



Adolescents 360 Evaluation Process Evaluation Methodology: Updated

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List of acronyms

A360	Adolescents 360
AYSRH	Adolescent and youth sexual and reproductive health
CES	Cost effectiveness study
CIFF	Children's Investment Fund Foundation
EQ	Evaluation question
FGD	Focus group discussion
FP	Family planning
HCD	Human-centered design
IDI	In-depth interview
MoH	Ministry of Health
OE	Outcome evaluation
PE	Process evaluation
PEER	Participatory Ethnographic Evaluation and Research
PSI	Population Services International
SES	Socioeconomic status
SFH	Society for Family Health
ToC	Theory of change

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1 Overview of A360

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. It aims to increase uptake of voluntary modern contraception among girls aged 15-19 years old.

A360 uses an approach that merges six disciplines: public health, Human Centred Design (HCD), adolescent developmental neuroscience, socio-cultural anthropology, youth engagement and marketing to yield country-specific AYSRH interventions (‘solutions’). From development to implementation, A360 aims to engage adolescents as equal partners, with solutions 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 catalyse novel approaches to AYSRH that can be replicated by partners around the world. A360 is being implemented in six phases (see Figure 1).¹

Figure 1 A360 timeline



1.1. The A360 solutions²



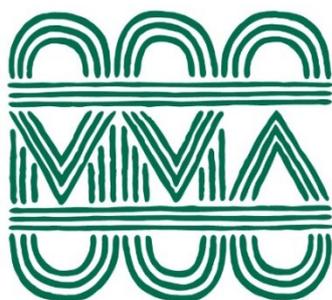
In Ethiopia, Smart Start uses financial planning as an entry point to discuss contraception with newly married couples. It leverages the nationwide Health Extension Worker (HEW) network, supported by a PSI-recruited Smart Start team, and existing community structures such as the Women’s Development Army. 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.



In Nigeria, 9ja Girls provides branded safe spaces in public health clinics for girls. Walk-in 1-1 counselling 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.

¹ The phases are fully described in the A360 Mid Term Review, available [here](#).

² Read more about the solutions at: <https://www.a360learninghub.org>



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 counselling. 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 counselling with a provider and a vocational skills class. MMA also works with religious leaders and communities, to emphasize the benefits of child spacing.



In Tanzania, Kuwa Mjanja delivers life and entrepreneurial skills training alongside opt-out, youth-friendly contraceptive counselling 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.

2 Overview of the A360 evaluation

Itad is working in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM) and Avenir Health to independently evaluate and distil lessons from the A360 program. The evaluation of A360 includes an outcome evaluation led by LSHTM, a process evaluation (PE) led by Itad and a cost effectiveness study led by Avenir Health (see Figure 2).

At the heart of each evaluation component is a cross-cutting engagement and research uptake strategy, outlining how the learning will be shared with internal and external stakeholders. The evaluation components are designed to be mutually reinforcing and complementary, with a view to being able to provide a comprehensive snapshot of the impact of A360.³

Figure 1: A360 Evaluation Design



3 Process Evaluation approach

The primary objective of the Process Evaluation (PE) is to present a descriptive and analytical account of how the implementation of A360 has played out, with the aim of improving understanding of how and why A360 is making a difference, in order to generate lessons for future policy and practice.

The specific PE objectives are to:

1. Provide analysis and learning to support adaptive management and course correction.

³ Read more about the overall evaluation here: <http://www.itad.com/knowledge-and-resources/adolescents-360/>

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.

The PE utilizes a theory-based approach, whereby the evaluation design and application are explicitly guided by theory about how A360 leads to change. At the heart of the evaluation is the ToC for A360 (Figure 2). In particular, the PE focusses on understanding the intermediate outcomes from the ToC which are referred to as the ‘pathway to behavior change’ (Figure 3). By exploring how and why A360 is (and is not) achieving these outcomes, the PE aims to provide evidence that can explain outcome evaluation findings.

Figure 2: A360 theory of change

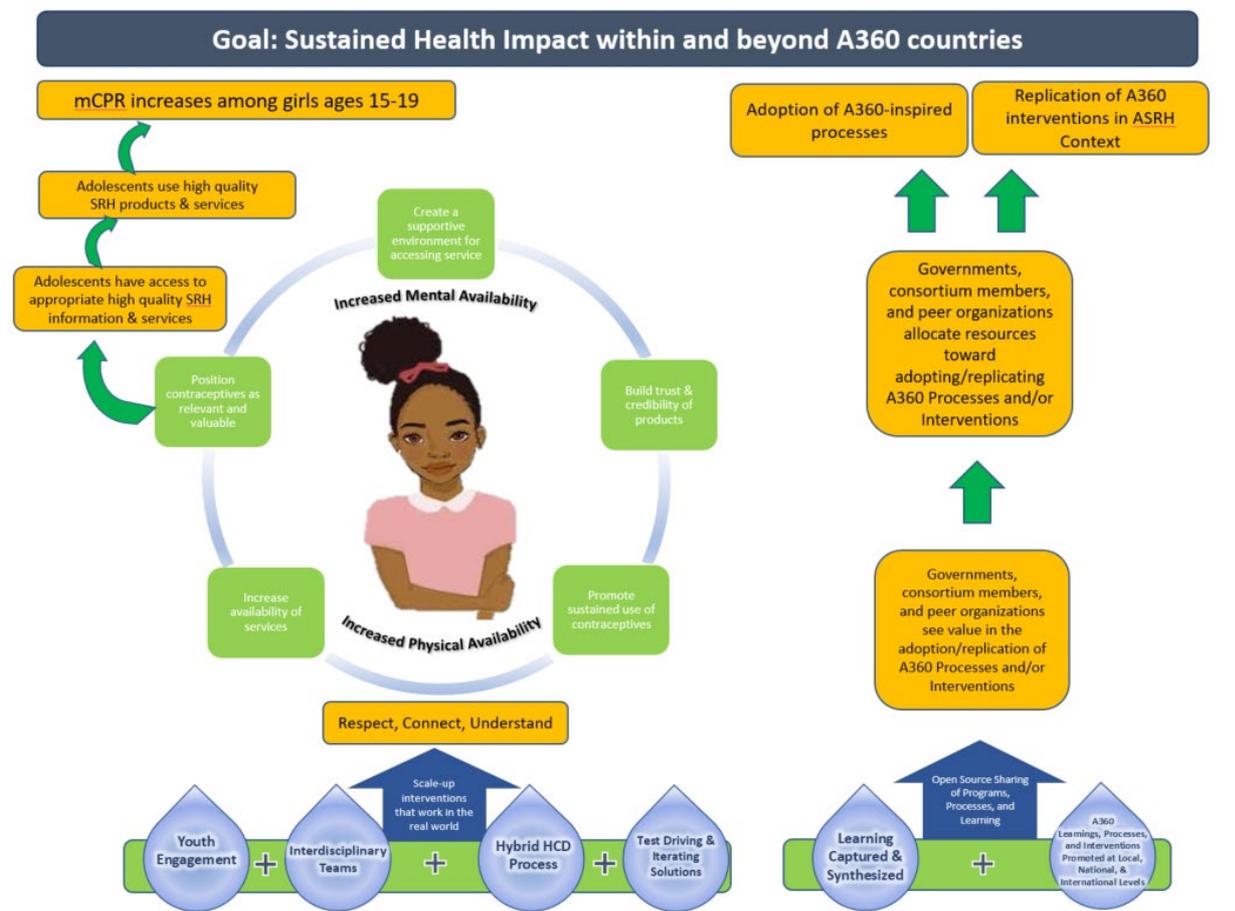
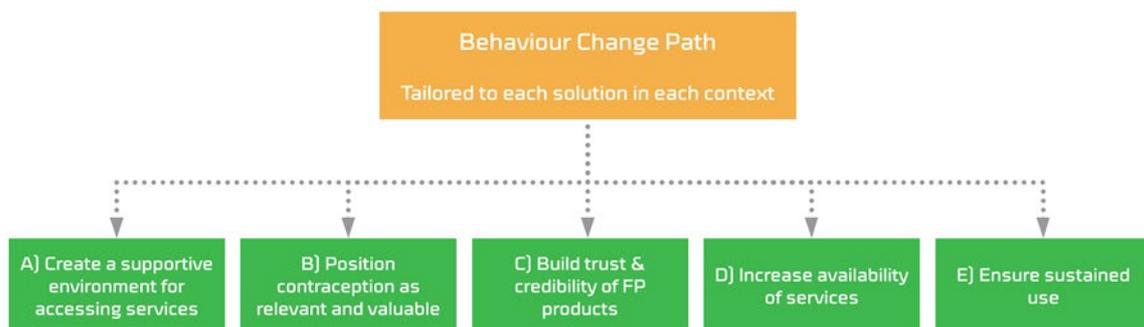


