Country Annex

A360 Process Evaluation Final Report

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Submitted by Itad

This document presents detailed data and analysis for each of the four A360 solutions, disaggregated by country. This supplements the synthesis of key lessons and insights presented in the A360 Process Evaluation Final Report.

Contents

List of acronyms

A360	Adolescents 360
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CHW	Community Health Worker
HCD	Human Centered Design
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
IPC	Interpersonal Communicators
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptive
LFH	Life, Family and Health
LLH	Life, Love and Health
MMA	Matasa Matan Arewa
MoH	Ministry of Health
MSI	Marie Stopes International
PSI	Population Services International
SFH	Society for Family Health
SRH	Sexual and Reproductive Health
SSN	Smart Start Navigators
STI	Sexually Transmitted Infection
USSD	Unstructured Supplementary Service Data
WDA	Women's Development Army

1. Introduction

The Final Report for the A360 Process Evaluation synthesizes insights from across the A360 countries and solutions. This Country Annex presents more detailed evidence on each of the solutions, disaggregated by country. It draws on process evaluation data collected between 2017 and 2020, as well as monitoring data collected by A360. Its purpose is to ensure the rich insights gathered by the process evaluation on the nature of the A360 solutions, how they have evolved over time, and key successes and challenges, are available to the wider adolescent and youth sexual and reproductive health (AYSRH) community to support learning.

Data and findings are presented by country, including:

- **What each solution looked like in practice:** its implementation model, its associated 'User Journey', and how it evolved over time including in response to COVID-19.
- **Solution performance based on A360 monitoring data**, summarizing data on girls reached, adopters, conversion rate, age distribution and method mix.
- **Key findings from the A360 process evaluation**, summarizing insights from 2016–2020.

See main report and Methodology Annex for full details on the process evaluation methodology.

User Journeys

'User Journey' models are visual depictions of how girls are intended to experience A360. They were developed by the evaluation team based on a document review in 2019, in collaboration with A360 global and country teams, and were updated in 2020 based on the final round of data collection.

User Journeys depict what each solution looked like at scale (prior to any adaptations made due to COVID-19). They detail the key touchpoints with girls, and how the solution works with government, community, service providers and mobilizers. Underpinning each User Journey are a set of underlying 'mechanisms of impact,' which explain how and why the solution is intended to work.[1]

Process evaluation findings for each country are presented in line with the User Journeys, describing how the solution played out in practice, whether the mechanisms of impact worked as intended, and key adaptations and contextual challenges that influenced the solution.

A360 monitoring data

Sections 2.2, 3.2 and 4.2 present headlines from A360 routine monitoring data. This data spans the final months of the Prototyping phase (from October 2017) to the end of the first phase of the program (end of September 2020). Data was collected by A360 and has not been independently verified by the evaluation team.

The process evaluation also conducted an independent descriptive and statistical analysis of A360 monitoring data in mid-2020, with insights incorporated throughout Section 2.3, 3.3 and 4.3.

[1] See A360 Process Evaluation Protocol for more information: https://www.itad.com/knowledge-product/adolescents-360-evaluation-process-evaluation-methodology-updated/

2. Tanzania

2.1. Introduction to Kuwa Mjanja

As of early 2020, the Kuwa Mjanja solution in Tanzania worked across eight regions through an outreach model. Outreach teams spent approximately a week in a ward before moving on, rotating districts each month, and working with local service providers to deliver in-clinic events (in public health facilities) and out-of-clinic events (in pop-up tents in community spaces). Kuwa Mjanja also runs 'parents' sessions' with parents of adolescent girls to start conversations about contraception and encourage participants to support their daughters to attend events.

Girls hear about Kuwa Mjanja through public announcements delivered by PSI staff or community mobilizers, through school-based mobilization, through peers (Kuwa Mjanja Queens) who visit girls in their homes, and/or through their parents or friends. At Kuwa Mjanja events girls receive life skills counseling in groups, based on the messaging of 'know your body' or 'know your path', and are introduced to the idea that contraception can help support their future plans. In out-of-clinic events, girls also attend an entrepreneurship skills demonstration and practice session from a trained provider – for example demonstrating jewelry or soap making. Kuwa Mjanja Queens use interactive games about contraceptive choices and side effects, with the help of tablets containing the 'Mjanja Connect' app, to engage girls between activities. All girls receive one-to-one contraceptive counseling with a trained government service provider unless they opt out, to ensure they have a chance to interact with a provider in private, and that girls who want to adopt a method are not singled out. Girls receive the method of their choice for free on the spot.

Girls are then provided with a 'next visit' card with details of a nearby facility, the phone number of a PSI staff member or service provider, and an Unstructured Supplementary Service Data (USSD) number they can text anonymously with questions.[2] Girls are also asked to provide their own phone numbers so PSI can follow up through a central call center. Kuwa Mjanja Queens act as a continuous point of contact for girls in their communities, helping to direct girls to youth friendly providers if they have questions or concerns.

Further details on Kuwa Mjanja are available on the A360 website.[3] See the Kuwa Mjanja User Journey (Figure 2 below) for further detail on the key touchpoints within the solution.

Design and evolution of Kuwa Mjanja

A360 began with a set of initial prototypes already in development, having conducted an HCD inquiry and insight synthesis process with unmarried girls in 2015 with funding from another donor. These were tested and iterated in 2016 into three core ideas: a youth friendly provider certificate program in which girls screened providers, a parent clinic day to build trust between parents and providers, and a girl clinic day using socially acceptable entry points to start conversations about contraception. In 2017, these prototypes were further developed, incorporating the 'Kuwa Mjanja' (Be Smart) brand, and a segmentation study to improve understanding of behavioral drivers among distinct segments of girls in Tanzania. In 2018, two

[2] USSD is a common technology used across East Africa to help girls find answers to their SRH questions for free, on-demand and without leaving any trace. The technology is available on all types of mobile phone and does not require internet access.(A360, 2019, Reimagining Healthcare through Technology for Good)

[3] See https://a360learninghub.org/countries/tanzania/

revised models were rolled out across 18 regions: a clinic-based model involving sessions for parents who were then asked to refer their daughters to a Kuwa Mjanja clinic session (targeted at younger girls in the 'Farida' segment identified in the segmentation study); and a pop-up outreach 'special event' model involving entrepreneurship skill sessions (targeted at older girls in the 'Bahati' segment). 'Kuwa Mjanja Clubs' to support sustained engagement were also piloted. In 2018, strong results from the pilot stage allowed PSI to leverage 15 outreach teams already on the ground and funded by other donors (DFID and KFW) to rapidly scale up to 18 regions.

In 2018, the program's emphasis was 'speed and scale', with a push from the donors to identify the 'minimum viable product' and reduce costs. This led to the decision to drop Kuwa Mjanja Clubs and parent-girl clinic days, as these were not generating as many adopters. The in-clinic model continued, but without associated parents' sessions. However, there were concerns (raised in the Mid-Term Evaluation[4]) that this narrower focus had reduced opportunities to engage influencers and build ongoing relationships with girls. In 2019 the program pivoted to a 'saturation strategy,' in which implementation was scaled back to fewer regions, with teams spending longer in each area in the attempt to reach a greater number of girls and engage more deeply with communities, and parents' days were reinstated. A360 explored the potential to reintroduce Kuwa Mjanja Clubs at this point but struggled to find a partner to help implement them at scale.

In 2019 A360 also worked to strengthen youth engagement. A youth 'SWAT team' was created to work with outreach teams, in order to improve the design of out-of-clinic events and roll out adaptations nationwide. With the support of the SWAT team, the role of Kuwa Mjanja Queens was further developed and expanded beyond mobilization. Further adaptations were made to support follow-up, including introducing a central call center and a text based USSD service allowing girls to text questions to an anonymous service. With an increased global focus on sustainability, A360 launched 'sustainability pilots' in three regions, to support government-led implementation of events. However, these were paused in March 2020 when the pandemic struck.

Figure 1 below displays a visual timeline of key evolutions in Kuwa Mjanja over the course of the A360 program.

Adaptations due to COVID-19

The first case of COVID-19 in Tanzania was confirmed on the 16th March 2020, after which the government closed schools, banned public gatherings, and restricted travel. This resulted in a complete halt of A360 activities, as both the in- and out-of-clinic models involved gatherings of sometimes large groups of girls, and the outreach model relied on staff being able to travel. National government guidance on safe resumption of sexual and reproductive health (SRH) services was not published until the end of May, resulting in a three month pause in service delivery. A revised model was piloted in June, developed by PSI following phone surveys with girls using the central Call Centre, and using adaptive implementation processes to consider how all the elements of the intervention could be adapted to meet girls' needs safely. The revised model involved in-clinic events only, as they attracted smaller number of girls making it easier to ensure social distancing. Mobilization was limited to door-to-door visits by Kuwa Mjanja Queens working alongside Community Health Workers, as mass mobilization through schools and public announcements attract girls in large numbers. The in-clinic events were modified to ensure that girls spent no longer than 30 minutes in facilities to minimize risk, including a short 'inspirational talk' which contained a shorter version of the 'know your body' and 'know your path' messaging to encourage girls to think about their life goals.

[4] See https://www.itad.com/knowledge-product/midterm-review-of-the-adolescents-360-program/

Figure 1: **A360 Timeline: Kuwa Mjanja (Tanzania)**

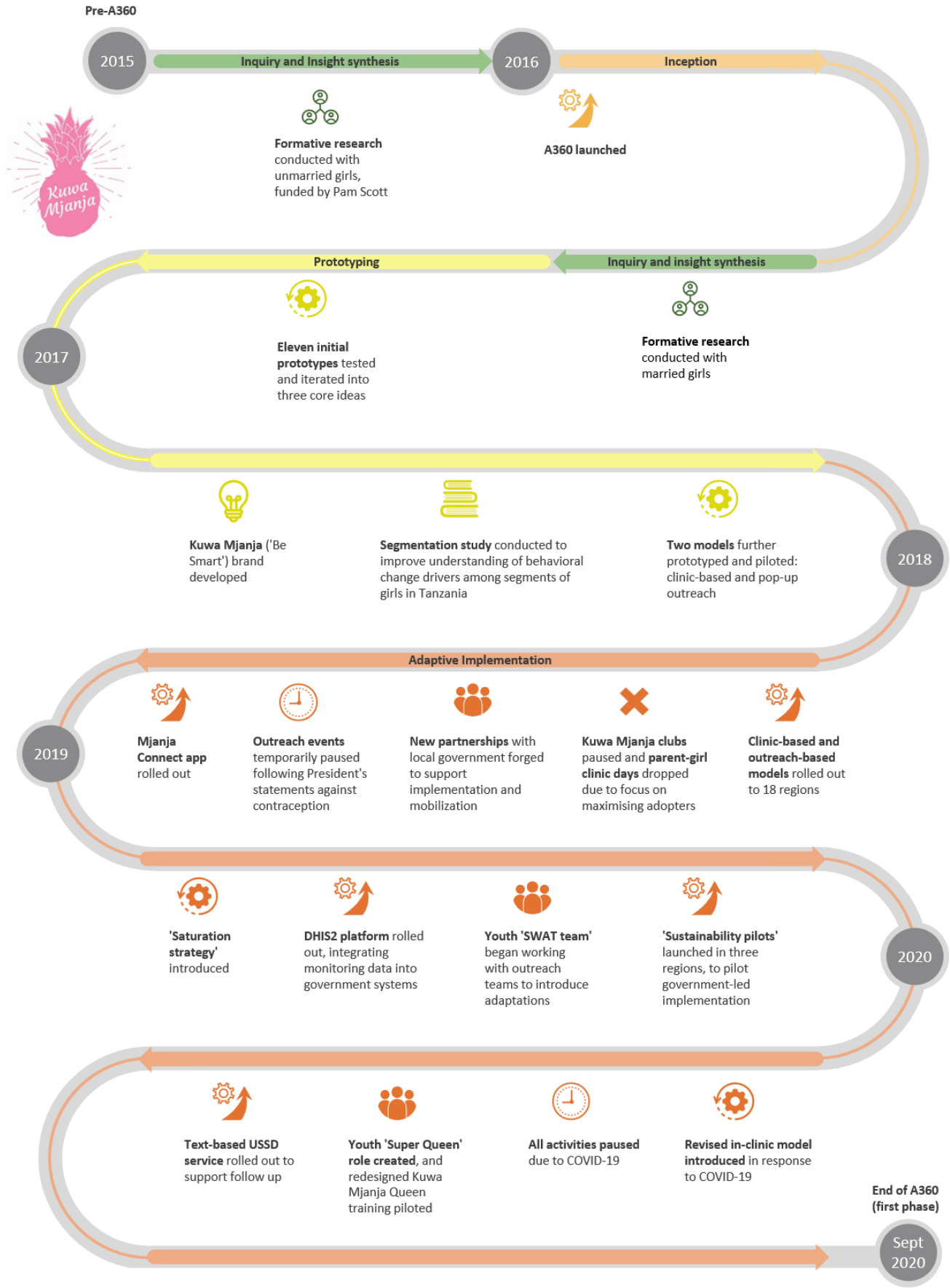
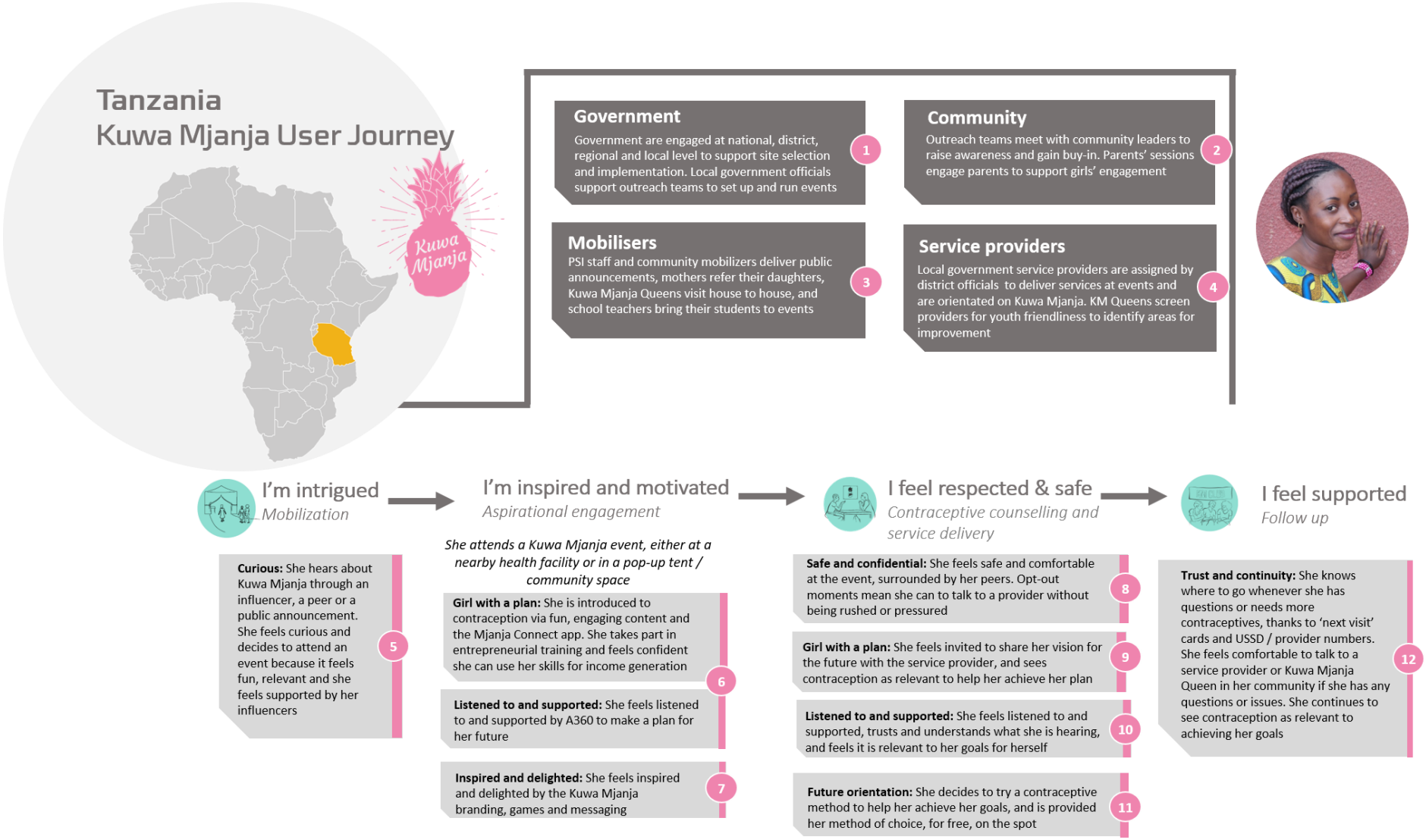


