Tanzania, Pilot phase

'I started well with the implant but now it is the third week I am still bleeding. I am planning to go to Safina so that they may remove it because I am bleeding daily. I no longer like an implant. I will opt for the other protection because the bleeding becomes worse as days go by.'
Adolescent girl, Tanzania, Pilot phase

4.4   Are the A360 solutions increasing availability of services?

In **Tanzania, Nigeria and Ethiopia**, A360 solutions are providing contraceptive services on-site, through outreach (in Tanzania and Ethiopia) or within public health facilities (all contexts). Wherever possible, the solutions seek to eliminate referrals and provide services on-the-spot. Girls are mobilized to attend A360 activities through peers and community members, and through husbands in Northern Nigeria.

Availability has been improved through providing additional service delivery points: pop-up events (Tanzania), Saturday clinics for girls (Nigeria), and door-to-door counselling in remote rural settings (Ethiopia). These solutions have promoted on-site delivery, eliminating referrals where possible. This is viewed by A360 as critical to user conversion and method adoption and is a key factor in the high conversion rates noted in Section 3.2. Through their involvement in the design of the solutions, girls have

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[51] Participatory action research conducted in July 2018 in Nigeria focused on service provider bias.

helped identify times, places and layouts that are most accessible to them, including well-defined guidelines on the 'look and feel' of A360 events.

Availability has also been addressed through training and engaging government service providers in implementing the solutions – although this has been challenging in some cases. A360 has provided youth-friendly service training, mainly to public sector health workers[52] using government curricula combined with PSI and/or solution-specific content. However, in Nigeria, the program has suffered from attrition challenges in retaining trained service providers, reverting to on-the-job training in some cases, which may not be as effective. As Kuwa Mjanja rapidly scaled in 2018, the Tanzania team reverted to working with service providers already trained in youth-friendly provision, rather than training new cohorts.

There are some signs that exposure to A360 solutions may influence the youth friendliness of providers by putting them into contact with adolescent girls, helping them understand their needs and challenges. Service providers interviewed through the PE generally report that their attitudes have become more positive toward providing adolescent girls with modern contraception. For example, in Ethiopia, Smart Start is associated with shifting HEW perceptions around married adolescents and helping them see girls as potential contraceptive clients (see Spotlight 4). However, while there is some evidence that attitudes are softening towards serving adolescent girls, provider attitudes when not engaged in A360 events are not well understood.

'There was no awareness about newly married couples' family planning usage before the introduction of Smart Start. Thanks to Smart Start it is a hot issue.'
Government Respondent, Ethiopia, PAR

Some providers are unable to offer the full suite of methods (due to a lack of method-specific training), specifically in relation to LARC. Of equal importance to acceptability by girls is the ability to remove the methods should there be a reason, medical or otherwise, to do so.

> **Critical success factor: Changing service providers' attitudes**
>
> Changing the attitudes of service providers is viewed as key to increasing the availability of services. Where service providers do not view adolescent girls as potential clients – for example because they believe that adolescent girls should not be having sex or assume that young married girls will start families straight away – this can prove a major barrier. In Nigeria and Ethiopia, the PE has found some evidence that A360 has begun to shift the attitudes of service providers, through deliberate engagement accompanied by training and on-the-job support and supervision. However, as highlighted above and in Spotlight 4, this alone is not enough to ensure service providers are actively counseling adolescent girls on all available methods, or to comprehensively overcome biases towards long-term methods.

4.5 How are the A360 interventions ensuring sustained use of modern contraception?

In **Tanzania** and **Nigeria**, A360 solutions link girls to youth friendly service providers for follow up support, in the hope that this will encourage sustained relationships. In **Tanzania,** girls are given a PSI staff member's phone number in case they have questions, and Kuwa Mjanja is working on various initiatives to engage girls in the longer term through online hubs and mobile apps. In **Ethiopia,** girls are linked in to the public health system through their engagement with HEWs.