Figure 3: A360 behavior change path



3.1 Evaluation questions

Table 1 lists the evaluation questions for the PE (see Annex 1 for further detail and sub-questions). These were revised at the end of the Pilot phase, to reflect the shift from the design phase of A360 to the implementation phase. The revised questions incorporated a greater focus on understanding the implementation of A360 solutions, in line with the pathway to behavior change.

- **Process** questions explore the A360 approach and how this plays out in practice during implementation.
- **Context questions** consider the contexts in which A360 operates, including the enablers and barriers to implementation.
- **Solutions and experience questions** look specifically at the interventions, considering how they have been operationalized and the experiences and perceptions of girls, community members and other stakeholders (such as government).

Table 1: PE evaluation questions

1. Process	2. Context	3. Solutions & experience
<p>1.1. What makes the A360 process different to traditional ways of designing and implementing interventions?</p> <p>1.2 How has the A360 approach adapted over the course of the program and why?</p> <p>1.3 How has the design and implementation of A360 been managed and with what implications and effects?</p> <p>1.4. What is the evidence of the adoption of the A360 inspired approach to design programs in PSI, consortium members, governments and peer organizations?</p> <p>1.5. What is the evidence of replication of the A360 developed solutions by PSI, consortium members, governments and peer organizations?</p>	<p>2.1. How does the context in each country enable or inhibit the A360 approach and its implementation?</p>	<p>3.1. Do the A360 solutions create a supportive environment to access services for adolescent girls in the communities they are operating in?</p> <p>3.2. Do the A360 solution position modern contraception as relevant and valuable to adolescent girls?</p> <p>3.3. Do the A360 solutions build the trust and credibility of family planning products among adolescent girls?</p> <p>3.4. Do the A360 solutions increase availability of services to adolescent girls?</p> <p>3.5 Does the solution promote ongoing interaction between the adolescent girl and the service provider/health system?</p> <p>3.6. How have the solutions been operationalized at scale in each country?</p>

3.2 PE workstreams and timing

The PE is operationalised through three interconnected workstreams:

1. **'Full rounds'** involve fieldwork in each country designed to address the full set of evaluation questions in Table 1. Full rounds are conducted at Inspiration, Ideation, Pilot and Scale phases of A360 with two 'full rounds' scheduled during the Scale phase.⁴
2. **'Global rounds'** are also conducted at Inspiration, Ideation, Pilot and Scale phases. They involve data collection at a 'global' level – encompassing interviews with PSI Global staff, A360 donors, consortium members based in the US, and external stakeholders within the SRH and HCD communities.

⁴ When the PE was designed, there were no plans for a stand-alone Optimization phase – this was added later to provide an opportunity for projects to identify the most cost-effective ways to deliver solutions at scale. The PE therefore did not conduct a full round in each country during this phase, but did collect data in all three countries through either a full round or a PAR.

- 3. Participatory Action Research (PAR)** was introduced in 2018, in order to provide a mechanism to answer implementers' 'burning questions' in a rapid way. PAR exercises are conducted on an ad-hoc basis, in line with the needs of the implementing teams. Research questions are co-developed with A360 programme staff, with rapid, light touch data collection and analysis conducted independently by the evaluation team. Participatory sounding workshops provide a space to discuss findings with implementers and co-create implications for the programme.⁵

Figure 2. Timing of PE data collection (tentative from Q3 2019 onwards)

	2016 <i>Inspiration</i>				2017 <i>Ideation and Pilot</i>				2018 <i>Optimization</i>				2019 <i>Scale</i>				2020 <i>Scale</i>			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Global				Yellow		Yellow		Yellow						Yellow				Yellow		
Tanzania			Green	Green		Green		Green		Green					Orange			Green		
Nigeria				Green		Green		Green		Green				Green				Green		
Ethiopia				Green		Green		Green		Orange				Green	Orange			Green		

Key	
Yellow	Global round
Green	Full round
Orange	PAR

3.3 Adjustments to the PE approach and methods at scale phase

In early 2019, the PE team undertook a review of the PE approach in order to identify areas for improvement as the evaluation enters its final stage. This gave rise to the following suggestions:

- 1. Draw more explicitly on well-established process evaluation frameworks.** A decision was made to draw on the UK Medical Research Council (MRC) framework for process evaluation, described further in Section 3.4 below. It was felt this would help to more systematically investigate the country-level solutions and answer EQ 3.6: *How have the solutions been operationalized at scale in each country?*
- 2. Unpack country-level solutions in more depth.** During the early stages of the A360 evaluation, the PE focused on exploring and understanding the A360 approach and how this was playing out. As the intervention progresses into its scale up phase and the solutions become more defined, there is a need for the PE to unpack each country-level solution in more detail and the theory behind it. This will help investigate where solutions are or are not working, how and why. It will also help to document adaptations to the solutions more systematically, to ensure the PE can accurately reflect the journey of each of the solutions and the reasons behind adaptations. User journeys are described in more detail in Section 3.5.
- 3. Adjust data collection methods and tools in order to best capture insights from adolescent girls.** The PE has used focus groups and participatory ethnographic research to capture evidence of girls' experiences of A360. However, there have been challenges in applying these methods, discussed further in Section 4. New and revised methods have been suggested to ensure the data collected is as rich and insightful as possible, described further in Section 4.
- 4. Incorporate more systematic analysis of A360 monitoring data.** During the scale phase, it was decided to more systematically review and incorporate A360 monitoring data into the PE, to ensure we are drawing on all available data in our analysis, and triangulating qualitative and quantitative data

⁵ See [here](#) for the 2018 Ethiopia case study, and [here](#) for the 2018 Nigeria case study.

sources. This has not been possible in earlier phases as A360 M&E systems were nascent and routine data systems not yet fully established. This is discussed further in Section 5 below.

3.4 Drawing on the MRC guidance for process evaluation

The MRC guidance for process evaluation (Moore *et al.*, 2013) categorize three key aspects of a process evaluation, which are all highly interrelated (Figure 4):

- *“Implementation: the structures, resources and processes through which delivery is achieved, and the quantity and quality of what is delivered;*
- *Mechanisms of impact: how intervention activities, and participants’ interactions with them, trigger change;*
- *Context: how external factors influence the delivery and functioning of interventions.”*

The MRC guidance suggests that a PE should provide a clear description of an intervention and its causal assumptions, and flowing from this, unpack how implementation has unfolded, what the key mechanisms of impact are, and how contextual factors shaped the intervention, how it unfolded, and how participants responded to the intervention to generate outcomes. Together this will help to explain the results demonstrated through the outcome evaluation – why have these results occurred? The MRC approach is influenced by concepts from realist evaluation (Pawson and Tilley, 1997), a theory based approach which *“places change mechanisms at the heart of evaluation...[and] emphasizes the contextually contingent nature of these mechanisms”* (Moore *et al.*, 2013).

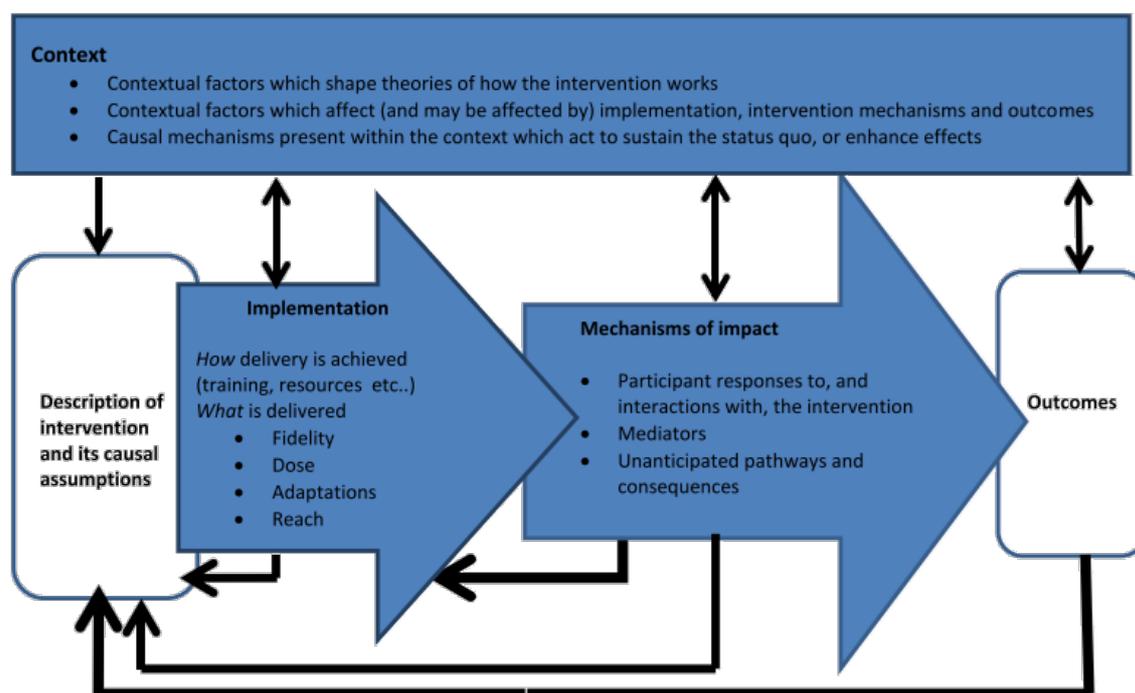
A complicating factor in the A360 PE is that it must look at the three dimensions on two levels:

1. The A360 approach (i.e. the transdisciplinary approach to developing AYSRH interventions, through HCD and the other A360 disciplines).
2. The solutions (country level interventions).

During the design phase the PE initially focused on understanding the A360 approach, with a growing emphasis on the solutions as they were prototyped and piloted. As the solutions move to scale, the PE needs to shift to a more detailed investigation of each solution in its content, and how it is being implemented.

A second complication is that the A360 solutions have constantly evolved throughout the HCD process, and continue to evolve through an adaptive implementation process being followed in each country. This presents challenges in differentiating between what was intended in each country, and what is actually being implemented.

In response to these challenges, we will employ **‘user journeys’** as a tool to explore implementation, mechanisms and context at the solution level.

Figure 4: Key functions of process evaluation, from Moore *et al.* (2013)

3.5 User journeys

A 'user journey' is a visual depiction of an A360 solution, from the perspective of a girl experiencing the intervention. We chose to develop user journeys rather than country level theories of change or logic models for several reasons:

- The implementing teams have not used ToCs to guide implementation, but have used user journey language and terminology in their strategy and design documentation. This approach therefore seemed likely to be more intuitive to programme teams, and able to build on existing program thinking.
- Each country level solution often incorporates more than one model (e.g. in-clinic and outreach). Each model has also evolved significantly over time, and continues to do so. User journeys provide a relatively simple way to visually depict what each model looked like at various moments in time over the course of the programme, allowing us to document adaptations quickly and easily, and helping to distinguish adaptations from unplanned 'drifts' away from implementation fidelity.
- The user journey approach builds on 'journey maps' from health research – a systematic approach to documenting service-user touchpoints with an intervention, capturing both the physical and emotional journey of the user, including behaviour, feelings, motivations and attitudes (McCarthy *et al.*, 2016).