Figure 2: **Kuwa Mjanja User Journey**



Mechanisms of impact

This section presents the intended 'mechanisms of impact' underlying the Kuwa Mjanja User Journey (numbers relate to the diagram above). These explain how and why Kuwa Mjanja is intended to lead to change. Section 2.3 discusses whether these mechanisms were observed in practice through the process evaluation.

1 **Close engagement of government at all levels from the outset** ensures support as the program scales and helps to institutionalize Kuwa Mjanja into the health system.

Collaboration with local government officials to run events supports an enabling environment by ensuring that trusted local authorities approve of and feel a sense of ownership over the intervention and its objectives.

2 **Engagement of community leaders** from the beginning of A360's work in an area helps introduce the program to communities and support buy-in.

Direct engagement of parents ensures Kuwa Mjanja is a familiar intervention to key influencers in girls' lives, building their support for girls to engage with the program and access contraception, and addressing concerns and misconceptions.

The life goals and entrepreneurship focus provide a bridge to contraception as part of being a girl with smarts, which communities can easily endorse.

3 **Working with youth 'Kuwa Mjanja Queens'** leverages existing social relationships and peer networks to identify and mobilize girls, build community support, and provide a continuous point of contact for girls' questions and/or need for referrals.

Using a combination of one-to-one, school-based and mass mobilization helps maximize turnout and increase community awareness of the program, and gives a wide range of girls the chance to access A360 services.

4 **Working with public sector providers to deliver services in communities as well as in facilities** enables Kuwa Mjanja to maximize reach to girls in urban and peri-urban areas, ensuring a variety of service delivery channels that girls can access according to their preference.

Using girls to assess the youth-friendliness of service providers helps ensure the quality of the service experience, engages girls at a deeper level in their own care, and helps outreach teams improve the quality of counseling to better align with Kuwa Mjanja and girl-specific needs.

Providers build empathy toward girls through engagement with the intervention, building their capacity and willingness to serve girls, and helping them understand the connection between contraceptive services and girls' goals.

5 **Ensuring events are held in discreet spaces that girls feel comfortable in** helps girls feel safe enough to attend.

Entrepreneurial and life skills components provide a 'hook' that makes girls curious and encourages them to attend events – and also makes parents more likely to support and encourage their daughters to attend.

6 **Introducing girls to contraception using Kuwa Mjanja messaging** helps engage girls through fun, engaging content, makes contraception relevant by reframing it within a larger narrative of helping girls figure out who they want to be and helping them get there, and builds girls' confidence to achieve their goals. Messages are tailored to girls' life stages to ensure they feel relevant – Farida's message uses puberty and

menses as a comfortable introduction into the conversation, while Bahati's message taps into her priorities around achieving goals, finding ways to make money, managing growing responsibility and navigating the transition into adulthood.

Delivering entrepreneurial skills sessions alongside information about contraceptives helps girls and their peers gain confidence in their self-defined goals, helps reinforce the relevance of contraception to achieving goals, and builds skills to help girls gain income and so greater control over their lives.

7 **The Kuwa Mjanja brand and messaging** builds on culturally established concepts of what it means to be a 'good' girl, providing an opportunity for girls to reclaim the concept as one that is empowering to them, and helping connect contraception to the idea of girls achieving their dreams.

8 **Positioning events as wellbeing events provides anonymity for girls.** It means that girls can see a provider without the fear of being judged by onlookers, helps girls feel safe and comfortable, and avoids community stigma. Out-of-clinic events are held in a non-medicalized environment, helping to reach girls who do not feel comfortable attending clinics.

Using opt-out moments in which all girls see a provider unless they 'opt out' helps make interactions with providers normal and unobtrusive for girls, increasing confidentiality and reducing the opportunity for judgment from onlookers.

9 **The Kuwa Mjanja messaging** gives providers a new, compelling way to discuss contraception with girls, helping implementers put girls at ease, address their fears, and provide information in a way they understand.

10 **Working with providers who are already trained in youth friendly services, and providing additional on-the-job orientation and support**, ensures girls receive high quality youth friendly counseling that makes girls feel supported and safe, and helps girls see how contraception can help her achieve her goals.

11 **Delivering girls' method of choice for free, on the spot** reduces barriers to uptake for girls and delivers contraception when and where a girl wants it. It also eases the decision-making process, reducing the number of steps required for girls to access contraception.

12 **Working with local providers ensures girls feel safe and comfortable to attend follow up visits in nearby clinics**, with providers they know and trust. This helps providers continue their relationships with girls and build girls' ongoing confidence in contraception.

Returning to communities periodically through further Kuwa Mjanja outreach events helps ensure girls have access to follow up services if they are unable or unwilling to visit a clinic

Enabling Kuwa Mjanja Queens to support ongoing dialogue and/or youth clubs with girls helps to ensure an ongoing support channel is available to girls after engagement through Kuwa Mjanja programmatic events. Staying connected helps manage discontinuation by providing support and answers to questions.

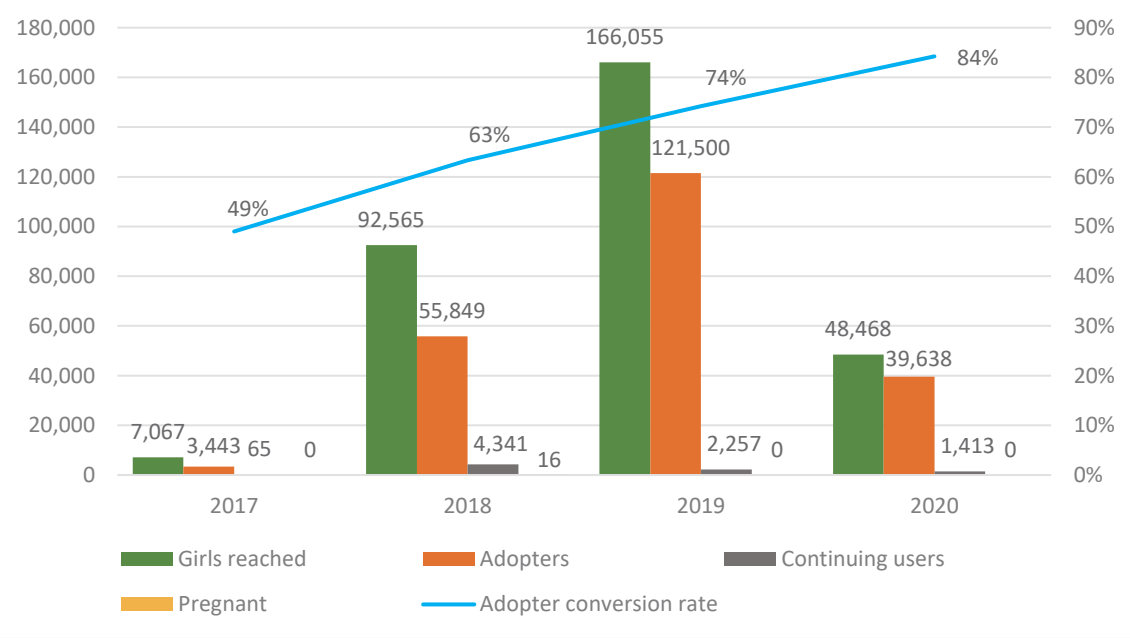
Providing providers' numbers, the number for a central call center, and/or a toll-free USSD text-based service ensure girls are able to contact the program, a local provider or an anonymous service to ask questions and seek advice

2.2. Performance data

By the end of September 2020, 314,155 adolescent girls had attended Kuwa Mjanja events, and 220,430 of these had adopted a modern contraceptive method. Overall, 72% of eligible girls (i.e. those not already using contraception or pregnant) adopted a method after attending an event. Conversion rates[5] have improved significantly over time (see Figure 3).

The high numbers of girls reached and adopters can be explained by the outreach model, which was designed to reach large groups of girls through out-of-clinic events and mass mobilization. This model meant that Tanzania was most affected by COVID-19 out of all the A360 solutions, resulting in a complete halt of services for three months in 2020 and a significantly scaled-back service offer once the program resumed in June.

Figure 3: **Kuwa Mjanja performance data (Oct 2017 – Sept 2020)** [6]

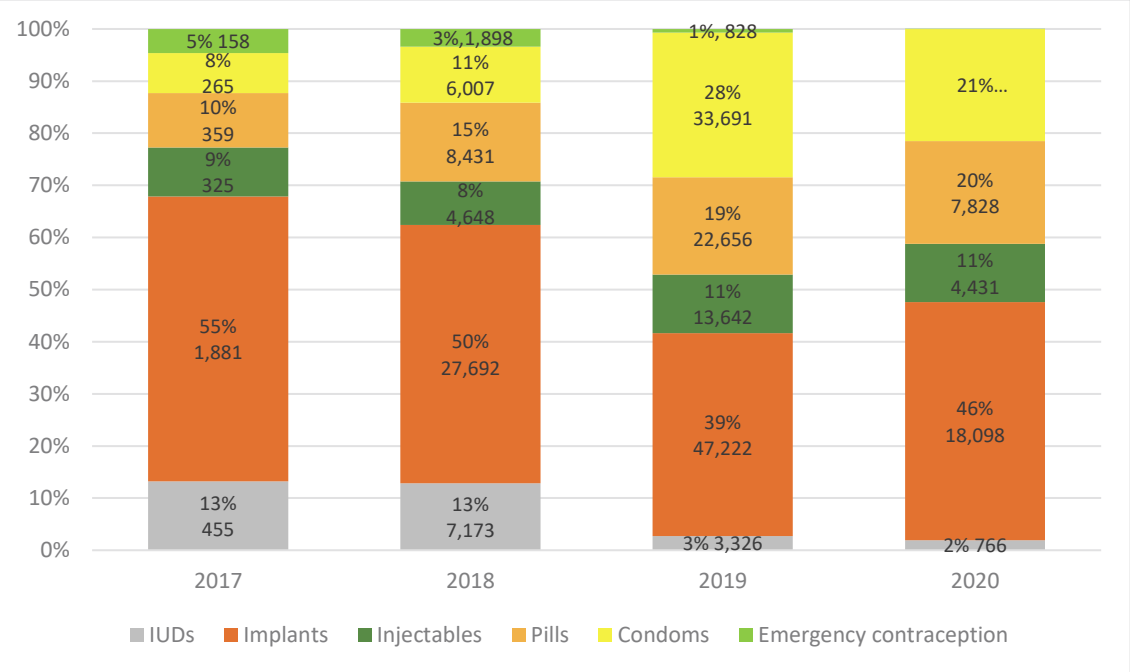


Long-acting reversible contraceptives (LARCs) accounted for 48% of methods adopted over the course of the program (see Figure 4). The proportion of LARCs adopted decreased from 62% in 2018 when the program first scaled to 42% in 2019 (rising again to 48% in 2020). Staff attributed this in part to the increase of younger girls served over the same period (see Figure 5), who are more likely to adopt short term methods.