All solutions offer referrals to public service providers for follow up—however it is unclear if continued relationships have been established between girls and the health system to ensure sustained use of modern contraception. A critical pathway to sustained use as conceptualized in the ToC is the

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[52] Training has mainly focused on public health workers, co-opted to the solutions. In some instances, this also included PSI/SFH staff or private providers on sessional contracts.

development of ongoing relationships between adolescents and girl-friendly service providers. This is particularly important as A360 events are generally short term – as a result of mobile outreach (Tanzania), a limited number of life skills sessions (Nigeria) or due to seasonality (Ethiopia). However, A360 is not collecting data on the number of girls who later visit a public clinic after receiving counseling or a contraceptive method from an A360 event. This is a concern for the program, as there are risks for girls if they experience side effects after taking up a method but are not willing or able to travel to a clinic. If not managed promptly, this may result in discontinuation, which is not monitored by the program. In Tanzania, A360 is seeking to address this challenge through a mobile app (Mjanja Connect) which will provide an interactive platform for adolescents *'to support recruitment, referral, linkage to care, and follow up'* as well as allow adolescents to evaluate providers.[53]

Sustaining relationships with service delivery points is particularly important in the context of Nigeria given that most girls are opting for short-term methods, specifically condoms. It is also important in Tanzania given reliance on pop-up events through outreach teams.[54] This model, while delivering the greatest numbers of adopters, may have the least fidelity to ensuring sustained use through continued relationships.

A360 has tested various activities to support sustained engagement, but some have been dropped due to poor translation to adoption and conversion figures. In Tanzania, A360 tested Kuwa Mjanja clubs as a way to build sustained relationships with girls. However, this component was dropped due to decreasing attendance, and because they were considered *'not a core area of expertise for PSI…we don't have the resources and funding to run them…. they are good for sustained use, but you don't get attributed health impact.'*[55] In Nigeria, a social media component was intended to promote and sustain relationships, but this was downgraded in the Pilot phase due to limited use by girls and an inability to link girls with services. Under Optimization, it appears that solution components less directly linked to adoption and conversion rates have been dropped or sidelined, while those more closely associated with reaching targets have been emphasized – discussed further in Section 1.

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[53] A360 Tanzania Business Case, Nov 2017.

[54] At the time of writing the MTR synthesis, the out-of-clinic pop-up events were being implemented full time by 19 outreach teams across 18 regions (4 A360 teams, 10 DFID teams, and 5 KfW teams), with each team concentrating in one district per month.

[55] PSI Tanzania Respondent, Pilot phase.

Spotlight 4:

Service providers— the battle to serve

Many service providers involved in A360 interventions reported that their attitudes have shifted towards serving adolescents. For example, in Ethiopia, married adolescents who have not yet had children have not traditionally been a target audience for Health Extension Workers, and Smart Start is felt to have changed this. Across all three countries, providers interviewed through the PE professed a desire to provide adolescent girls with contraception, linked to enabling girls to achieve their dreams and goals, helping married girls space their children, and in some cases reducing unsafe abortions and maternal mortality. It remains unclear how far this self-reported shift is due to A360 training in youth friendly counselling and service provision, and how much it is due to greater interaction with adolescents and understanding of their aspirations.

However, *'provider bias is grounded in culture and takes time to change.'[56]* Biases and capacity gaps are still apparent, throwing up barriers to effective service provision. These include:

- **Methods biases:** Side effects of contraception are often conflated with myths and misconceptions, and beliefs about the appropriateness of particular methods for girls (especially younger adolescents, aged 15-17 years): *'The IUD is for 18-to-19-year olds. The other contraception is for everybody. The IUD is for older girls because personal hygiene is needed for the safety of the girls [who use IUD]. Generally, the older ones can take good care of themselves to avoid complications with use of the method.'[57]*

- **Capacity gaps:** Some providers are unable to offer the full suite of methods, due to a lack of training on how to insert or remove them, specifically in relation to IUDs and implants. '*I need to learn how to insert the IUD. I can place all the other methods but not IUD.'[58]*

- **System challenges:** A360 interventions are largely integrated into public health systems, meaning providers face systemic challenges including periodic stockouts of consumables and commodities, and weaknesses in facility infrastructure.

- **Policy barriers:** In Nigeria, girls under 18 cannot be provided with a long acting contraceptive method without parental permission. This is perceived by as an acute barrier to the uptake of long acting methods by younger adolescents. In Tanzania, there are concerns that the policy environment is becoming more conservative. In September 2018, the President publicly denounced family planning: '*Those going for family planning are lazy ... they are afraid they will not be able to feed their children. They do not want to work hard to feed a large family and that is why they opt for birth controls and end up with one or two children only.'[59]* Outreach activities in Tanzania were briefly paused following this statement, and while activities have since resumed the future of the policy environment remains unclear.

- **Seasonal trends:** In rural Ethiopia, adoption and discontinuation are seasonally impacted. The rainy season is associated with discontinuation of short-term family planning methods and unintended pregnancy, as it is challenging for women to reach health posts. This is one of the

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[56] External ASRH Respondent, Tanzania, Pilot Phase.