We plan to use user journeys as a framework to structure data collection, in order to explore implementation, mechanisms and context at the solution level:

- Implementation:** The user journeys will provide a detailed description of each solution and the touchpoints between the solution and adolescent girls. This will be used to explore:

- **Fidelity and adaptation:** how far are solutions being implemented according to the ‘spirit’ of the solutions?⁶ What is being adapted and why? Are adaptations in line with PSI’s adaptive implementation framework and adaptation guidelines?⁷ What have the consequences of adaptations been?
- **Dose:** Number of touchpoints girls have with the solution, the proportion of participants accessing each touchpoint, and the extent to which solution components are being delivered in the planned numbers, districts and sites.
- **Reach:** how many girls are participating in A360 activities? Who is participating, from which groups, and how representative is this of the population of girls?
- **Mechanisms of impact:** The user journeys will help us investigate the causal assumptions within the solutions about how and why certain activities trigger change. Through them, we can map out how and why each element of the solution is expected to contribute to the outcomes in the behavior change path. Together with PSI, we will prioritize which mechanisms to investigate in detail in order to build understanding of how and why the solutions are (or are not) working.
- **Context:** The user journeys will help us drill in to how *specific* contextual factors affect *specific* aspects of the solution, helping mitigate the challenge we have faced throughout the PE of how to meaningfully integrate contextual analysis into our data collection and findings.

User journeys will be developed in draft form by the evaluation team through an initial document review, then discussed and finalised with global and country-level A360 teams through calls and workshops at the beginning of each data collection phase. Annex 2 presents the user journey for Smart Start in Ethiopia.

4 Study population and setting

Given the adaptive nature of A360, at the time of designing the PE the specific implementation geographies and target groups were not fully defined. The PE has had to be adaptive and adjust its study settings as the implementation geographies have evolved and changed over time. Table 2 presents the implementation geographies and study populations as of scale phase. PE primary data collection predominantly focusses on the Outcome Evaluation (OE) study settings, in order to complement the OE findings. However, data collection (particularly for PAR case studies) also takes place in other implementation sites, purposively selected in order to generate learning and insights for the program.

In Nigeria at Scale phase, we intend to conduct light-touch data collection at the Local Government Area level in the control sites for the outcome evaluation study, in order to capture data on contextual factors (e.g. policies and interventions) that may explain variance in outcomes between baseline and endline.

Table 2: A360 Implementation geographies and target groups

Country	Implementation geographies	Target groups	OE study settings (and main focus of PE primary data collection)
Ethiopia	Amhara, Oromia, Southern Nations, Nationalities and Peoples’ Region and Tigray	Married adolescent girls	Oromia
Nigeria (North)	Federal Capital Territory, Nasarawa and Kaduna	Married and unmarried adolescent girls	Nasarawa

⁶ Steckler and Linnan (2002) suggest that, when evaluating fidelity, evaluators should consider whether an intervention is being carried out in ‘the spirit in which it was intended.’ This is instructive in an adaptive program like A360, where it is not always possible to measure implementation against a pre-specified list of activities or plan.

⁷ These are internal PSI documents developed for each solution.

Nigeria (South)	Lagos, Osun, Ogun, Oyo, Edo, Delta and Akwa Ibom	Unmarried adolescent girls	Ogun
Tanzania	Kagera, Geita, Mwanza, Arusha, Tabora, Tanga, Dar es Salaam, Mbeya, Iringa and Morogoro	Married and unmarried adolescent girls	Mwanza

5 Data collection methods and tools

The PE primarily draws upon qualitative data collection methods and tools, in order to elicit perspectives and insights on experience, attitudes and behaviors – in line with the EQs in Table 1. Data collection is led by the core Itad PE team, in collaboration with national research teams comprising one junior and one senior researcher per country, who conduct data collection in local languages. In most cases, community-level research is conducted by a researcher of the same sex, unless this is not deemed necessary given the cultural context. Community access is facilitated by PSI and government staff, to ensure that field researchers have the necessary permissions and community support to operate in the selected study sites.

Semi-structured in-depth interviews

In-depth interviews (IDIs) are a key component of the PE methodology. During the design phase, through interviewing A360 Consortium members, these sought to understand the process of designing the interventions and the A360 approach, including the influence of the disciplines and how the consortium is working together. They also sought to understand what service providers and key stakeholders thought about A360 and the interventions being developed. At Optimization and Scale phase, there is a greater focus on understanding the effects of the interventions and how they are being implemented (what is working and why, where the challenges lie, etc.).

Members of the PE team employ semi-structured interview guides to guide discussion, structured around the user journeys and EQs. Guides are tailored for each solution and stakeholder group, subject to pre-testing and refinement, and designed to last between 40 minutes and 1 hour. Data is captured through tape recording and in note format by the PE team members and thereafter transcribed verbatim and (where relevant) translated into English.

Focus group discussions

Focus group discussions (FGDs) are conducted at community level with adolescent girls and community members who have been exposed to the interventions. These explore community perceptions of the A360 interventions.

We have also conducted a small number of FGDs with non-exposed community members, including adolescent boys, to explore knowledge and attitudes in relation to adolescent girls' uptake of modern contraception.

Two members of the PE team conduct FGDs, using prepared semi-structured discussion guides, subject to pre-testing and refinement as needed. FGDs take place in local languages and last no longer than 2 hours. At Scale Phase, visual aids have been used by researchers in focus groups with adolescent girls, depicting the solution brands and the different touchpoints, in order to aid discussion. FGDs are recorded and thereafter transcribed verbatim and translated into English.

Limitations and adjustments: Focus groups with girls, while providing useful insights into girls' experiences of the program, often have not provided the level of nuance or detail we would like to see. There are inherent challenges in using FGDs to discuss sensitive issues like contraception, among girls who may not be comfortable sharing their experiences in a group.

We will therefore conduct additional IDIs with adolescent girls at Scale phase, using simple versions of the user journey to explore their experience of the A360 intervention from mobilisation through counselling

to follow up. Where possible, girls will be identified with the help of PSI monitoring data, to aid triangulation between quantitative data and qualitative insights.