[5] Adopter 'conversion rate': percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

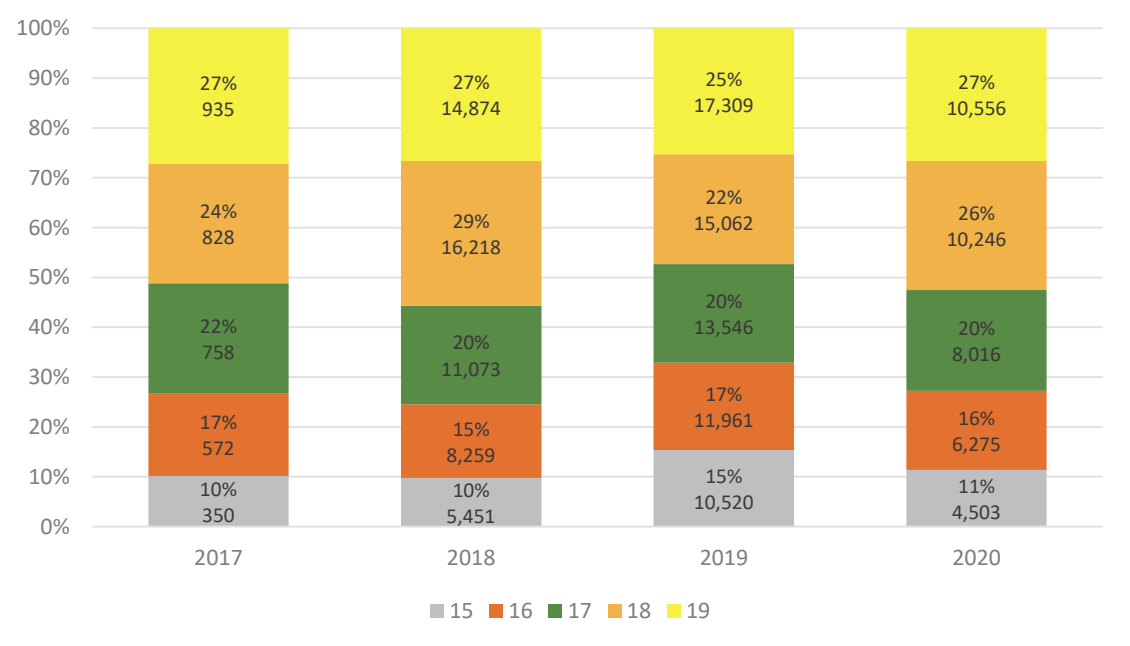
[6] Girls reached: girls who attend an A360 event. Adopters: girls who adopt a method for the first time. Note this definition was selected to align with government indicators, improving ease of measurement, and represents almost all of PSI Tanzania's adopters (98% according to Q1 2018 data). In order to make up for the slight shortfall, Tanzania also captures the small numbers of girls under 15 who adopt a method. Continuing users: girls who were already using a method. Adopter conversion rate: percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

Figure 4: **Kuwa Mjanja method mix (Oct 2017 – Sept 2020)**



Just under half (49%) of adopters were aged 15-17, compared to 51% aged 18-19. Kuwa Mjanja has proved significantly more effective at reaching younger girls than other A360 solutions – linked to the out-of-clinic event model, which particularly appeals to younger girls, The proportion of younger adopters increased from 44% in 2018 to 53% in 2019 (see Figure 5), attributed by staff to increased mobilization through schools which tends to bring large numbers of younger girls to out-of-clinic events. The proportion of younger adopters declined again in 2020 (to 47%), likely attributable to the shift to in-clinic events and away from school mobilization as a result of COVID-19.

Figure 5: **Age disaggregation of adopters by year (Oct 2017 – Sept 2020)**[7]



[7] Note there are discrepancies between the age disaggregation data and the overall performance data (53,000 adopters in 2019 are not included in the age disaggregated figures received by the evaluation team).

2.3. Process evaluation findings

This section presents key process evaluation findings on the Kuwa Mjanja solution in Tanzania, structured according to the User Journey model above. The findings reflect on how far Kuwa Mjanja is playing out in relation to each element of the User Journey, highlighting successes and challenges, and discussing how broader contextual factors are affecting the program.

2.3.1. Engagement with government, the health system, and key influencers

Government

Early and frequent engagement with government officials, advocacy meetings and sharing data and results have all helped secure government buy-in – although bureaucracy and frequent staff turnover can make this very time-consuming.

A360 engaged national government from the outset, and the process evaluation found that Ministry of Health (MoH) officials have generally been very supportive of the program. Engagement and coordination with regional health departments have proved crucial to building buy-in at the sub-national level, and program data has also played an important role – for example quarterly joint data-sharing and review meetings helped showcase program performance and results and generate confidence in the program. A360 transitioned to the District Health Information Software 2 (DHIS2) platform and app in 2019, which streamlined program monitoring data into the government data management system – this eased the sharing of results, although has resulted in some data gaps due to the way data is aggregated through DHIS2.[8] The program has been systematic in seeking the required authorisations from district officials before commencing activities in their area – an essential, but bureaucratic and time-consuming process. Engagement has also been made challenging by frequent turnover of government staff at national, regional and district levels, requiring significant efforts to onboard new stakeholders.

The political environment for AYSRH in Tanzania has also become more difficult over time, requiring Kuwa Mjanja to tread carefully.

Since 2017, high ranking government officials have made a series of comments criticizing family planning, and attitudes towards allowing pregnant girls to remain in school have hardened. While the MoH continued to support A360 and adolescent contraception provision throughout this period, much uncertainty was created among AYSRH actors in Tanzania, with actors feeling they had to read carefully – Kuwa Mjanja temporarily paused its outreach events following the comments in 2018 to avoid risk of backlash. Conservative attitudes at district and community levels, influenced to some extent by the national discourse, have also caused challenges, with District Commissioners occasionally halting activities or issuing complaints. Contraception is a particularly sensitive issue in relation to mobilizing girls in school. Eventually A360 began conducting additional advocacy meetings at the district and ward level, and enlisting the support of Regional Education Officers before approaching schools, which has helped manage these sensitivities. The support of district and regional MoH officials, such as District Reproductive and Child Health Coordinators, and the introduction of a national advisory committee to help mediate with district leadership where necessary, have also helped smooth over challenges when they arise. However, government buy-in has varied significantly between regions – some areas such as Katavi have enjoyed a high level of engagement with government, driven by concern about high levels of teenage pregnancy in

[8] Data collected through DHIS2 is aggregated by facility, rather than collated at the individual level, which limited the independent analysis of monitoring data conducted by LSHTM

the region, while other areas with less supportive local leadership have been more challenging to work in.

> *"Some of the political leaders in the councils still believe that adolescents should not be given contraceptives until they are grown up or married, so they tend not to allow some of the events to happen in their area of authority." (Regional A360 staff member, Tanzania, 2020)*

Working with local government networks has proved crucial for scale up and community acceptance, but achieving deep local engagement within an outreach model is challenging.

A360 has attempted to engage relevant government officials at national, regional and sub-national levels at all stages of implementation. As the intervention began to scale in 2018, A360 began to engage more at the local level, drawing on local government officials to support event logistics. This included the national network of Youth Development Officers – who had targets around youth engagement, and therefore the means, incentives and networks to support mobilization and event planning. These officials proved key partners during scale up, helping reach girls, identifying suitable government providers, and supporting event logistics. Working with local leaders in advance of activities commencing in new areas has also helped build community acceptance and buy-in, although formal advocacy meetings have not been held at the ward or community level, which was felt by some to be a gap.

However, anticipation of financial resources and capacity support by government officials has proved an ongoing challenge. Rapid scale-up and frequent rotation of outreach teams has meant at times there have been gaps in engagement, leading to some complaints from local government officials who felt they had not been sufficiently consulted. It has proved hugely time consuming for staff to ensure all relevant government officials are consulted and informed at national, regional, district and community level.

Entrepreneurship skills sessions have been an important factor in government buy-in and has helped navigate ideological opposition to contraceptive use.

Throughout the program, national and regional government stakeholders have been supportive of and enthusiastic about the life skills and (in particular) the entrepreneurship skills aspects of Kuwa Mjanja. They approved of the fact that events benefit girls economically as well as from a health perspective and frequently labelled this component as one of the key successes of the program. The entrepreneurship component appears to resonate with government concerns about economic challenges and lack of employment opportunities for youth, and helps navigate ideological opposition to family planning.

> *"What's good about Kuwa Mjanja is the life skills element. …Considering how the situation is with our leaders, when you come in straight away and say that you are advocating about family planning, it may not be good. But when you go in with the life skills…it will make it easier to get the support from our leaders from different levels." (National government stakeholder, Tanzania, 2020)*

The health system

Kuwa Mjanja has successfully worked with government service providers to deliver services through in-clinic and out-of-clinic events – but there are important gaps in training and orientation.

Each month, A360 works consistently with two district-level government providers who rotate with outreach teams as they move to different wards within the district, providing on-the-job

support and consistent exposure to program messaging. Each event is supported by an additional one to two service providers from a nearby facility.

One of the core prototypes in 2016 was a 'youth friendly provider certificate program', based on girl-led screening. During the design phase, girl 'mystery clients' were used to visit providers and assess their youth friendliness before recruiting them to work with the program. However, this proved too challenging to scale, and the government wished for more direct engagement in the allocation of providers to implementation teams. After the design phase, the program therefore recruited providers through district health officials, drawing on an existing national pool of providers already trained by other SRH organizations on youth friendly provision – this was a major factor in allowing the program to scale quickly in 2018. Although the official criterion for working with providers is previous training in youth friendly provision, this is often not the case in practice, exacerbated by staff shortages. At times, government and external partners have expressed concern that the program is not doing enough to expand the existing pool of youth friendly providers in Tanzania.

Unlike the other A360 interventions, Kuwa Mjanja has not incorporated formal training for service providers into its model as it scaled. The outreach model, in which new districts and wards are reached each month, has made large-scale training unfeasible given program resources. A360 attempted to introduce the PSI youth-friendly Counseling for Choice book, following observations of counseling weaknesses in 2018, but was unable to influence government training curricula. In later stages of the program, A360 has attempted to 'innovate around the edges' by introducing light-touch training aides, including a short video to help orient providers on the program and some basic elements of youth friendly provision before events; and has also supported government-led formal youth friendly services training in the three 'sustainability pilot' regions. In general, interviews with girls and service providers do not suggest any major issues with youth friendliness – however, internal supervisions and process evaluation interviews have both suggested the need for more training on both the program and contraceptive counseling provision. One important issue is that, without further training, providers are not always able to draw strong connections between the aspirational components of the program (girls achieving their dreams) and contraceptive choices during one to one counseling – a mechanism that has helped girls realize the value of contraception in both Nigeria and Ethiopia.

> *"I just provided [the counseling] the same way I do at the facility. I have not been taught about Kuwa Mjanja, and thus, I don't know how they are conducting their counseling…so, I worked by my job experience." (Service provider, Tanzania, 2020)*

Despite the lack of formal training, there is some evidence that engagement in the program has helped develop more favorable provider attitudes towards serving adolescents.

Over the course of the process evaluation, many service providers have reported that their attitudes towards adolescents using contraception have changed after being involved in Kuwa Mjanja – including beliefs that contraception (or some forms of it) are not suitable for adolescents but only for women who have already given birth. Some providers said that seeing the large turnout at Kuwa Mjanja events sent a message that girls need services, while others felt that gaining experience at youth-friendly events had helped change their attitudes. This shift is likely to also be influenced by the many other national AYSRH programs working with and providing youth-friendly services training to public sector providers in Tanzania, including Marie Stopes International, Pathfinder, and Engender Health.

> *"I used to say, 'why are you using contraception while you are a child?' But I gained experience after Kuwa Mjanja events on how to attend to a girl, how*

> *to behave as though I am her fellow youth, and I am not surprised when she adopts a method." (Service provider, Tanzania, 2020)*

Communities and influencers

Attitudes towards adolescent contraception vary widely both within and between communities, and stigma and fears about contraception pose major barriers to girls accessing contraception and taking part in the program.

The process evaluation found significant variation in support for adolescent contraception within communities. Fears about contraception encouraging promiscuity or causing infertility and other harmful side effects are widespread, premarital sex is highly stigmatized and often not talked about within families, and contraception is frequently viewed as being unsuitable for adolescent girls. Religious beliefs that contraception is a sin, and cultural norms around early marriage and childbirth within particular communities, pose another major barrier.

However, many stakeholders interviewed for the process evaluation felt that acceptability of adolescent contraception is gradually improving over time in some communities, and that it is easier to access contraception now than it was in the past. Concerns that pregnancy will stop girls from pursuing their studies (in a context where education is often highly valued) is a major driver of support for many parents and increasing use of family planning among older groups is helping to dispel some fears and misconceptions.

'Parents' sessions' have been positively received in communities but have not been systematically scaled and reach small numbers of participants.

A360 formative research emphasized that parents are crucial gatekeepers to contraception and access to Kuwa Mjanja activities for unmarried girls – a finding that has been consistently reinforced by the process evaluation. Parents' sessions were designed to provide a forum for engaging parents on the challenges their daughters face and educating them on family planning and Kuwa Mjanja. They aimed to build support for contraception and participation in program activities, and help parents start conversations with their daughters about sexual and reproductive health in a context where it is not the norm for parents to discuss these issues with their children.

Many parents interviewed for the process evaluation spoke very positively about the sessions, and several indicated that their attitudes had shifted, and they had felt more equipped to have conversations (sometimes for the first time) with their daughters about sex and contraception. However, other parents had not been persuaded, and fears about side effects and promiscuity persisted. This is not surprising given the light touch nature of the activity and highlights the challenges of incorporating meaningful community engagement into a program that is not designed from the outset to influence social norms.