[57] Service Provider, Nigeria, PAR case study (2018): https://www.itad.com/wp-content/uploads/2019/01/A360_PAR-case-study_Nigeria_Dec-18.pdf

[58] Service Provider, Nigeria, PAR case study (2018).

[59] President John Magufuli, Tanzania, 9th September 2018. Quote taken from *Tanzania's John Magufuli advises against birth control:* https://www.aljazeera.com/news/2018/09/tanzania-john-magufuli-advises-birth-control-180910193120646.html

main reasons the Ethiopian Ministry of Health is promoting long-acting reversable contraception. This emphasis may be skewing choice, and was not initially accompanied by ensuring Health Extension Workers had the skills to remove methods – although this is now being rectified.

All of these factors may contribute to service providers not providing active counseling on all available methods, which has implications for girls' informed choice. This may have attributed to the high numbers of condoms provided by A360 in Nigeria, as well as emphasis on implants in Ethiopia, given the government's 'push' on LARC.

The A360 solutions are operating in the context whereby shifting service providers' attitudes towards providing adolescent girls with contraception is only part of the challenge. A360 is actively seeking ways to overcome some of the challenges service providers face in their desire to serve adolescent girls.

Findings: Context

Summary of findings

Contextual enablers and challenges

While engaging the **MOH** from the start of the program has enhanced buy-in, full ownership is still limited. In Nigeria and Tanzania, A360 is also faced with the challenges of unclear MOH policies around adolescents accessing modern contraception, linked to age of consent. This is felt acutely in Nigeria as a barrier to uptake of LARCs.

Working in the **public health system** presents both challenges and opportunities for A360. While it is linked to having the best potential for sustainability, the health systems in all three contexts are challenging and face human resources or health challenges, stock-outs and a weak infrastructure.

The solutions are being implemented in **communities** in which myths and misconceptions and stigma are associated with family planning and the adolescent girls who use it. 'Flying under the radar' has the potential to leave service providers, mobilizers and adolescent girls exposed to community backlash, despite some pragmatism regarding the advantages of contraception.

Adolescent girls' perceptions towards contraception stems from the community around them, mired in stigma and misinformation, fueled by communal myths and misconceptions. With the solution focused on interpersonal communication primarily, there is little being done to address community level knowledge and acceptance of contraception.

Consortium factors that have enabled or inhibited success:

- Bringing together a diverse group of partners and developing a **productive consortium dynamic** took time but by the Ideation phase, there was a clear sense that partners understood each other and were working together as a team to move A360 forward.

- The A360 approach takes **significant management resources** and **intense communication** to implement.

- Gaps in key roles, notably at **Project Director** level and in **M&E,** were keenly felt until they were filled.

- In country, implementing teams navigated **organizational norms** and processes, buoyed by senior management support and onboarding those working in support functions.

- A360 is very demanding, with a high workload, and the potential for **staff burnout** is a concern.

- The **Foundations** were seen as supportive partners, but as the design phase reached Pilot, there was a sense of pressure to go to scale and reach targets, along with an increasing focus on driving down cost.

5 What have been the main enablers and challenges for A360?

This section discusses the factors that have been important enablers for A360, and the factors that have created challenges for the program. It represents a synthesis of key points and reflection on emerging trends and issues, identified over the course of the design period and into early implementation. Section 5.1.1 discusses enablers and challenges that affect adolescent contraceptive use, and Section 5.1.2 discusses enablers and challenges associated with the A360 Consortium and working in partnership.

5.1 What enablers and challenges affect A360's ability to influence adolescent contraceptive use?

Enablers and barriers that affect the uptake of modern contraception by adolescents have been discussed throughout the findings above. This section synthesizes them around four main categories: MOHs, public health systems, communities and individuals. These factors do not operate in isolation, but rather, are interconnected aspects of complex contexts.