Participatory youth research

The PE is committed to using methods that meaningfully involve young people in data collection, synthesis and analysis. We have drawn on the principles of Participatory Ethnographic Evaluation and Research (PEER),⁸ which *'is based upon training members of the target group... to become peer researchers. The peer researchers are trained to carry out in-depth conversations interviews among their own peer group.'*⁹

Participatory ethnographic research was trialed in Ethiopia and Tanzania during Pilot and Optimization phases. Girls were trained as peer researchers and engaged in co-creating interview questions. Girls then interviewed their peers about the A360 intervention, such as their interaction with service providers.

Within this process, other participatory techniques are utilized, including:

- **Critical group reflection methodologies**, to promote dialogue over the findings between the peer researchers;
- **Role plays**, to enhance understanding of the interview questions and consent process, as well as unpacking some of the issues raised through data collection;
- **Visual story telling** through the form of drawings, to explore and validate the findings from the peer research.

Workshops are facilitated by researchers who speak the local language, and all data, research questions, activities, etc., are conducted in the local language.

Limitations and adjustments: Participatory ethnographic research has generated rich insights into girls' perspectives and experiences. However, the nature of girls' interactions with A360 in both Ethiopia and Tanzania (through potentially one-off outreach events or counselling sessions) has made participatory ethnographic approaches difficult to apply, as they rely on a good degree of exposure and saturation in target communities. At Scale phase, we will carefully consider whether a participatory ethnographic approach is suitable in each context. Where we feel it is not, we will trial lighter-touch participatory **sensemaking workshops** with girls who have taken part in IDIs and FGDs instead. These half-day workshops will involve sharing and discussing insights from interviews and focus groups with a subset of girls who participated in data collection. Girls will be encouraged to reflect on the emerging findings, helping the research team to deepen understanding of the issues being raised. The workshops will utilize participatory techniques including critical group reflection methodologies, role plays and/or visual story telling as detailed above.

Structured observations

Direct observation includes key events and process points for the A360 program, as well as the implementation of solution activities in different contexts. During the design phase, this included structured observations of A360 processes (e.g. design workshops), to capture and document the HCD process in action. At Scale phase, observations will focus on solution activities (e.g. counselling sessions and outreach events), using structured observation guides. Figure 4 shows some of the key activities observed by the PE.

⁸ PEER was developed by Options Consulting Ltd in collaboration with Swansea University.

⁹ The PEER Method: https://options.co.uk/sites/default/files/peer_process.pdf

Figure 4: A360 events and process points

Inspiration	Ideation	Pilot	Scale
Kick-off workshop •Formative research – data collection and synthesis	•Prototype iterations •Ideation synthesis •Asset handover	•Implementation of pilot interventions •A360 meetings (e.g. Annual Performance Review)	•Implementation of solution activities (e.g. counselling sessions) •A360 meetings (e.g. Annual Performance Review)

Exit interviews

At Scale phase, we will conduct short exit interviews with girls and other participants in solution activities, as part of our direct observation process. Exit interviews will be conducted with girls immediately after their engagement with an A360 activity, to allow us to understand girls' immediate feelings about and responses to the intervention.

Document review

Each phase of data collection involves a review of key implementation documents (including PSI reports to donors, strategy documents, and solution materials such as curricula and implementation guidelines). Secondary data sources relevant to adolescent and youth sexual and reproductive health (ASYRH) policy and programming, are also reviewed.

At Scale phase, we will also be analysing PSI country-level monitoring data in line with full rounds of data collection, in order to answer Solutions and Experience questions (EQs 3.1-3.6). This data includes detail on implementation sites, the number of girls who receive A360 counselling / attend events, and the number who adopt a method (and which method). This will give us a national-level overview of A360 performance, as well as detailed insights on performance in the sites selected for PE data collection. We will use this data to identify issues to explore in more depth through qualitative data collection (for example around site selection, uptake and method mix), and will triangulate these insights with qualitative data during the analysis phase.

Further work to map PSI's monitoring system is being undertaken in Q2 2019, in order to understand how we can further integrate the use of monitoring data into our evaluation strategy. This will be done in collaboration with PSI.

6 Sampling and recruitment

A purposive sampling approach is applied, in which study participants are selected based on their role on the A360 program or in implementation and/or because of their socio-cultural relevance to the adolescent girl (see Table 3). This is tailored to each country context and intervention.

Study participants are recruited primarily through working with program mobilizers and field staff to support the identification of service providers engaged in the interventions and adolescent girls and other community members who have been exposed to the interventions. Through mobilizers, PSI/SFH field staff and meetings with MoH representative, we have also mapped other key community influencers appropriate to the context, for example *kebele* (village) leaders in Ethiopia.

Table 3: Data collection and recruitment methods and estimates of sample size per study geography

Stakeholder type	Inclusion criteria	Recruitment method	Tool and approx. sample size, per country, per full round
Adolescent girls	<ul style="list-style-type: none"> Girls 15-19 who have been exposed to A360 Sample to include girls who have been counselled but who did not choose to adopt a method Individuals representative of a range of socioeconomic groups (including lower SES) 	<ul style="list-style-type: none"> Where possible, monitoring data will be used to identify a sample of girls through unique identifiers Where this is not possible, PE team will ask for referrals from PSI staff / solution implementers 	<ul style="list-style-type: none"> 3 FGDs Up to 30 peer conversations from 15 youth researchers 6 IDIs (from 2019) Exit interviews following observations of A360 activities (from 2019)
Adolescent boys / husbands of adolescent girls	<ul style="list-style-type: none"> Individuals 15–19 years of age (both married and unmarried) OR husbands of adolescent girls from communities with A360 activities Individuals representative of a range of socioeconomic groups (including lower SES) 	<ul style="list-style-type: none"> PE team ask for referrals from PSI staff / solution implementers PE team ask youth peer researchers to identify adolescents in their community PE identifies adolescents from observations (i.e. those visiting an A360-supported site, attending a community moment, etc.) 	<ul style="list-style-type: none"> 3 FGDs
Community influencers (e.g. community and religious leaders)	<ul style="list-style-type: none"> Influential community member (e.g. religious leaders, local chiefs and government officials, teachers, women’s leaders, representatives of community-based organizations, etc.) Aware of and/or engaged in A360 	<ul style="list-style-type: none"> Purposively select from stakeholder mapping (conducted by the PE with input from A360) 	<ul style="list-style-type: none"> 4 IDIs
Community members (e.g. parents, mothers’-in-law)	<ul style="list-style-type: none"> Individuals from communities with A360 activities Individuals representative of a range of socioeconomic groups (including lower SES) Where possible, individuals whose children / daughters-in-law have been exposed to A360 	<ul style="list-style-type: none"> PE team ask for referrals from PSI staff / solution implementers PE team ask for referrals from PSI local partners PE team ask youth peer researchers to identify individuals in their community PE team identifies individuals from observation (i.e. those attending an A360 community moment) 	<ul style="list-style-type: none"> 3 FGDs
Service providers	<ul style="list-style-type: none"> Provider engaged in implementing A360 solution (e.g. health workers) 	<ul style="list-style-type: none"> Purposively select from sampled ward / kebele 	<ul style="list-style-type: none"> 5 IDIs Up to 6 observations per round
Government	<ul style="list-style-type: none"> Government officials working with A360, at a national and sub-national level 	<ul style="list-style-type: none"> PE team ask for referrals from PSI staff / solution implementers 	<ul style="list-style-type: none"> 3 IDIs
A360 Consortium staff, CIFF, the Gates Foundation	<ul style="list-style-type: none"> Working with one of the A360 Consortium organizations or the foundations 	<ul style="list-style-type: none"> Purposively sampled based on role and involvement in this phase of A360 implementation 	<ul style="list-style-type: none"> 10-15 IDIs
External AYSRH stakeholders	<ul style="list-style-type: none"> Staff in organizations working on AYSRH programming who have had some exposure to A360 	<ul style="list-style-type: none"> PE team ask for referrals from PSI staff / donors 	<ul style="list-style-type: none"> 3-5 IDIs