> *"As a parent this program opened me up a lot. I didn't know if I could talk to my daughter about sexual relationships. I used to think she might be shy…But it's my responsibility to stand firm and teach her…and advise her on what to do." (Mother, Tanzania, 2018)*

The sessions largely dropped out of the solution as it scaled in 2018 – they were judged less cost-effective in a context where rapid scale up and reaching adopter targets were the key priorities of the donors. They were reintroduced in late 2018 in order to address concerns raised in the evaluation Midterm Review about a drift in focus from enabling environments and social norms.[9] However, as of 2020 the sessions were not being systematically held across all sites (they are sometimes run only when there is active opposition from communities that

[9] See https://www.itad.com/knowledge-product/midterm-review-of-the-adolescents-360-program/

hinders program activities), and the program has not collected data on the number of sessions, participants or girls referred by their parents. The numbers of parents attending the events is also small given the size of the catchment areas served by the program, and more regular parents' sessions in earlier phases were sometimes attracting the same mothers rather than reaching new audiences.

There is some evidence to suggest that Kuwa Mjanja has helped raise awareness and shift the narrative around contraception in some communities, particularly through its community mobilization and out-of-clinic events.

Despite the fact that the program has not involved substantial community engagement, staff and Kuwa Mjanja Queens interviewed for the final round of the process evaluation reported that communities often become more accepting over time when the program returns to the same areas. This was attributed partly to the mobilization activities (public announcements and door to door visits, supported by local government officials and word-of-mouth), and partly to the very visible presence of pop-up tents in communities for out-of-clinic events. Interviews also suggest that the program's presence in communities is helping to start conversations – between girls, between girls and their parents, and between parents – which may be playing a role in increasing acceptability over time. Some girls become advocates after taking part in the program, sharing what they have learned with sisters and others in the community. This appears to help raise awareness among other girls, improve community acceptability, and make contraception seem more 'normal.' Some parents and teachers also felt that teenage pregnancies had reduced since the program first came to their area, which has helped to increase community support. Overall, qualitative evidence from 2020 suggests that the program may be *indirectly* influencing community attitudes, although the extent to which this is happening across Tanzania is not possible to conclusively verify through the process evaluation.

Entrepreneurship skills sessions are an important driver of community acceptability and parental support, and the messages of 'being smart' and 'helping girls achieve their dreams' resonates with teachers and parents.

The process evaluation has found that the promise of helping girls become 'liberated' or financially independent resonates strongly with parents, teachers, and community leaders – particularly in a context of poverty and challenges in finding formal employment. Interviews with community stakeholders across multiple years suggest that the aspirational component of the program is a critical factor in building community support for girls' participation in events. One important hypothesis shared by many stakeholders is that when girls can generate their own income, they are more independent and able to help themselves through the challenges they face, and so can avoid 'temptations' from men or boys who offer them gifts in the context of sexual relationships. Interestingly, the entrepreneurship component thus seems to appeal to stakeholders who are concerned about promiscuity – because they see it as offering girls the potential to be independent, and not have to rely on men for income.

> *"It's through life skills that a youth can avoid unprotected sex and other temptations…many of them get tempted because of money. But when she learns how to make baskets, soaps and so forth…she will get money and she won't be tempted to go and have unprotected sex." (National government stakeholder, Tanzania, 2020)*

2.3.2. Girls' journeys through A360

Mobilization

Kuwa Mjanja has successfully used a combination of mass and one-to-one mobilization, supported by local government officials, to attract large numbers to its events.

Kuwa Mjanja has successfully employed a range of mobilization approaches. Public announcements using Kuwa Mjanja cars in public spaces can reach large numbers of girls, and at the same time raise more general awareness of the program within communities. Working with networks of government officials has been an important enabler of mobilization as the program has scaled – with officials drawing on their own networks of community announcers and community leaders as well as their knowledge of where and when to reach adolescents in their communities. While effective in reaching large numbers, this has sometimes resulted in distorted messages about what the program involves.

The program is also using one-to-one peer mobilization, with 'Kuwa Mjanja Queens' trained to visit girls' homes and invite them to attend events. This reportedly works well alongside the mass mobilization approach – with the public announcements generating wider awareness which helped prepare the ground for Queens to visit girls and invite them one-to-one. The process evaluation has found that Kuwa Mjanja Queens enjoy their role but face various challenges, including lack of transport, low levels of phone ownership, and occasionally the need to navigate uncooperative or resistant parents, who have sometimes 'chased girls away.' The program has also faced challenges with retaining Queens, given the intermittent nature of program activities in any given area. It is also unclear how many girls are mobilized through this channel. A360 monitoring data from 2017-2018 shows that most girls (51%) heard about events through public announcements, and only a small number (under 6%) heard about events through Kuwa Mjanja Queens.[10]

The program has not consistently worked with Community Health Workers (CHWs), finding that girls were sometimes not willing to talk to them as they are often much older. However, in 2020 the program increasingly began to bring in this cadre to support mobilization throughout the pandemic – finding the process worked best when CHWs work alongside Kuwa Mjanja Queens to visit girls, door-to-door, and invite them to events. Staff feel that this pairing helps build CHW's capacity to engage girls in a youth-friendly way, while adding credibility to the invitation due to the CHW's known and trusted position in communities.

Schools have proved a fruitful, but sometimes fraught, mobilization channel – especially for younger girls.

Schools are a challenging environment for mobilization, frequently displaying conservative attitudes towards SRH education, and with girls often facing routine pregnancy tests and expulsion if they found to be pregnant. However, the program has found schools a useful avenue for reaching large groups of younger girls. Initial engagement with schools was informal and relatively ad hoc. In 2018, the process evaluation found that the program's approach was potentially risky, due to girls arriving at events wearing school uniforms in potential contravention of government policy and accompanied by teachers who did not know the purpose of the event. At one point this led to conflict when teachers complained to the District Commissioner after realizing that girls were being offered contraception.

The program changed tactics in 2018 - formalizing the process through writing to schools with the support of regional education officers. The program has also moved away from mobilizing in religious and boarding schools. This appears to have helped mitigate some of the earlier challenges. However, the fact that schools bring girls to events in large numbers can sometimes limit the time each girl can spend with providers, and threaten freedom of choice and confidentiality – some girls are not willing to see a provider one to one because they do not want their teacher to think they are adopting a method. Although the program has not

[10] LSHTM analysis of A360 monitoring data (Nov 2017-Nov 2018). More recent data from Tanzania was not available, due to the integration of monitoring systems into the government DHIS2 system in 2019.

specifically monitored how mobilization through school affects adoption rates, staff generally felt that this approach generates large numbers of attendees (although fewer adopters) and allows the program to reach younger girls. A360 monitoring data shows the proportion of 15-16-year-old adopters increased from 25% in 2018 (when the program was moving away from in-school mobilization), to 33% in 2019.[11] The program is reaching fewer younger girls since the modified COVID-19 model was rolled out (only 23% of adopters were aged 15-16 in the third quarter of 2020). This model no longer involves mobilization through schools as this results in overly large gatherings.

The process evaluation has found that there are pockets of support for adolescent contraceptive service provision among teachers, although this is by no means universal. In 2020, the process evaluation found that some teachers took on an active role in preparing girls for Kuwa Mjanja events and reinforcing Kuwa Mjanja messages afterwards in class – suggesting that the program could potentially do more to harness the enthusiasm of supportive 'champions' among teachers.

Entrepreneurship and life skills sessions have proved a useful 'hook' to attract girls to events.

The process evaluation has found that entrepreneurship skills sessions are an important 'hook' for many girls, playing a role in attracting them to attend events, although some girls are more attracted by the promise of SRH and other education. The 'Kuwa Mjanja' (Be Smart) slogan also appeals to girls, with several noting that they came to the events because they wanted to receive information that would make them smarter or would help them achieve their dreams.

Kuwa Mjanja has more or less explicitly adopted a 'flying under the radar' approach, which has helped it reach large numbers of girls in a context of high stigma, but which has not been without risk.

In earlier stages of the process evaluation, interviews suggested that many parents, community members and teachers were unaware that outreach events offered contraceptive services to girls. In many cases, service providers and mobilizers were deliberately vague about the content of events, emphasizing the life skills and entrepreneurship components of the events and often not informing parents or girls that contraceptives would be offered.

> *"If we let the parents know, we will lose many of the girls because the parents can prevent them from taking part… So, we still keep it a secret because the people are not aware of the importance of such services." (Kuwa Mjanja Queen, Tanzania, 2018)*

This strategy has undoubtedly helped girls access services in a context of widespread disapproval of adolescent contraceptive use, allowing girls to attend events without stigma. A360 staff have framed this approach as respecting and emphasizing girls' choice. However, the process evaluation has raised concerns that this places a burden of secrecy on girls, and potentially puts them at some risk. Interviews with girls and community members have highlighted many examples of girls hiding their contraceptive use from their parents. Girls talked about the risk of being "*chased away from home"* or beaten if their parents found out they had accessed contraception and discussed various strategies of secrecy used by girls who adopted methods.

> *"Some girls tell their parents when they go to attend the Kuwa Mjanja events and some don't. For those who don't, they say they are afraid that*

[11] Overall A360 performance data, 2018-2019

their parents would prevent them from going, hence, they go secretly." (Adolescent girl, Tanzania, 2018)

In the final round of data collection, the process evaluation found that the ambiguous framing of Kuwa Mjanja events appears to have been largely successful – presenting events as 'wellbeing events' has helped ensure community acceptability, but (in most cases) mobilizers do not actively hide the fact that contraception is offered, but rather emphasize the provision of health education. Overall, A360 largely seems to be succeeding in the way it is introducing itself to communities, and in the way it is framing its events. The sense among Kuwa Mjanja Queens, community leaders, teachers and parents interviewed for the evaluation was that most people know that contraception is provided, even if this is not explicitly discussed. Having the support of national, regional and local level government also helps to mitigate the risk of backlash. Over the course of the program there have been only a small number of high-profile instances of backlash from parents, which have been resolved with the help of district health officials.

However, the potential risks to girls of keeping their contraceptive use secret are difficult to monitor, and so it is important that staff and mobilizers are given clear guidance around how to sensitively frame and discuss the program and its activities to different stakeholders without actively withholding information. There is also some concern that the deliberate ambiguity of program messaging is not helping to make the enabling environment more conducive for girls, and potentially makes discontinuation more likely. The reintroduction of the parents' sessions was intended to address this gap, but has been patchy, as discussed above.

Out-of-clinic events help improve reach to girls who live further from health clinics. However, reach is still limited in more remote areas.

The out-of-clinic model in particular allows the program to reach girls who live in more remote and rural areas. However, it is still challenging to hold events far from health facilities, and the push for 'speed and scale' in 2018 provided a disincentive to focus on harder-to-reach girls. As one PSI staff member reported: *"Some districts are very difficult…we cannot take more time to invest in them because we won't get the numbers."*

In late 2018, a 'saturation strategy' was introduced to help deepen engagement in a smaller number of target regions (reducing from 18 in 2018 to eight in 2020) before moving outreach teams to new areas. However, although outreach teams now spend longer in each ward (a week at a time), unmet need has proved higher than anticipated, making it difficult to reach saturation in targeted areas. Some wards are exceptionally large, with dispersed rural settlements that can be very difficult to access. Particularly during rainy months, the out-of-clinic events are challenging to implement. Many stakeholders interviewed for the process evaluation felt that the program is 'stretched too thin' and would benefit from staying longer in one place and reaching more neighbourhoods, including more rural and isolated communities where unmet need is high.

Aspirational engagement

The Kuwa Mjanja branding and messaging has resonated strongly with girls.

The 'Kuwa Mjanja' brand was designed to reflect an aspiration of being smart and clever, using storytelling, symbolism and beauty to connect with girls. The process evaluation found that the brand and associated messaging clearly resonates with girls and service providers. Girls clearly articulated the purpose of the program in interviews – talking about how it helped girls to 'be smart', clever and more self-aware. Girls often mentioned the pineapple imagery used by Kuwa Mjanja, although the intended metaphorical link ('sweet on the inside, tough on the

outside') was not always fully understood. Many service providers also talked positively about the Kuwa Mjanja messaging, and felt it helped to engage girls and was widely recognised in communities. The message of 'being smart' and 'helping girls achieve their dreams' has also resonated with teachers and parents.

> *"It is not just providing family planning methods as we were doing formerly but also assisting the girls to get at their dreams." (Service provider, Tanzania, 2018)*

The 'body changes' and life skills components have reportedly helped increase girls' knowledge, confidence and self-esteem

Kuwa Mjanja has not monitored the potential empowerment outcomes of the aspirational component of the program. Many girls attend only a single event, and so exposure to empowerment messages is limited. However, girls interviewed for the process evaluation frequently said they enjoyed learning about their health and bodily changes, as well as how to be self-aware and reach their goals, and many said they had gained knowledge, confidence or self-esteem.

> *"I took some good advice from the event, that the girl should stand by her own opinion so that she may be able to reach her dreams. There should be nobody to discourage her…she is to stand by her opinion, and she will make it." (Adolescent girl, Tanzania, 2020)*

The wellbeing focus of the out-of-clinic pop up events has been central to Kuwa Mjanja's success in reaching large numbers of girls – although they are challenging to implement and increasingly complex, raising questions about sustainability.

Out-of-clinic events provide a girl-only 'safe space' for girls to access services in the context of an event that is framed around skills and wellbeing, helping participants avoid the stigma attached to visiting clinics. As such, they are a key mechanism for the program to reach younger girls and first-time contraceptive users. As discussed above, these events also play an important role in building community acceptability for the program, and also help to start conversations about and raise community awareness of adolescent contraceptive services more generally. Out-of-clinic events are held less often but reach more girls. Between November 2017 and March 2020, 2,945 out-of-clinic events were held compared to 4,299 in-clinic events. In 2019-20, on average approximately 70 girls attended each out-of-clinic event, compared to 35 who attended each in-clinic event.[12] Monitoring data also shows that girls attending out-of-clinic events were generally younger[13] and had no children when compared to participants at in-clinic events.[14] This raises some concern around the adapted COVID-19 model, which involves in-clinic events only and means the program is no longer able to reach girls who do not feel comfortable to come to a clinic.