Enabler	Challenge
MOH: In all three countries, A360 engaged with the MOH very early in the process, focused initially at national level. While this has yet to translate to full ownership of the solutions, it is considered a key enabler for A360 to date.	**MOH**: Ambiguity in adolescent contraceptive policies and their interpretation has emerged as an impediment to A360 and adolescent contraceptive service delivery. This is most acute in Nigeria, where girls under 18 cannot accept a LARC without parental permission. The A360 team and partners are actively advocating for a change in unclear policies relating to modern contraception for adolescent girls.
The public health system: In all contexts, the solutions utilize the public health system to some extent, leveraging resources invested by the MOH and other partners in those facilities (e.g. commodities). This also builds the capacity of public sector service providers and increases the potential for sustainability of the solutions.	**The public health system:** Across all contexts, there are challenges with the reliability and functionality of the health system. In Ethiopia, A360 is working with HEWs, who are already overburdened with the health package they deliver. To address this, PSI Ethiopia have adapted Smart Start to make it shorter and more accessible for HEWs to implement. Individual and systemic biases are also prevalent within the public health system,[60] which A360 has tried to mediate.
Community: Given the grave consequences of pregnancy out of marriage, there is some sense of pragmatism that A360 has been able to tap, which has facilitated community entry and (some) acceptance of the program and its focus on adolescent contraception.	**Community:** In all contexts there are negative connotations associated with the use of contraception. This creates a risk of community backlash against adolescent girls, service providers and mobilizers involved in A360. To circumvent this, a 'flying under the radar' strategy has been adopted in some cases, discussed in Section 4. However, this means that girls and providers are left to contend with social risks. While some effort has been made to engage community members, through mothers' sessions for example, these are labor intensive (and may not be scalable). Conversely, adolescent pregnancy is not viewed as a 'problem' for married adolescents in rural Ethiopia and northern Nigeria, where early marriage is practiced, and there is pressure to prove their fertility before considering family planning. Given the social consequences, adolescent contraception may be accepted in secret, and targeting husbands or households may expose adolescent girls already taking a method in secret.
	Individual: Adolescent girls' perceptions toward contraception tend to be mired in stigma and misinformation, fueled by community myths and misconceptions. As A360 touch points are at an individual level through activities mainly targeting adolescent girls and providers, this does little to address wider influencers.

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[60] To note, the evaluation team does not have data to compare with service providers' bias in the private sector.
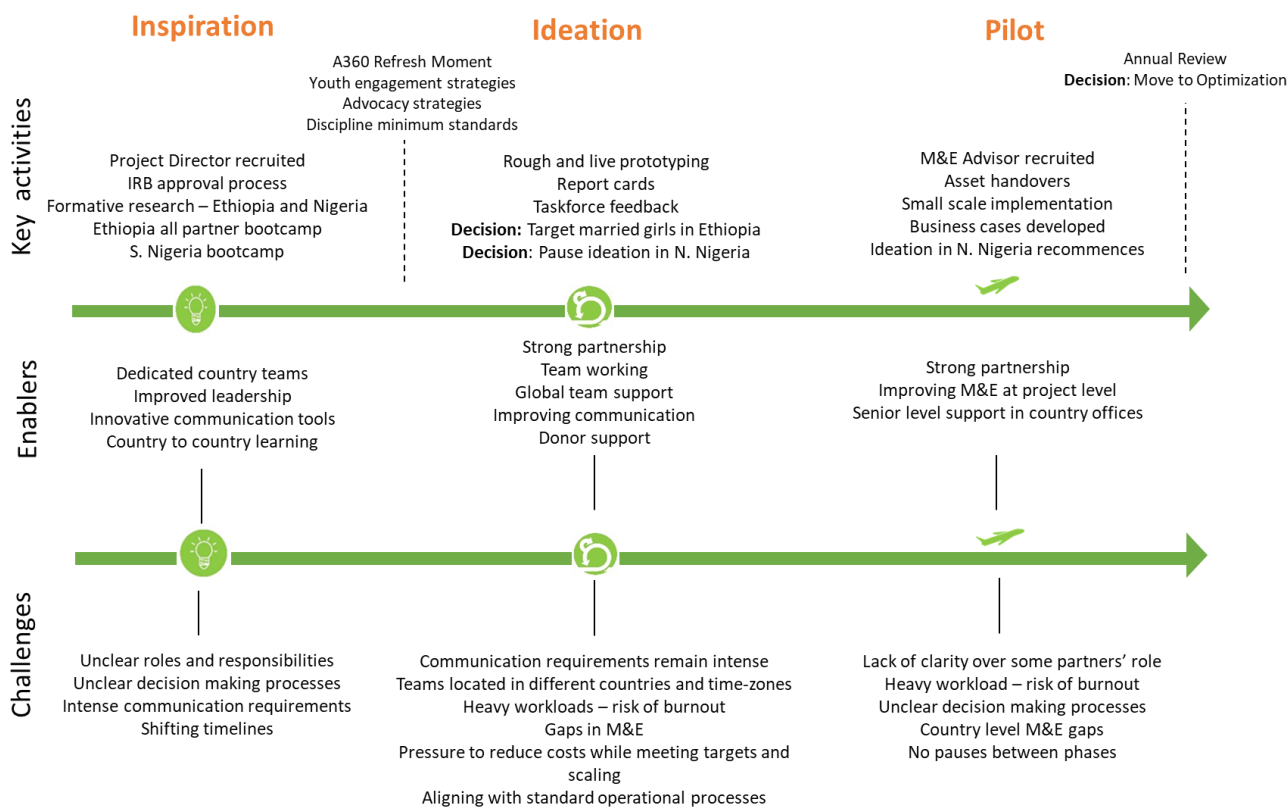
5.2 What organizational and consortium factors have enabled or inhibited success?