7 Data analysis and reporting

Data analysis is conducted separately for each country and workstream. This involves a number of pre-tested steps, which have been refined as the PE has been implemented:

- IDIs and FGDs are digitally recorded (with the permission of the respondents), transcribed verbatim and translated into English.
- Transcripts from primary data collection are coded thematically using qualitative analysis software¹⁰ by a member of the core PE team engaged in data collection. Coding is primarily deductive, using a coding framework structured according to the EQs and user journeys. Additional inductive codes are generated as coding commences, for example to describe relevant contextual factors emerging from the data. At the start of each phase of analysis, the coding frame is piloted by two researchers, with results compared to ensure consistency in application.
- Secondary documentation is reviewed by the lead analyst, with summary notes compiled using Excel evidence matrices and/or in Word, structured according to the EQs. Quantitative monitoring data is also reviewed, and analyzed using pivot tables and descriptive summaries.
- Data sources are then synthesized thematically, through reviewing all insights relating to a particular EQ and area of the user journey to draw out themes. An analytical narrative is developed, providing detailed findings, references to data sources and a range of supportive quotations, in order to provide a sense of the weight of evidence underpinning the findings.
- The draft analytical narrative is then reviewed by the PE team lead and evaluation Team Leader before being shared with PSI / SFH.
- Sounding workshops were introduced in 2018 to facilitate deeper engagement of A360 staff with PE findings. The 1-day workshops bring together key staff with the PE team to review and discuss the draft findings, verify insights, and collaboratively identify implications for A360 and the wider sector.

The analytical narrative is then written up and presented to the A360 Consortium, the Gates Foundation and CIFF through:

- **Slide decks:** For each round of analysis, consolidated slide decks of findings are shared with the A360 Consortium, the Gates Foundation and CIFF. When there is opportunity, these are presented at relevant A360 meetings.
- **Webinars:** The PE team facilitates webinars to share and discuss findings with the A360 Consortium.
- **Reports and case studies:** The PE and cost effectiveness study teams produced joint reports for each of the design phases, bringing together PE finding and costings. The PAR findings are written up into externally-facing short case studies, and published on the Itad website. The PE findings up to Optimization phase were also synthesized in the A360 Mid Term Review.

Findings from the PE will be considered when developing the approach and survey tool for the endline Outcome Evaluation, in October 2019. Specifically, PE findings will help to refine the measurement of dose-exposure, ensure questions are asked about emerging outcomes noted in the PE that may not have been anticipated at the time the baseline OE surveys were designed, and ensure the endline surveys are specific about the types of A360 interventions adolescents may have been exposed to in each context.

8 Research ethics

The following steps are followed to ensure adherence to accepted international ethical good practice throughout the process evaluation:

¹⁰ The team initially used Dedoose, moving to MAXQDA at Scale phase as it was judged to have better functionality for the large quantities of data collected.

- **Submitting process evaluation study designs for approval by Institutional Review Boards (IRBs)** in Ethiopia, Nigeria and Tanzania. Revisions to the methodology described in this document (such as the addition of exit interviews with adolescent girls) have been submitted for IRB approval in 2019.
- **Ensuring independence of the data collection teams** from policymakers and program implementers so that they are free of any pressure to present findings in a good light.
- **Ensuring that potential conflicts of interest are disclosed and properly addressed** through mitigation plans. Individuals or organizations which are significantly conflicted are not permitted to work on this evaluation.
- **Respecting cultural differences** such as local norms, religious beliefs, gender, age, ethnicity, disability and other social differences when planning and undertaking this evaluation, including the need to avoid over-burdening particular groups.
- **Recognizing the risk that research participants may experience psychological discomfort** in being asked to discuss culturally sensitive topics, such as sexual activity or the use of contraception, and putting in place risk and mitigation measures accordingly. These include ensuring that participants feel free to abstain from answering questions which cause discomfort; orientating the PE team to signs of post-traumatic stress; and establishing a protocol to deal with distress and/or disclosures of violence, abuse or coercion.
- **Ensuring confidentiality of information and the privacy and anonymity of participants.** Field researchers are trained in study procedures and in research ethics to ensure they are sensitized to risks and respectful of privacy. All identifying information needed for recruit of study participants, whether adults or adolescents, is destroyed at the completion of data collection. Participants are not asked for their own personal views or behaviours during FGDs; instead, participants are asked about the general situation or attitudes in the community.
- **Ensuring verbal informed consent of all participants.** Signed consent documentation is collected by the field researcher and stored in a locked box. Consent forms will not be retained for longer than one year (365 days) from the completion of data collection.

9 Limitations

- **Limited generalisability of community-level findings:** Community level data collection is conducted in a limited number of sites (1-2 per round), meaning that insights relating to EQ 3 have limited generalizability across the solution as a whole. This challenge is mitigated to some extent by triangulating findings with a comprehensive document review of key solution documents, as well as national level monitoring data and interviews with national level stakeholders and program staff.
- **Quality of monitoring data:** While the PE draws on program monitoring data and triangulates it with primary data collection, it is not within the evaluation team's remit to conduct data verification or quality checks on this data.
- **Keeping abreast of a fast-paced process:** A360 is a fast-paced program, with solutions constantly adapting, and shifting targets and implementation geographies. This presents challenges for the PE in its attempt to document how implementation has played out, as many decision points fall between PE data collection phases and may go undocumented.
- **Measuring adoption and replication:** Through interviews with A360 staff, national level government officials and global AYSRH stakeholders, the PE is able to generate some insights on where A360 has been adopted and/or replicated, either globally or nationally. However, it is not within the scope of the PE to investigate this issue in depth, or verify claims of adoption and replication.