A360 has been 'trying to perfect' out-of-clinic events since 2018 and has made a number of adaptations to the model to improve girls' experiences. PSI purchased tents (with partitions to allow private counseling and service delivery) after many challenges attempting to hire adequate tents locally. A team of 'youth experts' (informally known as the 'youth SWAT team')

[12] LSHTM analysis of A360 monitoring data (Jan 2019 – March 2020) Note: the evaluation team received attendance data for only 76% of facilities, and 11 regions did not have information about in-clinic vs out-of-clinic events.

[13] LSHTM analysis of A360 monitoring data (Nov 2017 – Nov 2018: more recent data on age was not made available to the evaluation team). Odds ratio of in-clinic events (vs out-of-clinic) was 0.43 (95% confidence interval: 0.40-0.46) for 15-year olds (vs 18-year olds). Results of a logistic regression mixed model.

[14] LSHTM analysis of A360 monitoring data (Nov 2017 – Nov 2018. Odds ratio of in-clinic events (vs out-of-clinic) was 3.1 (95% confidence interval: 3.0-3.3) for girls with one or more child (vs girls with no children). Results of a logistic regression mixed model adjusted for age.

were also deployed to observe, develop innovations and roll out adaptations to the event model in 2019. This included a new floor plan, improvements to the flow of events, increased engagement of Kuwa Mjanja Queens, and new games and activities to keep girls occupied while waiting and breaking up large groups. Digital tools have also been incorporated – Kuwa Mjanja Queens use the Mjanja Connect app to engage girls with games and activities that help them think through their contraceptive needs before they see a provider.

Staff reported that these adjustments have helped ensure that girls receive the 'full package' of activities no matter when they arrive, reducing the number of girls who leave before seeing a provider. Monitoring data shows an improvement in conversion rates in 2019 following the roll out of the adaptations (see Figure 3 above). However, the out-of-clinic events are time consuming to organize and implement, and their increasing sophistication and complexity poses challenges for integration into government health services. Government capacity to implement events has proved a barrier in the three 'sustainability pilots' A360 has been running in 2019-20.

Girls love learning entrepreneurial skills, but the light-touch sessions do not always match high expectations.

A central element of the out-of-clinic event model is the entrepreneurial skills sessions. At all stages of the process evaluation, girls emphasized how much they loved this component. As discussed above it is also a key factor attracting girls to attend events, and in securing community and government buy in. Unsurprisingly, given the narrative of entrepreneurship skills leading to empowerment, girls often want more from the program than is offered – including more time for in-depth learning and practice, support to purchase tools and materials, and lessons on a greater variety of skills. Many girls, parents and government officials interviewed for the process evaluation have the expectation that the program will support girls to become entrepreneurs, helping them 'achieve their dreams' even if they are not able to find formal employment.

However, entrepreneurship was designed more as a 'hook' and A360 is unlikely to succeed in supporting girls to generate income based on a short, one-off demonstration and practice session without follow up support. While some respondents gave anecdotal examples of girls earning money through applying the skills they learned, most of the girls interviewed for the process evaluation had not been able to generate income from the skills they had learned through the program. A360 is aware of these limitations, and in response recently begun encouraging girls to band together into co-operative groups to make and sell products; and attempting to connect them to opportunities to access small loans. However, as of June 2020 there were only a few groups in operation.

The segmentation model has been challenging to apply in practice.

During the pilot phase, two priority customer archetypes were introduced: the younger (average age 16.9), less sexually experienced (but sexually active) 'Farida', and the older (average age 18.2), more sexually experienced 'Bahati'.[15] Initially, different types of events were developed for the different archetypes – in-clinic sessions for Faridas, which used puberty and menarche as an entry point), and out-of-clinic pop up events for Bahatis, with a 'know your path' message (using goals, dreams and skills sessions as an entry point).

When the parent-and-girl clinic model was dropped it became more difficult to deliver segmented messages, as staff found a mixture of Faridas and Bahatis would attend any given event. A360 staff reported that they responded by ensuring both messages were incorporated into conversations both in- and out-of-clinic. However, it was unclear how outreach teams

[15] See Gottfredson et al (2018) Improving SRH outcomes among girls and women in Tanzania: A behavioral segmentation based on developmental stage and behavioral drivers. https://a360learninghub.org/open-source/insight-synthesis/segmentation-tz/

were making decisions about which messages to deliver to which girls, and it appeared that different teams had different tactics that may not align with the nuances of the segmentation model – for example deciding which messages to give solely according to a girl's age.

Contraceptive counseling and adoption

Girls reported feeling safe and comfortable during contraceptive counseling sessions, and many (although not all) reported more positive attitudes towards contraception. However, there are ongoing weaknesses in counseling quality.

The vast majority of girls interviewed for the process evaluation said that service providers were friendly and listened to them, and that they felt safe and comfortable, free to speak and express themselves, and trusted what they heard. Interviews with girls also suggest that contraceptive counseling is shifting some beliefs and attitudes towards contraception – through what for some girls is their first exposure to sexual and reproductive health education – including concerns that contraception is harmful for adolescents. However, several girls still hold misconceptions after the counseling – unsurprisingly given the prevalence of these fears in communities, which may be difficult to shift in the course of a single counseling session.

> *"[The counseling] removed the fear a little bit but not that much because, sometimes you become afraid when you think about the side effects. You have to be very careful when you are using these methods because…you might end up getting the problems you were trying to avoid." (Girl, Tanzania, 2020)*

However, the process evaluation has found that service providers are not always giving girls accurate information about side effects, which can reinforce popular myths and misconceptions when girls do experience effects such as changes to menstruation, or delayed return to fertility following the injection. Some girls reported that they were not told about side effects at all or were told that there are no side effects 'if you follow the instructions'. Mothers and girls pointed out that side effects such as delayed fertility or prolonged bleeding can have harmful consequences in a context where girls are expected to get pregnant shortly after marriage, where they may be hiding contraceptive use from parents, or where it is difficult to attend school during menstruation because of the cost of sanitary towels.

Both the process evaluation and an external quality assurance process conducted in 2019 found that service providers sometimes steer girls towards or against particular methods, compromising girls' freedom of choice. Several providers interviewed for the process evaluation said they preferred girls to use certain methods – for example discouraging the injection because they are concerned about delayed conception or promoting condoms as the most appropriate method for unmarried girls. Interviews suggest that abstinence messaging is also creeping into the counseling, with some providers encouraging girls to 'avoid temptations' from boys and men.

Out-of-clinic events and opt-out moments have helped girls to access contraception in a context of stigma. However, there have been some challenges with privacy and with the fidelity of the opt-out moments.

As much as possible, Kuwa Mjanja has ensured that girls can adopt methods on the spot during events, eliminating the need for referrals. This is valuable as many girls reported feeling more comfortable at out-of-clinic events, due to the fear of being mixed with older women and the in-clinic services being seen as 'for mothers.' Contraceptive counseling happens through one-to-one 'opt out moments' that take place after the general health talk (in-clinic events) or entrepreneurship sessions (out-of-clinic events). The idea is that all girls see a

provider unless they 'opt out', helping to further reduce stigma and normalize the counseling among all girls whether or not they want to adopt a method.

The process evaluation suggests that both the out-of-clinic events themselves – framed as wellbeing events enabling a wider variety of girls to attend – and the opt-out moments within them have created a safe space for girls who would otherwise not have been able to access counseling or services due to stigma and other barriers. However, privacy within out-of-clinic events has been an important concern – it is more difficult to achieve in a pop-up tent in a public setting, and several girls interviewed for the process evaluation felt that the location was not private enough and were concerned about bystanders listening in. Several interview respondents reported that schoolgirls who attend events with their teachers are less likely to visit the provider, because they do not want their teachers (or peers) to think they are adopting a contraceptive method.

Evidence from the process evaluation and PSI external quality assurance processes also suggest that the opt-out moments do not always operate as intended. Some girls interviewed for the process evaluation felt they did not need to see a provider unless they wanted to adopt a method or had a problem to discuss, and there have also been issues with long queues and waiting times meaning some girls leave before the one-to-one session. In 2019, the program made some adaptations to the opt-out moment to improve the experience for girls. Youth experts introduced a new interactive card game after girls had seen a provider, designed to help educate girls about side effects while also keeping them occupied to avoid them talking to their friends about their experience and diluting the effect of the opt-out moment. Games are organized for girls to play while they wait to see the provider, to reduce the likelihood of them leaving because they are bored of waiting. Performance data suggests that these innovations have helped, as discussed above.

A360's method mix has been gradually shifting towards short term methods, particularly condoms, since 2018 (see Figure 4 above).

In January 2020, the program hit a peak of 31% condom adopters[16] (this still compares favourably to the latest Demographic and Health Survey data from 2015, in which 56% of girls used condoms). The greater proportion of girls reached through out-of-clinic events since scale-up has likely contributed to the shift towards short-acting methods in the country's method mix. Staff noted that the issue also seemed to be a result of increased mobilization through schools, which generally tend to yield fewer adopters as discussed above. Interviews with girls who adopted short term methods for the process evaluation suggest a number of reasons for their method of choice – including a desire to prevent STIs, fear of long acting methods' side effects, and encouragement from service providers to use condoms. Some girls also choose the injection because it will not be noticed by partners or husbands.

Follow up

The outreach model poses a challenge to systematic follow up, which has been difficult for A360 to address.

The intention was for outreach teams to visit the same areas every three months, to ensure that girls who adopt injectables are able to access follow up services, as well as provide continued access for girls who are not willing or able to visit health facilities. However, in practice this has been challenging, in part because of government requests for the program to visit new areas that have not yet been served. In October 2019, A360 reported that under 25% of facilities had received a repeat visit and those that had were not always at the three-month

[16] LSHTM analysis of A360 monitoring data (Nov 2017 – Nov 2018)

interval. Several girls and Kuwa Mjanja Queens felt that events are spaced too far apart, leaving some girls without access to services (see Figure 3 above).

> *"It becomes a challenge…[some girls] who take the method from [a Kuwa Mjanja event] don't want anyone else to find out, she thinks she will be taking it from there all the time…she finds herself in a dilemma not knowing what to do." (Kuwa Mjanja Queen, Katavi)*

Although PSI call center data and interviews for the process evaluation suggest that many girls do return to subsequent Kuwa Mjanja events when the program returns to their communities, program monitoring data shows that the number of continuing users attending events is low and has not increased much over time (only 2,644 continuing users were recorded in 2019–20, comprising 1.5% of all attendees – see Figure 3 in Section 2.2).

'Kuwa Mjanja Clubs' were prototyped and piloted at the beginning of the program, as a mechanism to support sustained engagement and ongoing dialogue between girls and service providers. While the clubs were appreciated by girls, maintaining attendance was difficult, they were not viewed as cost effective in terms of reaching new adopters, and they proved too challenging to scale. A360 were unable to find a suitable partner to support the clubs at scale and plans to train Kuwa Mjanja Queens to set up and run the clubs were abandoned due to a lack of resources and competing priorities. In the absence of the clubs, Kuwa Mjanja Queens are the only in-person form of follow up support to girls – some reported that girls call or visit them if they have challenges, and they help direct them to a nearby youth-friendly provider. However, this support is informal and may not always be available, as not all Kuwa Mjanja Queens stay engaged after A360 leaves their area.

A360 has been experimenting with several virtual follow up strategies – however many rely on access to a phone, which may limit reach.

A360 initially planned to develop a virtual hub to allow girls to continue engaging with the program after events. However, discussions with a potential partner did not come to fruition and the idea was dropped. Instead, A360 has pursued a number of lower-tech strategies to support follow up.

A360 has set up a central phone line that girls can call if they face problems or need further information. This 'call center' has proved useful for learning, allowing A360 to collect national data on user experience, but there are very few girls on the database, and not many girls are calling the number. In many cases, providers and outreach team staff take girls' numbers and call them to follow up or give girls their own numbers so they can contact them directly – but this process is not formalized and is left to service providers' discretion and does not appear to be happening everywhere. As of the end of 2019, girls are also provided with a toll-free USSD number when they attend events, which allows them to text questions to an anonymous service and receive information about side effects and other issues. A360 reported that around 3,000 girls aged 15–19 used the platform in the first quarter of 2020, half of whom were users of contraception (this figure equates to about 9% of A360 adopters during the same period).[17]

However, all of these strategies rely on access to a phone, which potentially exclude poorer and harder to reach girls. Access to mobile phones among adolescent girls is relatively high in Tanzania although phone ownership is low,[18] and the latter has been hampered by a recent policy requiring all SIM card users to register their cards. Rural location and poor network

[17] The platform is available to both sexes and is not restricted to adolescents: in total 10,000 unique users were registered in Q1 2020, of which around one third were 15-19-year-old girls (A360 internal report).

[18] In 2018, A360 research found that 76% of Faridas and 80% of Bahatis had access to a phone, and 62% of Faridas and 69% of Bahatis were able to use the phone how they want when they have access to it.

coverage pose a challenge, and girls living in rural with poor network coverage cannot easily get their questions answered through the USSD or call center routes.

A major challenge is that the program is not monitoring how many girls attend a clinic for follow-up services after a Kuwa Mjanja event, so it is not possible to determine the success of these follow-up strategies.

Some girls feel confident to access services in the future from a clinic, but others still fear stigma or being charged for services, raising concerns about continuity of care.

The hope is that by working with service providers from nearby facilities, Kuwa Mjanja will support sustained engagement by increasing girls' confidence to seek services from local providers. Girls are given 'next visit cards' with details of who to contact and which facilities to visit when they need more contraceptives or have any questions or concerns.