The A360 approach has been implemented by multiple partners (see Box 1 above), at different levels and at varying degrees of effort. The 'forming and norming' of the consortium took place across time and space, with, as seen in Figure 13, different enablers and challenges coming to the fore in the different phases of A360. However, some themes where consistent throughout the phases:

- **A strong sense of partnership between consortium members**: Team dynamics – particularly between the dedicated IDEO.org and country teams – took some time to establish, but once in place were considered as meaningful and productive. By the Pilot phase, this unique partnership was considered one of the aspects of A360 that sets it apart from other projects and approaches, with a sense that boundaries between organizations had been broken down.

- **Learning, forming and implementing a new approach to AYSRH design**: A360 is very different to business as usual for implementing teams. Without explicit capacity building time and resources, partners grappled with the need to understand the different disciplines and form the approach, while simultaneously implementing it. Important guidance documents, such as the youth engagement strategy and discipline minimum standards, were created as a need for them became apparent.

- **Significant management and communication are required to implement the A360 approach:** The composition of consortium members and implementation teams, located in different sites on two continents, required significant management oversight. This was challenging initially as there was a gap in leadership during the Inception phase, but it improved notably once a Project Director was in position. Various communication tools were employed such as Slack, SharePoint and Zoom, while bespoke tools and processes such as the report card and taskforce model were co-opted to mediate dialogue within the consortium and communicate with donors about solutions. Despite these tools, A360 carried a high burden of communication, particularly for country teams, who had to balance the need to be in frequent communication with PSI Washington and other consortium partners, with the need to be in the field implementing. This was often compounded by internet and time zone challenges.

- **Managing organizational norms**: At country level, the teams have navigated the standard operating procedures of their organizations. These tend to be procedurally grounded, which did not always meet the needs of an approach that is iterative and requires nimble processes; challenges were often associated with delays in procurement and recruitment. Primarily for communication needs, the A360 country teams also had to work odd hours and were concerned about the perceptions of this among their colleagues. With support from senior management at country level and onboarding of operations teams, these tensions appeared to ease as A360 matured.

- **M&E was a consistent gap**: Concerns regarding the quality of the consortium's own M&E outputs were consistent in both Ideation and Pilot. Aside from operational challenges of making decisions without 'perfect data', the lack of evidence led to some implementers being reluctant to promote the A360 approach to other stakeholders.

- **The potential for burnout:** There was an acute sense that staff working on A360, particularly at country level, were at risk of burnout. Country teams were small (most notably in Ethiopia and Nigeria), and faced intense periods of field work, demanding communication requirements and pressure to conduct MOH advocacy and activities to promote replication and adoptions. The A360 Consortium has had to balance the pressure of operationalizing complex solutions with the need to also maintain a focus on internal requirements to actively apply adaptive implementation guidelines to scale up.

- **The role of the Foundations**: The Foundations were recognized as being supportive throughout the A360 design phases, from facilitating meetings with other partners in Nigeria, to meeting the MOH in Ethiopia and bringing motivation to the teams through their visits. However, as the program entered

Pilot phase, donor expectations for country teams to meet targets and move to scale at the same time as driving down costs created additional pressure and in some cases anxiety for implementers.