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Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. London: Sage.

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Annex 1. Detailed Evaluation Questions

1. Process	2. Context	3. Solutions & experience
<p>1.1. What makes the A360 process different to traditional ways of designing and implementing interventions?¹¹</p> <ul style="list-style-type: none"> • <i>What is the theory behind A360?</i> • <i>How is the theory playing out during implementation?</i> • <i>How have the public health, development neuroscience, youth-adult partnership, social marketing and sociocultural anthropological lenses influenced the implementation of A360?</i> • <i>To what extent have there been synergies or tensions between disciplines?</i> 	<p>2.1. How does the context in each country enable or inhibit the A360 approach and its implementation?</p> <ul style="list-style-type: none"> • <i>What are the contextual enablers and barriers to implementation?</i> • <i>What else is happening in the ecosystem that is influencing implementation?</i> 	<p>3.1. Do the A360 solutions create a supportive environment to access services for adolescent girls in the communities they are operating in?</p> <ul style="list-style-type: none"> • <i>How does exposure to the solutions affect the perceptions and opinions of co-habiting adults (mothers and/or husbands) of adolescent girls' use of modern contraception?</i> • <i>How does the implementation of the solution in a community impact wider community view/acceptance (e.g. community leaders) of adolescent girls' use of modern contraception?</i>
<p>1.2. How has the A360 approach adapted over the course of the program and why?</p> <ul style="list-style-type: none"> • <i>How have the role and approaches of different partners (including donors) evolved and why?</i> • <i>How has the approach adapted over time and why?</i> • <i>What has driven adaptations?</i> 		<p>3.2. Do the A360 solution position modern contraception as relevant and valuable to adolescent girls?</p> <ul style="list-style-type: none"> • <i>How does exposure to the solutions affect the perceptions and opinions of adolescent girls about modern contraception?</i>
<p>1.3. How has the design and implementation of A360 been managed and with what implications and effects?</p> <ul style="list-style-type: none"> • <i>What organizational and consortium factors have enabled or inhibited success?</i> • <i>What capacities and processes are needed to effectively introduce and implement a program such as A360?</i> • <i>Have there been any unintended consequences of the A360 approach during the design and implementation process?</i> 		<p>3.3. Do the A360 solutions build the trust and credibility of family planning products among adolescent girls?</p> <ul style="list-style-type: none"> • <i>Does exposure to the A360 solution dispel myths and misconceptions around modern contraceptive methods among adolescent girls?</i> • <i>How do adolescent girls perceive their interaction with service providers and other associated implementers of the solution?</i> • <i>To what extent do the solutions demonstrate alignment with quality standards such as privacy, confidentiality, rights/choice, safety?</i>

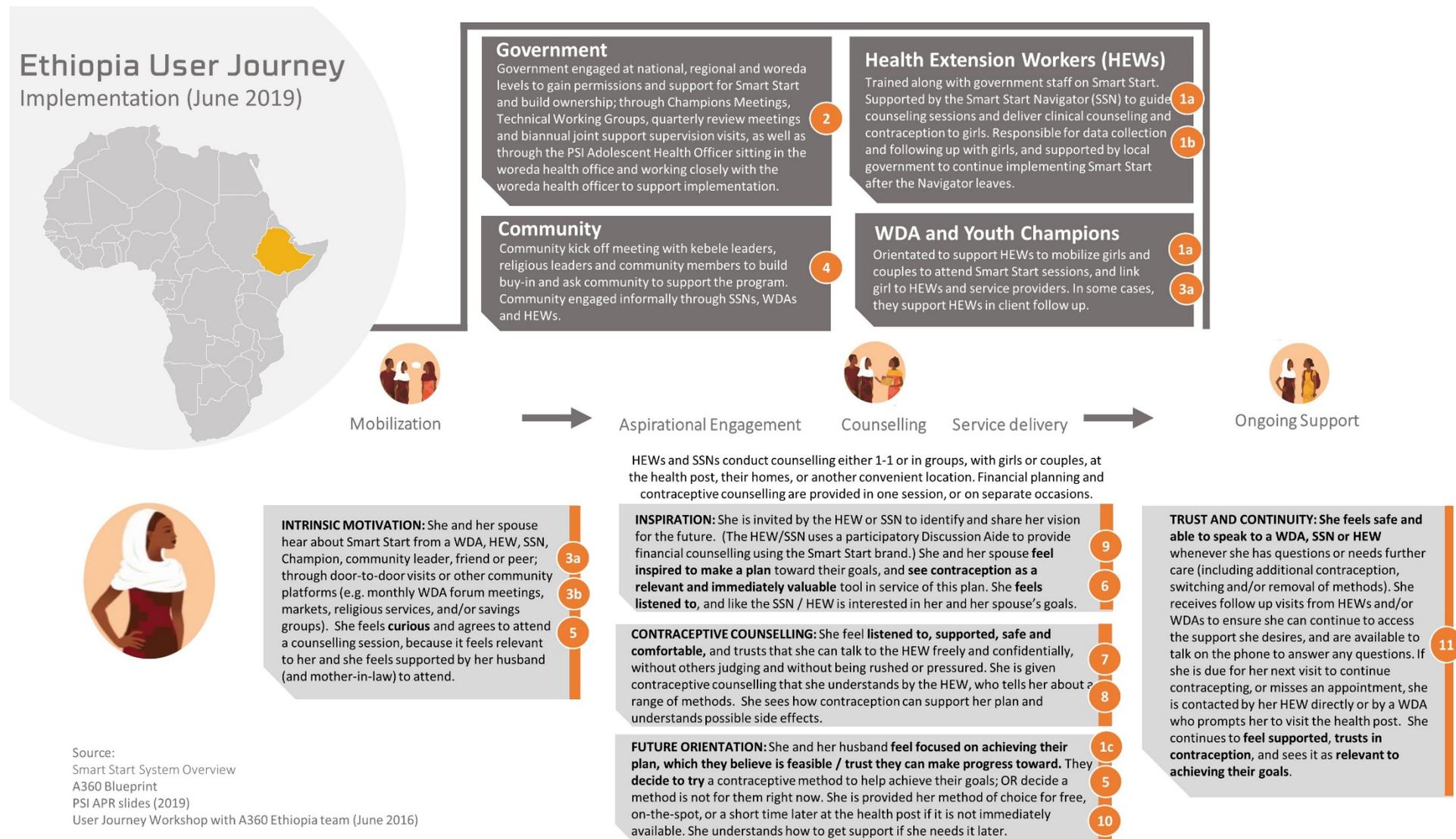
¹¹ "Traditional ways of designing and implementing interventions" is framed subjectively, based on respondents' experience.