The process evaluation found that some girls felt more confident to visit a clinic after attending a Kuwa Mjanja event, because they now knew a local provider and knew what to expect. However, other girls said they were still unwilling or unable to visit a clinic, due to fears of being seen and judged by others from the community, distance from the nearest clinic, or fears that they would be asked to pay for services. These concerns are particularly acute for younger girls. Because of this, several girls and service providers expressed a wish that Kuwa Mjanja events would happen more often.

> *"Girls find it easier to go to the facility because we know we will find some nurses who can help." (Adolescent girl, Tanzania, 2018)*

> *"Most girls don't like going to the clinics. Most are concerned regarding how they would explain themselves…Some go but they are usually very afraid to go." (Adolescent girl, Tanzania, 2018)*

As Kuwa Mjanja does not train local providers and only works with them for a short period of time, girls may also not have access to a youth-friendly provider in her area. There is some concern about the longer-term consequences of providing large numbers of girls with implants (almost 95,000[19]) in contexts in areas where there are limited providers with skills to remove them. Staff and providers report that removals of long-term methods are fairly rare. However, it is not possible for the program to know how many girls wish to have their implants or intrauterine devices (IUDs) removed but are unable to access services. USSD data in early 2020 showed that almost 60% of implant users aged 15–19 were unhappy with their implants due to side effects – suggesting that some girls may be unwilling or unable to access removals when they want them.

> *"You might find that when she comes for removal, she is turned down by harsh words…told to come on the next day, or to wait until the expert provider is around. If the girl goes through that experience and goes to share with her fellows, it can become a big problem." (Service provider, Tanzania, 2020)*

[19] Overall A360 performance data, Oct 2017-Sept 2020.

3. Ethiopia

3.1. Introduction to Smart Start

In Ethiopia, Smart Start uses financial planning as an entry point to discuss contraception with newly married couples in rural areas**.** It leverages the nationwide Health Extension Worker (HEW) network to deliver services in rural kebeles across four regions,[20] augmented by a A360-recruited Smart Start team, and existing community structures such as the Women's Development Army (WDA). HEWs, with the support of PSI Smart Start Navigators, are trained to host conversations and provide services in an approachable way for rural, married adolescent girls and their husbands.

Girls and their husbands are reached through door-to-door visits and invited to attend a counseling session at home or at the local health post. Smart Start Navigators and HEWs use a visual discussion guide to provide financial and contraceptive counseling, encourage couples to consider how contraception can help them achieve their financial goals, and provide methods on-the-spot for free.

After the initial six-week implementation period, Smart Start Navigators move on to a different community, leaving HEWs and WDAs to continue implementing the program with the support of regional A360 and government staff. Through their constant presence in the community, HEWs and WDAs are able to follow up with girls regularly and support them to continue accessing contraceptive services.

Further details on Smart Start are available on the A360 website.[21] See the Smart Start User Journey (Figure 7 below) for more information on the key touchpoints within the solution.

Design and evolution of Smart Start

In early 2017 A360 prototyped seven initial concepts targeting in-school girls, unmarried adolescents in relationships, and married couples. A360 decided to prioritize married girls over the other two targets, as it proved overly challenging to design multiple systems for different segments of girls with distinct needs at once. Married girls were selected as most adolescent pregnancies in Ethiopia occur in the context of marriage.[22]

Three refined solutions were then further prototyped: Start Healthy (helping young mothers transition into motherhood), Strong Start (financial counseling sessions for young couples to help them plan their finances and family plan) and Smart Family (integrated concept where married girls or young couples received financial and health counseling information with family planning through youth extension worker). These evolved into the Smart Start concept: using financial planning as an entry point to reach young married couples, and equipping HEWs to serve married girls with tailored, nuanced materials. During later stages of prototyping in 2017 various adaptations were made to simplify the program model, including streamlining the guide for HEWs, and changing the carefully designed HEW bag (developed to ensure HEWs could carry all the relevant equipment and materials to counsel and serve girls on the spot door-to-door) to a simple 'shopper' style due to fears that the bag attracted attention and put HEWs at risk.

[20] A kebele is the smallest administrative unit in Ethiopia, equivalent to a ward or neighborhood.

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

[22] See https://www.rutgers.international/sites/rutgersorg/files/PDF/RHRN-HLPF_A4leaflet_Ethiopia.pdf

In 2018, donor priorities led to pressure to develop the most cost-effective way to implement the solutions while retaining fidelity to the design. A360 prototyped various concepts to increase cost effectiveness in Ethiopia, including a version of Smart Start without A360 Smart Start Navigators. However, a learning visit in May 2018 found that the Navigators were highly valued by the government and their role (and that of the regional A360 Adolescent Health Officers) were critical to support overburdened HEWs. As a result, these staff were retained.

During 2018 PSI identified other ways to reduce the burden on HEWs. A full adaptation design sprint with the support of IDEO.org and the global A360 team resulted in a much shorter Discussion Guide, which halved the time required by HEWs to deliver financial planning and contraceptive counselling. During the 2018 design sprint A360 also decided to formalize the role of WDAs as mobilizers, and develop low-literacy materials and procedures to support WDAs to mobilize girls and support follow up.

Smart Start was initially considered a 'silent movement' as it did not enter communities loudly promoting contraception, but instead attempted to use financial planning as an acceptable community entry point. However, the program moved away from this from 2018 after observing that Smart Start's message was generally well-received by communities, and that the community kick-off meeting was helping to build support for girls' contraceptive uptake.

Strong performance in 2018 drove the decision from the Federal Ministry of Health to expand Smart Start nationally, and discussions began between A360, CIFF and the Ministry to begin designing a follow-on program with funding from CIFF: The Roadmap for Integrating Smart Start in Ethiopia (RISE). RISE was officially launched in early 2020, and design work began to adapt Smart Start for pastoralist communities as well as in-school girls. A360 also received $1 million funding from Maverick Next from late 2018[23] to strengthen the husband engagement component of Smart Start and identify ways to link young couples of livelihoods opportunities.

Figure 6 below displays a visual timeline of key evolutions in Smart Start over the course of the A360 program.

Adaptations due to COVID-19

COVID-19 led to some disruption to service delivery in Ethiopia. Mobilization activities were significantly reduced due to limited movement, and trainings and group counseling were put on hold. While service delivery continued, it was significantly reduced due to restrictions on movement, competing priorities for HEWs, and fear among girls about going to clinics.

A360 replaced physical supervision by regional staff with remote monitoring via mobile phone. Field staff were trained on COVID-19 prevention through a combination of virtual meetings and small group sessions. Government health extension officers provided PPE and trained HEWs and WDAs on COVID-19 prevention using small group cascade training model. The government also started developing a digital Smart Start discussion guide for HEWs.

Community kick-off meetings were reduced to a maximum of four people, with COVID-19 messages incorporated and social distancing observed. Smart Start Navigators (SSNs) reported adapting their community engagement approach to focus more directly on key individuals rather than groups of community stakeholders.

In-clinic and household level counseling were adapted for safety, including through the use of remote private counseling and by incorporating COVID-19 prevention messaging into the sessions. Field team members reported inconsistencies in availability of family planning commodities, particularly implants and injections. The program responded by promoting LARCs and injections to reduce the need for more frequent resupply.

[23] See https://maverickcollective.org/wp-content/uploads/2020/03/MaverickNext_2020_Report_Final_WEB-1.pdf

Figure 6: **A360 Timeline: Smart Start (Ethiopia)**

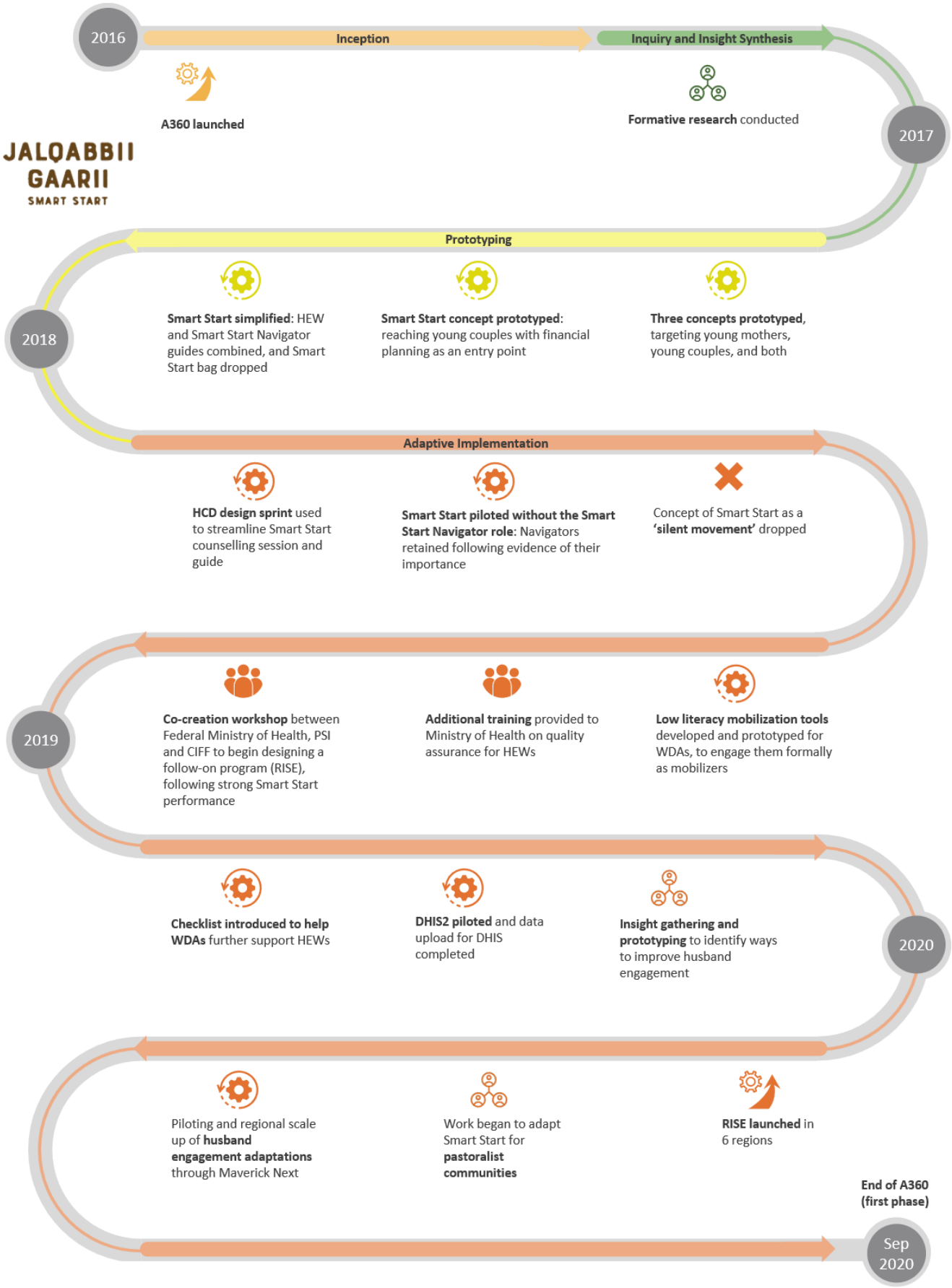
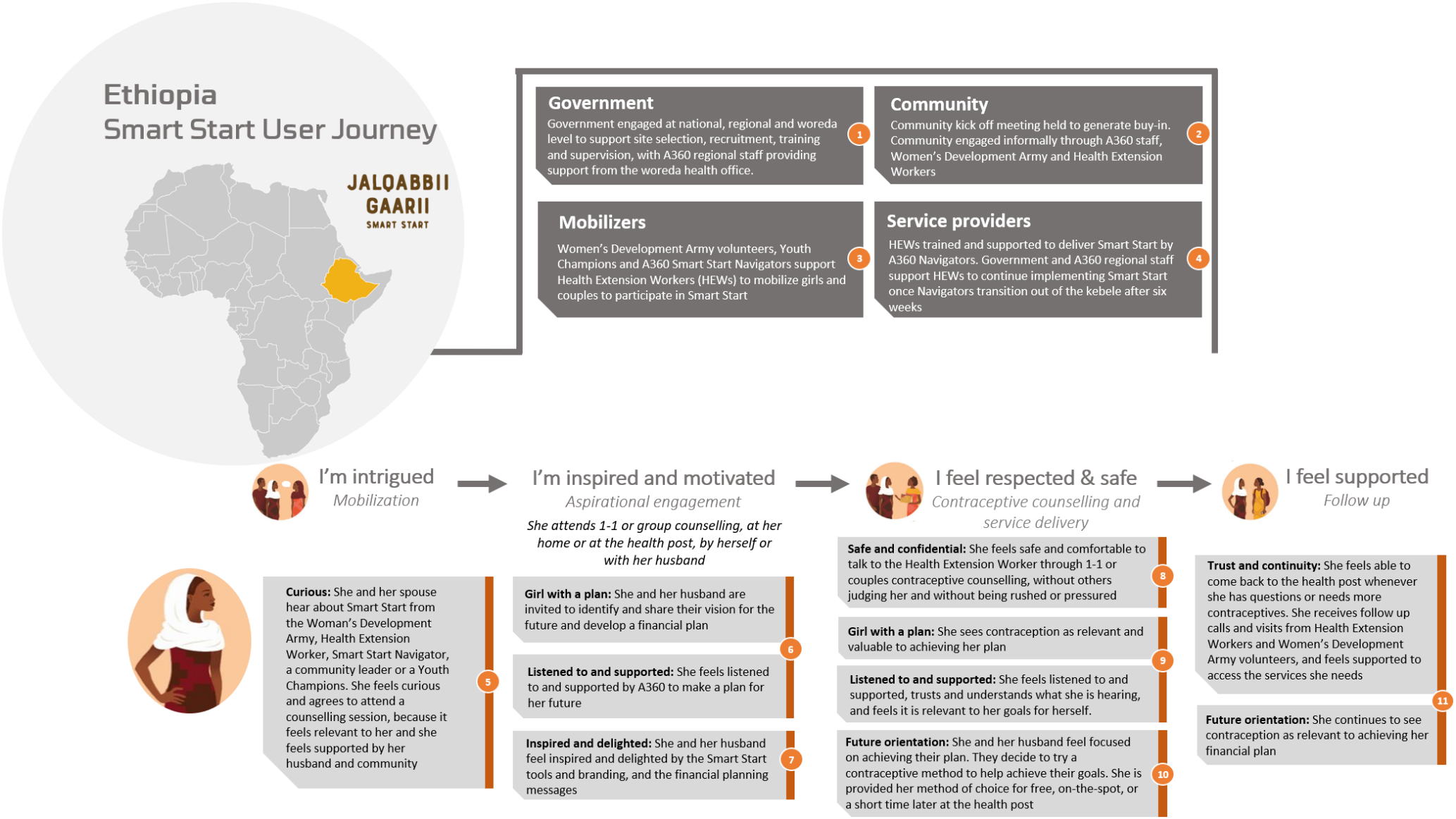


Figure 7: **Smart Start User Journey**



Mechanisms of Impact

This section presents the intended 'mechanisms of impact' underlying the Smart Start User Journey (numbers relate to the diagram above). These explain how and why Smart Start is intended to lead to change. Section 3.3 discusses whether these mechanisms were observed in practice through the process evaluation.