Figure 13: Key consortium activities, enablers and challenges over the phases

Inspiration **Ideation** **Pilot**

Key activities

A360 Refresh Moment
Youth engagement strategies
Advocacy strategies
Discipline minimum standards

Annual Review
Decision: Move to Optimization

Project Director recruited
IRB approval process
Formative research – Ethiopia and Nigeria
Ethiopia all partner bootcamp
S. Nigeria bootcamp

Rough and live prototyping
Report cards
Taskforce feedback
Decision: Target married girls in Ethiopia
Decision: Pause ideation in N. Nigeria

M&E Advisor recruited
Asset handovers
Small scale implementation
Business cases developed
Ideation in N. Nigeria recommences

Enablers

Dedicated country teams
Improved leadership
Innovative communication tools
Country to country learning

Strong partnership
Team working
Global team support
Improving communication
Donor support

Strong partnership
Improving M&E at project level
Senior level support in country offices

Challenges

Unclear roles and responsibilities
Unclear decision making processes
Intense communication requirements
Shifting timelines

Communication requirements remain intense
Teams located in different countries and time-zones
Heavy workloads – risk of burnout
Gaps in M&E
Pressure to reduce costs while meeting targets and scaling
Aligning with standard operational processes

Lack of clarity over some partners' role
Heavy workload – risk of burnout
Unclear decision making processes
Country level M&E gaps
No pauses between phases

Critical Success factor: The organization and people behind the approach

Since the beginning of the program, the team working on A360 have put themselves at risk of burnout through an extremely demanding process and high workload. This has been met with a passion to generate innovative solutions to reach adolescent girls with modern contraception. The commitment and motivation of the individuals working on this program, has, undoubtedly, been a key force driving A360 forward. Particularly in Tanzania, PSI's existing network of outreach teams and relationships with health providers has also been critical in enabling A360 to take solutions to scale.

Looking Forward

6   Conclusions

A360 has ambitions to transform ASRYH programming. To achieve this, the program embarked on a complex design process that brought together six disciplines, a large consortium, multiple country-level partners and an external evaluation team. This involved significant financial investment and a novel approach to intervention design, grounded in HCD and led by non-traditional partners, all undertaken at a fast and demanding pace.

Two years into the program, A360 has developed four solutions to increase uptake of modern contraception among girls aged 15 to 19 in four settings: rural Ethiopia, Northern and Southern Nigeria, and Tanzania. While it is too early to determine the effectiveness of the solutions and therefore A360 as a whole, the value of the A360 approach is starting to emerge. At the same time, the program has faced a number of challenges and trade-offs that the consortium continues to navigate.

Design

A360 has succeeded at 'putting the adolescent girl at the center.' However, other users were not designed for, and aspects of addressing gender and social norms have been sidelined. Grounded in HCD, putting the desires of adolescent girls at the center of the design process and decision making is considered a valuable contribution of the A360 approach. However, initially, A360 did not design for solution implementers, who are fundamental to the success of the program. In Ethiopia and Nigeria, additional work was undertaken in the Optimization phase to develop a more in-depth understanding of service providers' perspectives. There is also some concern that by encouraging a focus on the individual (girls' needs and desires), HCD may draw attention away from broader, more abstract drivers such as gender and social norms. Although gender empowerment is not an explicit objective of A360, some of the solutions are reinforcing traditional gender norms, for example through emphasizing the role of husbands as primary decision makers around family planning. Although these norms have been leveraged to engage male partners and facilitate adolescent contraceptive access, this is still an area of concern.

Youth engagement is hailed by A360 as one of the successes of the approach. However, there are some questions about how meaningful it has been in all cases. In all three countries, young people have been actively engaged in data collection, analysis, prototyping, M&E, recruitment and implementation. The inclusion of young people has reportedly added real value throughout the design process and shifted the mindset of the designers and implementers. However, as A360 has moved away from design and towards implementation, it has proved challenging to ensure young people continue to be involved in a meaningful way. It is also difficult to measure what impact youth engagement has had on the solutions themselves, or on the capacity, agency and opportunity of the young people involved, as this has not been systematically monitored by A360.

A360 has created a cadre of implementers with the capacity to work in a new way. Through exposure to HCD and youth engagement, A360 has impacted the teams designing the solutions by increasing their empathy towards young people and their capacity to design projects with users at the center. Although an unintended consequence of A360, this is already paying dividends as these teams contribute to other projects within their organizations.

Solutions

A360 has increased adolescent girls' access to contraception by connecting contraception to aspirations and in some cases enabling them to 'fly under the radar' to access services – however this may bypass rather than addresses community myths, misconceptions and stigma. A360 has employed aspirational messaging to link contraception to broader dreams and ambitions – such as financial security through child spacing in Ethiopia and Northern Nigeria, and 'achieving dreams' through delaying pregnancy in Tanzania and Southern Nigeria. HCD has played a key role in helping identify and hone these elements, which represent a successful outcome of the design process. Particularly with unmarried girls, the solutions also employ approaches that allow girls to access modern contraception 'under the radar,' thus helping them circumnavigate entrenched community stigma. This has been achieved through opt-out counselling moments, framing activities using aspirational brands which avoid direct reference to contraception, and using 'hooks' such as entrepreneurship or vocational skills classes to encourage attendance at events. However, while the evidence suggests that 'flying under the radar' does work to increase uptake of contraception in the short term, this may be at the cost of actually addressing (not just evading) harmful community myths, misconceptions and stigma around contraception for girls.