<p>1.4. What is the evidence of the adoption of the A360 inspired approach to design programs in PSI, consortium members, governments and peer organizations?¹²</p> <ul style="list-style-type: none"> • <i>How has the A360 approach been adopted internally in PSI?</i> • <i>How does the A360 approach influence how the wider AYSRH community design programs aimed at adolescents?</i> 		<p>3.4. Do the A360 solutions increase availability of services to adolescent girls?</p> <ul style="list-style-type: none"> • <i>How does the solution address availability of services to adolescent girls? (e.g. sites, providers)</i> • <i>How does the solution improve access to services for adolescent girls? (e.g. financial, logistical, informational)</i> • <i>How does the solution facilitate uptake should an adolescent girl choose to use a contraceptive method? (e.g. reduce referrals)</i>
<p>1.5. What is the evidence of replication of the A360 developed solutions by PSI, consortium members, governments and peer organizations?¹³</p> <ul style="list-style-type: none"> • <i>How has the process of replication worked in other contexts, including Northern Nigeria?</i> • <i>How do key country stakeholders perceive the A360 solutions?</i> • <i>What is the evidence that the solutions or components of the solutions are being replicated by other partners at country level?</i> • <i>What is the evidence that the solutions or components of the solutions are being replicated beyond the solution geographies?</i> 		<p>3.5 Does the solution promote ongoing interaction between the adolescent girl and the service provider/health system?</p>
<p>3.6. How have the solutions been operationalized at scale in each country?</p> <ul style="list-style-type: none"> • <i>How is SFH/PSI implementing the solutions with other partners?</i> • <i>To what extent did the solution change over time, and why? (Design fidelity)</i> • <i>What were the successes and challenges in the scale up of the solutions in each country?</i> • <i>How attractive/ desirable do girls and community members find the solutions being scaled?</i> • <i>Have there been any unintended consequences of the solutions (either positive or negative)?</i> 		

¹² **‘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.

¹³ **‘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 counselling moment for adolescent girls, or components of the Smart Start, 9ja girls or Kuwa Mjanja curriculums.

Annex 2. User Journey for Smart Start in Ethiopia (August 2019)



Mechanisms of impact

Creating a supportive environment

- 1c **Training and supporting Health Extension Workers to implement Smart Start** supports HEWs to build empathy and address biases, helping HEWs to recognize married adolescents as in need of family planning, and giving them the skills to counsel them in a youth-friendly way.
- 2 **Working closely with government at national, regional and woreda levels** ensures Smart Start seamlessly integrates into the existing health system, building government ownership so that they continue to support HEWs in implementing the program, promoting integration into the health system, and addressing gaps such as stockouts.
- 3a **Working with the WDA and youth champions** leverages existing community structures and peer networks to identify and mobilize girls. Youth Champions are able to mobilize their peers. The WDA are known and respected in the community and by girls, and can use their influence as older women to outline the benefits and social acceptance of family planning to recently married couples, sharing personal stories which resonate with girls. WDAs know which girls have recently married and are eligible for Smart Start, can leverage the 1-5 network to easily reach out to girls where they are, and talk to husbands and mothers-in-law to get them on side.
- 4 **Engaging the community (through the kick-off meeting and in an ongoing way through the HEWs / SSN)** demonstrates respect, and helps build community support through positioning contraception as a tool that can help young couples manage scarce resources and build better lives. This messaging resonates with community leaders and helps secure their support.
- 5 **Involving husbands** in Smart Start encourages joint-decision making and acknowledges the husband as a key ally in decision making, using financial planning to create a new value for contraception.

- 7 **The Smart Start brand** builds on national dialogue about the importance of resource stewardship to advance national economic growth, and a national sense of pride. The life goals and financial planning orientation builds on this concept, providing a bridge to family planning that girls and their communities can endorse. At the community level, the brand and messaging is universal enough to resonate with communities and help show how contraception can help address community problems.

Positioning contraception as relevant and valuable

- 6 **Delivering financial planning messaging alongside information about contraceptives** helps girls and their husbands (and other influencers) see contraception as relevant and valuable to helping them achieve their goals, in order to contribute to family income and raise healthy children - in a context where family planning is already a norm for older married women, but taboo for newly married girls because they need to prove their fertility.
- 3b **Introducing Smart Start concepts through the Women's Development Army**, using visual low-literacy mobilization cards, helps position contraception as relevant and valuable during mobilization visits, encouraging girls and their husbands to attend a counselling session.
- 11 **Continuing follow up visits by HEWs and WDAs** build relationships and ongoing confidence in contraception as relevant and valuable among girls. HEWs / WDA can continue to meet girls wherever they are in their journeys, particularly after her first child, to follow-up on goal progress, help girls access services if she desires, and ensure continued use.

Mechanisms of impact

Building trust and credibility

- 1a **Working with Health Extension Workers and WDAs** leverages their position in communities as known and trusted local actors.

- 8 **Using a Smart Start Discussion Aide to deliver a combination of financial and family planning messaging** gives providers a new, compelling way to discuss family planning with married girls and young couples. The visual, low-literacy discussion guide works in a rural context, ensures consistent delivery of information and helps HEWs put girls at ease, address their fears, and provide information in a way they understand. The Discussion Aide resonates with girls because the pictures look like them in their rural environment

Increasing availability of services

- 1b **Delivering Smart Start through Health Extension Workers** enables the program to reach girls in rural kebeles, and utilizes existing health posts to support scalability.

- Training Health Extension Workers in Smart Start, and providing ongoing support through SSNs** supports
- 1c HEWs to build empathy and address biases, helping HEWs to see married adolescents as in need of family planning, and giving them the skills to counsel them in a youth-friendly way.

- 9 **Conducting counselling sessions door-to-door or at convenient locations** such as under trees or through other community groups, as well as at the health post, lessens the burden on girls and makes it easier to access services, minimizing distance as a barrier.

- 10 **Delivering girls' method of choice on the spot – including through during door-to-door visits** – reduces barriers to uptake for girls and delivers contraception when and where a girl wants it.

Promoting sustained use

- 11 **Follow up visits** help providers and WDAs continue their relationships with girls, and build ongoing confidence in contraception among girls. They ensure HEWs can continue to meet girls wherever they are in their journeys, particularly after her first child, to follow-up on goal progress, help girls access services if she desires, and ensure continued use.



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