1 **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 stock-outs.

2 **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.

3 **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 their networks to easily reach out to girls where they are, and have influence with to husbands and mothers-in-law to help gain their support.

4 **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 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.

5 **Involving husbands** in Smart Start encourages joint decision making and acknowledges the husband as a potential key ally, using financial planning to create a new value for contraception.

Introducing Smart Start concepts through known and trusted local actors builds trust and helps ensure community acceptability.

Introducing financial planning concepts during mobilization helps position contraception as relevant and valuable, encouraging girls and their husbands to attend a counselling session.

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.

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.

8 **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.

9 **Using a Smart Start Discussion Guide 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 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 Guide resonates with girls because the pictures look like them in their rural environment, and the examples make sense in their context.

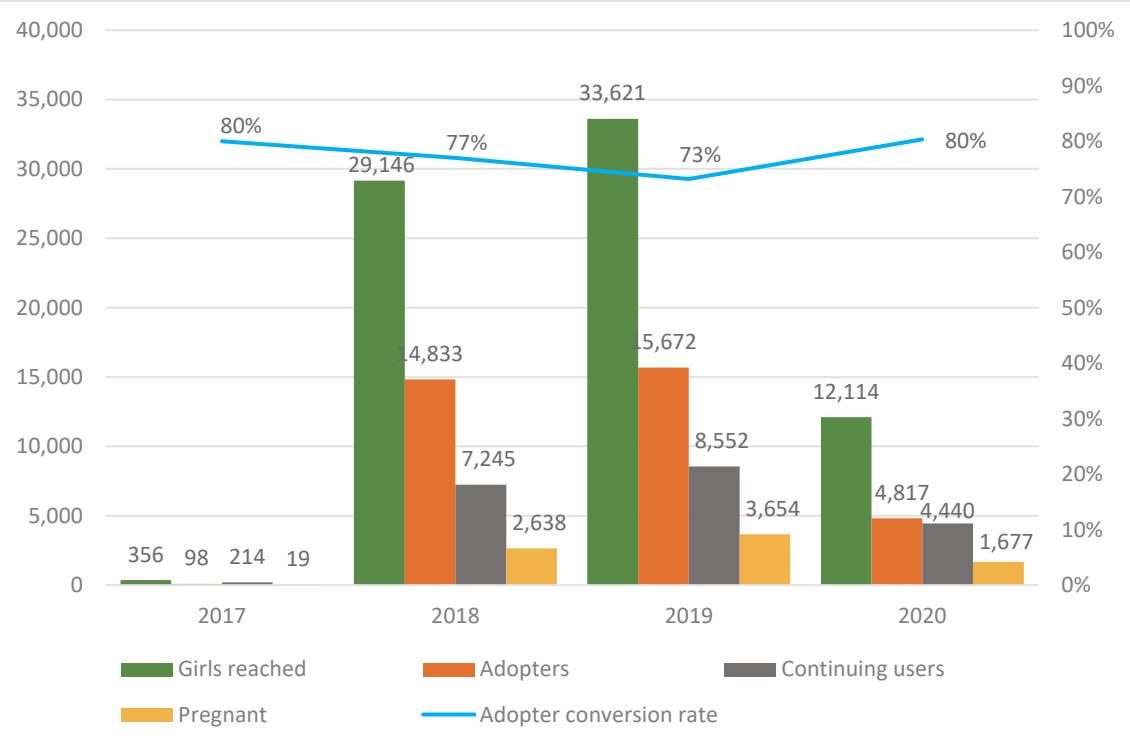
10 **Delivering girls' method of choice on the spot – including through door-to-door visits –** reduces barriers to uptake for girls and delivers contraception when and where a girl wants it.

11 **Follow up visits** help providers and WDAs build and 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 having their first child, to follow-up on goal progress, help girls access services if they desire, and ensure continued use.

3.2. Performance data

By the end of September 2020, 75,237 adolescent girls had been counselled through Smart Start, and 35,420 of these had adopted a modern contraceptive method. Overall, 76% of eligible girls (i.e. those not already using contraception or pregnant) adopted a method after attending an event. Conversion rates[24] remained relatively stable over time (see Figure 3). Smart Start in Ethiopia targets rural, married adolescent girls – a dispersed and hard to reach group, reflected in lower overall numbers compared to other solutions. Numbers in Ethiopia declined in 2020 as most sites had transitioned out of A360 and into the follow-on investment RISE. Additionally, most kebeles in target districts had been reached, and remaining kebeles tended to be nearer to town with lower unmet need for family planning, reducing the number of eligible girls.

Figure 8: **Smart Start performance data (Oct 2017 – Sept 2020)** [25]

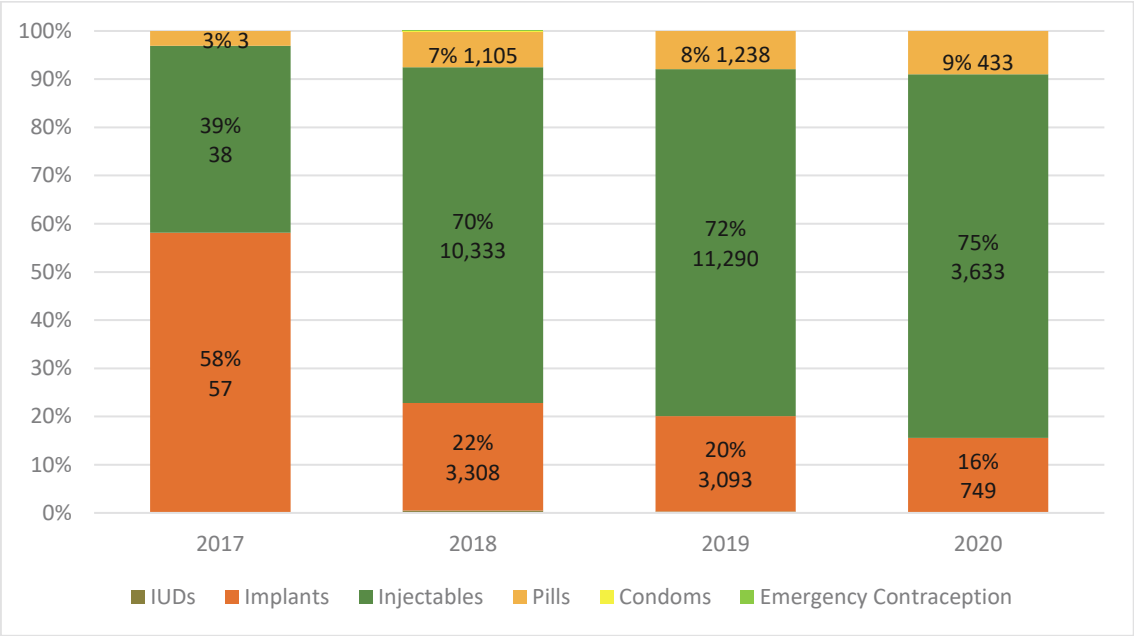


Long-acting reversible contraceptives (LARCs) accounted for 20% of methods adopted over the course of the program (see Figure 9). This is lower than the other A360 solutions. A high proportion of Smart Start adopters (71%) choose the injection – in part due to familiarity and popularity of this method in communities, and in part due to unavailability of LARCs at the health post level (not all HEWs are trained to insert and remove them, and stock-outs also frequently affect uptake).

[24] Adopter 'conversion rate': percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

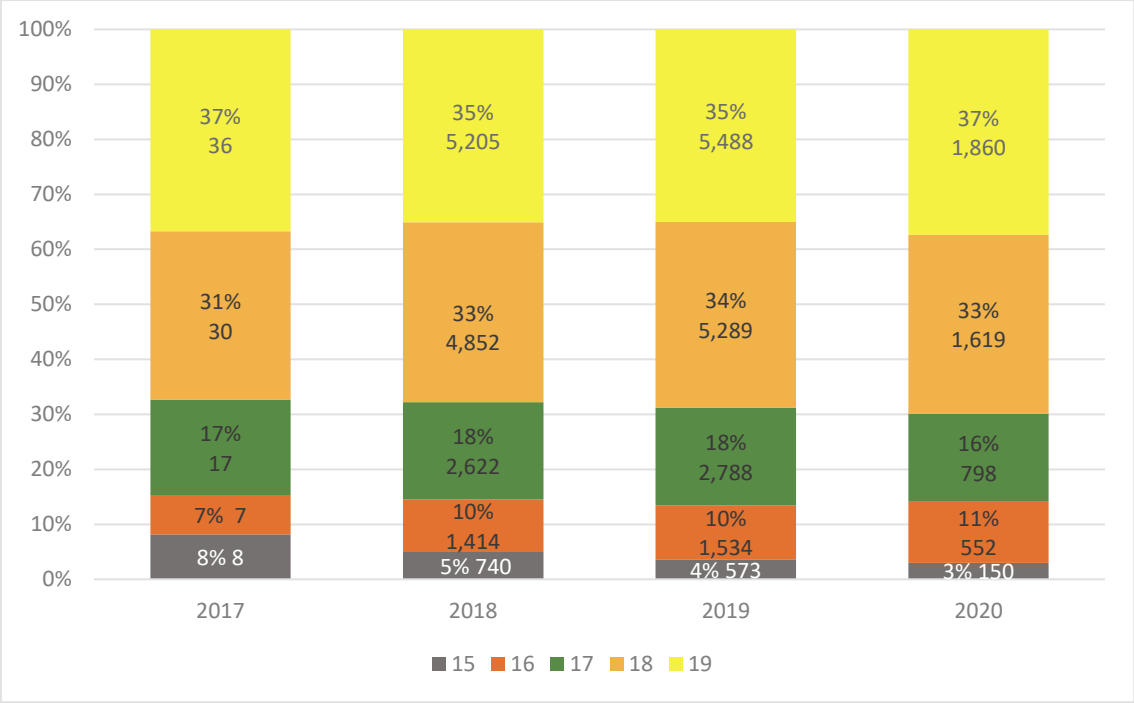
[25] Girls reached: girls counseled through Smart Start at active sites. Adopters: girls who adopt a method, who did not use modern contraception when they were last active. Continuing users: girls who were already using a method. Adopter conversion rate: percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

Figure 9: **Smart Start method mix (Oct 2017 – Sept 2020)** *Note: values under 100 not shown*



13% of adopters were aged 15-17, compared to 87% aged 18-19. The proportion of younger adopters decreased from 26% in 2018 to 11% in 2019 (see Figure 10). It is unclear what the reasons are for this shift. Independent analysis of A360 monitoring data shows an association between adoption and girls' age: 64% of 15-year-olds adopted a method compared to 75% of girls aged 19.[26]

Figure 10: **Age disaggregation of Smart Start adopters by year (Oct 2017 – Sept 2020)**



[26] LSHTM independent analysis of A360 monitoring data (June 2017-October 2019). Odds of 15-year-olds adopting a method (vs 19-year-olds) was 0.42 (95% confidence interval: 0.37-0.47). Results of a logistic regression mixed model, adjusted for data dependency between observations from the same health facility (random effect). Continuing users and pregnant girls not considered.

3.3. Process evaluation findings

This section presents key findings on the Smart Start solution in Ethiopia from the process evaluation, structured according to the User Journey model above. The findings reflect on how far Smart Start is playing out in relation to each elements of the User Journey, highlighting successes and challenges, and discussing how broader contextual factors are affecting the program.

3.3.1. Engagement with government, the health system, and key influencers

Government

A360 has successfully engaged federal government to support integration into the national health system, through demonstrating contribution to national family planning goals.

A360 has enjoyed a supportive policy environment, with family planning viewed as a 'top priority' at the federal government level in the Ministry of Health (MoH). The government has invested significantly in SRH over the past 20 years, and more recently there has been increasing recognition of the need to reach adolescents in order tackle teenage pregnancy rates. A360's effective communication of its strong results has been important to maintaining buy-in, demonstrating how Smart Start contributes to various MoH priorities and objectives. The integration of financial planning messaging with contraceptive counseling is widely appreciated by government stakeholders.

> *"Reducing teenage pregnancy from the current 13% to 3% by 2020 is our major goal. To achieve this goal, the Smart Start approach would increase access to and use of modern contraceptive among adolescents reducing teenage pregnancy...and maternal and child mortality associated from teen pregnancy and birth." (National government stakeholder, Ethiopia, 2017)*

Initially, A360 struggled to engage the Federal Ministry of Health during the design phase, due to some scepticism about the HCD process. High profile donor visits have helped bolster national government buy in, along with the support of a high-level government champion who became an advocate for Smart Start and influenced regional health bureaus. A360 staff feel this champion bought into the program despite initial scepticism after hearing directly from young designers, highlighting the value of youth advocacy.