A focus on adoption, conversion and cost effectiveness as benchmarks for success has reduced incentives to implement aspects of the solutions designed to address gender and social norms challenges. A360 aims to reach just under 250,000 girls with modern contraception – an ambitious target. In the Optimization phase, this saw a focus on identifying the most cost-effective way to implement the solutions and improve adoption and conversion rates at scale. However, this created a disincentive to invest in activities that did not directly translate into higher adoption numbers, but which may be important for sustainability and sustained use. Some such activities (for example parents' clinics and girls' clubs) were dropped from the solutions, as country teams focused on honing elements that make an immediate difference to contraceptive uptake.

A360 is beginning to shift service providers' attitudes towards serving adolescent girls. It is not yet clear if this due to solution specific training, exposure to adolescent girls through implementing the solutions, or a combination of both. However, important provider biases towards specific methods remain, and some providers are unable to offer the full suite of methods due to a lack of method-specific training.

A360 has been actively promoting its approach and solutions to encourage others to adopt or replicate them. However, this may have been premature. Outcome indicators on replication and adoption have created pressure to communicate the successes of both the A360 approach and the solutions from early on in the program, before clear evidence was available on their effectiveness. While this has encouraged open communication about learning and innovation – a welcome development in the competitive environment of SRH programming – there is a risk of declaring success too early, before solutions have been rigorously tested. Such a strong focus on adoption and replication from the outset also consumed substantial financial and human resources during critical implementation periods.

A360 has actively pursued new partnerships for implementation, but these have proved difficult to secure. A360 has struggled to identify and solidify partnerships to scale up the A360 solutions. This appears attributable to the competitive environment of SRH, the intense resourcing required to pursue partnerships, and the expectation that the partner will secure or have access to resources for implementation. Recent progress in both Ethiopia and Tanzania suggests that a fully formed solution may be easier to 'sell' than a solution that is still being developed, and that senior management support is an

important aspect of securing commitment to partnerships. Each of the Foundations has tried to facilitate partnerships between A360 and its other grantees, but to little avail to date, potentially suggesting the need for appropriate contractual incentives.

Intense and sustained pressure to deliver an innovative program with new teams to a complex and changing specification has sometimes been counter-productive. Pressures to go to scale with new services, while also meeting ambitious targets, pursuing new partnerships, and promoting adoption and replication, has placed huge pressure on the A360 Consortium. As A360 moved towards the end of the design phase, this pressure intensified. Strong incentives to rapidly scale up the solutions has posed risks to fidelity and quality of implementation and care. While the Foundations and PSI actively negotiated targets and implementation geographies, other activities, such as replication and promotion activities, have not been deprioritized to enable country teams to focus on implementation and scaling.

Context

7 Recommendations

Recommendations are presented for A360 as it progresses to scale, and for future implementing organizations or donors interested in adopting the A360 approach or aspects of it. See Annex 4 for phase-specific implications generated by the evaluation during the design phase.

7.1 How might A360 need to adapt as it progresses to scale?

- **Revisit the Theory of Change and use it as a tool for decision making:** Cost, adoption and conversion metrics only tell part of A360's story. Grounding decisions on these factors alone skews attention from key drivers of change, such as sustained use and gender and social norms. Country-specific 'nested' theories of change linked to empirical evidence could be developed to map particular planned changes (such as national ownership), and used as tools to guide progress to longer term outcomes over time.

- **Ensure a focus on meeting targets does not detract from building enabling environments, quality programming and promoting sustained contraceptive use:** Linked to the first recommendation, while A360 is under pressure to meet targets, it is important to ensure that due diligence is paid to key aspects of programming. This includes attention to the training needs of service providers and adequate community engagement. This could be aided by revisiting aspects of the design that have been dropped due to implementation and cost challenges.

- **Focus on producing the right evidence at the right time:** A360 is considered a flagship of AYSRH programming and is contributing to the evidence base on what works to reach adolescent girls. However, it is important that A360 balances the desire to promote the A360 approach and solutions as proven best practice, with the due rigor required for evidence-based implementation and scale up. This may require reviewing the A360 ToC and addressing the hierarchy of program outcomes so increasing mCPR is the ultimate area of focus, with replication and adoption outcomes taking a less prominent role in the immediate future.

- **Increase understanding around key aspects of the solutions and approach:** A360 continues to offer learning opportunities for adaptive management as well as the wider AYSRH community. Deepening and sharing the evidence behind aspects of the approach and solutions will be a significant contribution to AYSRH. For example, to understand how A360 is shifting service providers' attitudes towards serving adolescent girls, a time-series Knowledge, Attitude, Practices (KAP) study could follow a cohort of new service providers recruited during scale. A measurement framework for meaningful youth engagement, using existing tools and guidance, could also generate valuable evidence on the value of engaging youth in an AYSRH program.

7.2   Recommendations for future programs

A360 has generated significant learning for other implementing organizations and donors of AYSRH approaches and solutions. Here, we present some recommendations and suggestions for consideration in future programs:

Implementing organizations should:

- **Use the inception phase to 'storm and norm':** In a complex program like A360, the inception phase is a key time for establishing relationships between partners, understanding each other's technical speak and delineating timelines, decision making processes and roles and responsibilities.

- **Design for national ownership and shared delivery from the onset and maintain that focus:** Ensure that stakeholder engagement is part of the accountability framework for the program, with clear key performance indicators and incentives. This aspect of the program should be clearly mapped out in the ToC, and follow a program theory based on evidence, including consideration of the mechanisms or change processes which can lead to the use of evidence for policy change in government.[61]

- **Carefully consider and monitor fidelity and quality during the Scale phase**: Rapid scale up of a solution may result in a loss of fidelity to the design, or quality challenges. A360's adaptive implementation approach has helped provide ongoing feedback to implementation teams during the scale-up phase.

- **Consider the potential of aspirational messaging.** Tapping into adolescent girls' and couples' aspirations has resonated in the four A360 implementation contexts, for both married and unmarried adolescents. There is also evidence that a similar aspirational approach is also working in Kenyan and Zambian contexts.[62]

Donors should:

- **Balance the need for flexibility with an understanding of what success will look like from the outset**: Setting targets and implementation geographies in the absence of a defined solution may create unnecessary tensions. Putting in place agreed parameters around the design challenge, rather than strict targets, may serve to keep the design team headed in the direction of success, without overly restricting the solutions through pressure to deliver specific targets. As the solutions solidify, clearer targets and indicators can be put in place.

- **Partner according to areas of strength:** Donors play an important role in helping to identify and connect partners with complementary implementation strengths (e.g. community sensitization and family planning services) and incentivizing them to work together, potentially through an appropriate contract model with joint milestones.

- **Prioritize implementation over promotion of adoption and replication:** Give the program time and space to implement the approach and resulting solutions without the pressure of promoting adoption and replication in parallel. This will allow the program to build up a sufficient evidence base from which to communicate successes and learning, and allow the implementers to focus on implementation during the intense design period.

- **Balance demands for short term results and cost effectiveness with a focus on quality, continuation, and consideration of social and gender norms.** Ensuring quality, programming for continuation, and influencing gender and social norms, will all drive up the cost per CYP and adopter. This should be anticipated when setting targets and allocating budgets.

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[61] https://www.itad.com/knowledge-and-resources/bcure/

[62] MSI, 2018, Future Fab: Dreaming big, taking action: https://www.mariestopes-us.org/wp-content/uploads/2018/04/MSI-Kenya-Youth-Fact-Sheet-online-042018-lo-1.pdf; Soul Beat Africa, 2018, Diva Centres and Divine Divas, http://www.comminit.com/africa/content/diva-centres-and-divine-divas

Next steps for the evaluation

Following this MTR:

- The PE will continue to deliver findings to support course correction and understand implementation in 2019 and 2020.

- The OE will draft endline protocols in 2019, through consultation with implementation teams and the Foundations. Endline data collection will take place at the end of the program, in early-mid 2020, with results available in 2021.

- The cost-effectiveness study will periodically collect cost data associated with the implementation of the interventions in 2019 and 2020.

The final evaluation report will be available in mid-2021.

In the interim, evaluation products will continue to be shared on the A360 evaluation page on the Itad website: https://itad.com/knowledge-and-resources/adolescents-360/

We want the resources invested in international development to have the greatest possible impact on people's lives. We provide the insight and ideas to ensure that they do.