Buy-in and ownership of the program at woreda and kebele level has improved over the years but there are still gaps.

In general, regional and woreda level government have been supportive. Over the course of the program Smart Start has increasingly integrated into the daily work of health officers who help select kebeles, participate in monitoring, supervision and program activities, and are responsible for supervising HEWs after the program transitions out. Stationing regional A360 staff in woreda health offices has also helped support buy in, with staff helping to trouble-shoot issues when they arise.

> *"We include this program in our daily health activities. It is our regular jobs, merged into our daily planning and evaluation activities. It is highly welcomed by our office and considered as an opportunity to further improve public health status." (Woreda government official, Ethiopia, 2019)*

However, local government officials are faced with many competing priorities. High turnover, budget constraints and poor communication between government departments and levels all constrain program ownership and buy in – as well as hinder the work of A360 staff stationed in their offices. Many HEWs felt they were not receiving sufficient support from woreda officials

after the program transitions out: *"They only talk to us about Smart Start during the six-month review meeting."* PSI staff at the woreda level are frequently too busy and oversee too many kebeles to offer much hands-on support. Smart Start has not yet been fully integrated into health reporting systems, meaning the program has been unable to accurately monitor how many girls are reached after Smart Start Navigators transition out of kebeles.

> *"Kebeles are far apart, infrastructure is not that developed, and field staff don't have computers or motorcycles. The assumption was that woreda health offices would provide these…but it's different from place to place. In some places they are invested and in others they are not. It has created unease and dissatisfaction among the field team." (A360 national staff member, Ethiopia, 2019)*

The health system

A360 has successfully integrated into the Health Extension Program, allowing it to access hard-to-reach rural girls, and influencing Health Extension Workers to view girls as potential clients.

The Ethiopian Health Extension Program (HEP) was launched in 2004 and has been a significant driver of increased family planning access in Ethiopia. Maternal and child health has been a key priority for the HEP, and the government has increasingly promoted long-acting methods. The decision was made to integrate Smart Start into the HEP from the design phase – at the time, this was considered risky given acknowledged capacity gaps and challenges, and the fact that the first phase of the HEP was due to expire before A360 ended. However, there were no other viable service delivery channels to reach rural married girls, and the decision has paid off. The second generation of the HEP was announced in 2019, helping secure the future of Smart Start.

The decision to link in to the HEP from the outset has proved both strategic and sustainable, allowing A360 to successfully scale up, and reach rural communities through existing local health providers who are widely known and trusted. It has also allowed the program to leverage annual immunization and malaria interventions, which require house to house visits, as additional avenues to reach married girls.

> *"We are well respected and accepted by the community. We approach women in the community like our friends, they don't fear to share their secrets with us. In my opinion approaching the community with the health extension workers is a wise decision. This program made the right choice to involve us in this program." (Health Extension Worker, Ethiopia, 2017)*

The process evaluation suggests that Smart Start is changing HEW attitudes around delivering contraception to adolescent girls. Many HEWs reported that they had previously not considered recently married girls as potential clients, due to community norms that expect girls to have a baby soon after marriage. Many were happy that Smart Start had 'opened their eyes' to the needs of girls and were satisfied that they were helping to prevent maternal mortality and complications such as fistula. The Smart Start messaging – that contraception helps young people manage their incomes better and avoid poverty – has also resonated with HEWs, and many interviewed for the process evaluation talked about how they appreciate the visual counseling manual and how easy it is to use.

> *"The training reminds me to give due attention to adolescents…we think we are very familiar with family planning since it is included in the health extension package. But frankly speaking this program is totally new to us. I*

> *realize that I didn't give due attention for adolescents at this age group though they are at high risk." (Health Extension Worker, Ethiopia, 2017)*

However, the Health Extension Program is overstretched and Health Extension Workers overworked, posing major challenges especially after A360 staff transition out of communities.

Throughout the four years of the program, a persistent concern among government and health worker stakeholders has been that HEWs are overworked, with ever-increasing responsibilities, and A360 represents one more package of health services to deliver. Workload fluctuates by season and is particularly acute in the dry season when HEWs do more door-to-door visits. This can lead to fatigue and burnout.

> *"You know everything on earth with regards to community health seems left for HEWs alone." (Health Extension Worker, Ethiopia, 2018)*

The program has attempted to support HEWs as much as possible to minimize the burden on them – particularly through stationing A360 Smart Start Navigators in communities to work alongside HEWs for the first six weeks, while Adolescent Health Officers at woreda levels continue to provide remote support thereafter. The program has also reduced the length of the counseling guide by half, following consistent feedback from HEWs and girls that the counseling was taking too long, and the WDA has been increasingly enlisted to support HEWs with mobilization and follow-up (discussed further below). Most HEWs interviewed for the process evaluation were supportive of the program despite concerns about their workload, motivated by their desire and sense of responsibility to serve their communities.

However, there have been concerns from HEWs and others that the training received (a two-day course run by PSI prior to the program's launch in a new kebele) is not sufficient for HEWs to feel fully confident in delivering the counseling, especially the financial planning component. The training aims to build on HEWs' existing knowledge of family planning and contraceptive methods counseling but may not be sufficient if there are weaknesses in existing knowledge and capacity.

The A360 Smart Start Navigator role has been a key enabler across Ethiopia, and there are some concerns about the impact on the follow-up program once they are phased out.

Across much of Ethiopia the SSN has been a key enabler, viewed as a critical 'extra pair of hands' to support the initial implementation of the program – including door to door mobilization and financial planning counseling. Many are highly committed, walking for hours a day to reach kebeles due to a lack of transport. HEWs interviewed for the process evaluation very much appreciated the support and presence of the SSNs and felt that working together with the SSN helped cement the lessons from the training. A360's cost analysis of SSNs during the optimization phase found their role important and highly valued by government. Monitoring data also shows that SSNs play an essential mobilization role during the six-week implementation period – mobilizing almost 40% of girls in the states where SSNs are present.[27]

Amhara is the only region where SSNs have not been engaged, as the regional government did not want an additional role in their health system structure. Monitoring data shows that this has not affected performance – adoption rates are higher in Amhara than in other regions. However, the HEP is considered particularly strong in this region, with regional government focused on tackling high levels of early marriage. There is also some evidence to suggest that HEWs in Amhara may not be implementing the program as faithfully as those in Oromia (the main study region for the process and outcome evaluation). Process evaluation

[27] LSHTM independent analysis of A360 monitoring data (June 2017-October 2019).

data from a case study in 2019[28] suggests that financial planning counseling may be less effective, with more emphasis on child spacing (a message that HEWs are more familiar with); and monitoring data shows that husbands are less likely to participate in counseling with their wives in Amhara than in other regions.[29]

Other health system weaknesses pose challenges to continuation and method of choice.

Stock-outs and shortages of consumables and commodities have frequently posed a challenge for the program. While A360 staff (particularly at the regional level) have worked closely with government in the attempt to mitigate and address these challenges, this has limited the methods available for girls to choose from. In some cases, LARCs are not available at the health post, requiring girls to travel to a health center – possibly contributing to the high take up of injectables. This is in part because only senior HEWs are trained to insert implants, while removals can only happen at a health center. Access to health centers is often challenging for girls, particularly in the rainy season given poor road networks.

Communities and influencers

Early marriage and cultural norms around the need to prove fertility are major drivers of early pregnancy in rural Ethiopia, but family planning for older women has become increasingly normalized.

In Ethiopia, 17% of girls in Ethiopia are married before age 18, and while outlawing child marriage has increased marital age it has not reduced childbearing before 20. [30] The widespread norm is for newly-married girls to conceive straightaway – to prove fertility, and also to 'bind' the husband to prevent separation or divorce. Pressure for girls to get pregnant immediately is often particularly acute from in-laws, and family planning is generally not at all encouraged until a girl has her first child. This is also linked to persistent fears that contraception can cause infertility and other problems for girls. The odds of adoption through A360 for girls with children was 1.9 times those of girls without children, which is strongly linked to these social norms.[31]

Awareness and acceptance of family planning in general has increased in recent years, as the government has expanded community health provision and provided free family planning services through the HEP. This has helped to create a norm for family planning and child spacing for older, married women, which A360 has attempted to build on.

Nonetheless, stigma around family planning is still a barrier, with religious values often viewed in opposition to contraceptive use in some areas. Stigma and resistance to family planning is higher in more remote communities, which have less exposure to the HEP and poorer access to health facilities. Politicization is also an issue in some areas, particularly Amhara, where opposition politicians have framed family planning as a government strategy to reduce population size among particular ethnic groups. This has increased rumours and

[28] Melanie Punton, Abrehet Gebremedhin, and Mary Lagaay, "The A360 Journey: How Are Girls in Nigeria and Ethiopia Experiencing A360, and What Factors Affect Whether They Continue or Discontinue Contraception?" (Brighton, 2019), https://www.itad.com/knowledge-product/the-a360-journey/.

[29] Only 17% of girls are counseled with their husband in Amhara, compared to 41% in Oromia and 27% in SNNPR. Only 10% of girls are counseled with their husbands in Tigray. LSHTM independent analysis of A360 monitoring data (June 2017-October 2019).

[30] UNFPA, "Adolescents and Youth Dashboard - Ethiopia," 2020, https://www.unfpa.org/data/adolescent-youth/ET; CSA Ethiopia, "Ethiopia Demographic and Health Survey," July 1, 2016, https://dhsprogram.com/publications/publication-FR328-DHS-Final-Reports.cfm.

[31] LSHTM independent analysis of A360 monitoring data (June 2017-October 2019). 95% confidence interval: 1.8–2.0. Results of a logistic regression mixed model, adjusted for age and for data dependency between observations from the same health facility (random effect). Continuing users and pregnant girls were not considered.

misinformation about family planning, often spread through social media, which reinforces community stigma.

Married girls lack autonomy to make their own decisions about contraception, and so engaging husbands is a key cornerstone of Smart Start – but has persistently proved challenging.

Husbands are generally seen as the primary decision makers on family planning, and girls are unable to make decisions about whether to adopt a method without their husband's consent. A360 designed Smart Start from the beginning to involve husbands, designing a model based around couples' counseling. Girls interviewed for the process evaluation generally preferred attending counseling with their husbands, in recognition of their decision-making role, and in some cases to help convince them of the value of contraception. Girls were 1.6 times more likely to adopt a method when accompanied by their husbands,[32] with 57% of girls counseled with their husbands adopting a method compared to 45% of girls counseled alone (see Table 5).

Table 1 – Counseling outcome by inclusion of husband (June 2017- Oct 2019)

Counseling outcome		Discussion includes husband		Total
		No	Yes	
Adopter	n	18,523	9,148	27,671
	%	45.15%	56.92%	48%
Continuer	n	10,686	2,983	13,669
	%	26.05%	18.56%	24%
Pregnant	n	3,774	1,836	5,610
	%	9.2%	11.42%	10%
Non-Adopter	n	8,043	2,104	10,147
	%	19.6%	13.09%	18%
Total		**41,026**	**16,071**	**57,097**

Where the program has been able to engage husbands, it has been successful in countering misconceptions around contraception. This is helped by widespread recognition of the authority and knowledge of the HEWs.

> *"At the beginning I hated Smart Start because I assumed that I will never get children once we start using contraception. I was not interested at the beginning. But later, after getting more information during training and looking its benefits my feeling is changed and I became interested on using contraception. Now I trust the HEWs." (Husband, Ethiopia, 2020)*

However, it has been consistently challenging to reach husbands, who are often working away from the home during house-to-house visits. In some communities, men frequently migrate for work for months at a time. Some husbands have also been unwilling to engage in conversations about family planning. There are also some concerns that husband engagement risks undermining girls' agency – observations of counseling sessions suggested it limit girls' time and space to speak and ask questions, with husbands dominating discussions and receiving more attention from the provider.

[32] 95% confidence interval: 1.5–1.7. Results of a logistic regression mixed model, adjusted for data dependency between observations from the same health facility (random effect). Data from LSHTM independent analysis of A360 monitoring data (June 2017-October 2019)

The program has not routinely engaged mothers-in-law, who often put pressure on young couples to start a family quickly.

While mothers-in-law are sometimes reached through door-to-door mobilization, this is not done systematically. Pressure to conceive can be acute – in some areas interview respondents told stories of husbands' relatives threatening violence on couples who use family planning before having a child. The process evaluation has found that girls are often able to resist pressure from in-laws to conceive if husbands are supportive of contraception, but in-laws have more influence when couples are living with them or reliant on them for income.

However, some mothers-in-law reported feeling motivated to support the program because they identified with the challenges girls faced, highlighting their own struggles with childbearing and financial hardship when they were younger.

> *"For us, it has been truly enlightening! I only wish this program had come to me when I was young. I would not have had four children. … I had to go through a lot of misery and challenge to raise my children. Now I know I didn't have to go through all that pain." (Mother-in-law, Ethiopia, 2020)*

There is some evidence that A360 has helped increase acceptability of adolescent contraceptive use, through connecting it to financial security and working with community influencers.

Smart Start was initially framed as a 'silent movement', as it did not enter communities loudly promoting contraception and asking for widespread support, but instead using financial planning as an acceptable community entry point with young people. There has been a move away from this as the program scaled, due to the larger than expected impact of the community kick off meeting, held in kebeles before the start of program activities. Although small in scope (with 30-40 participants), these meetings have proved a valuable mechanism to introduce the concept of contraception as a tool to keep girls safe and help couples achieve financial security. The meetings are informal and interactive, attended by kebele and religious leaders, WDAs, A360 and woreda health staff, and occasionally mothers in law. However, there have been some complaints that the meetings do not reach wider members of the community. Towards the end of the program, Smart Start began to experiment with utilizing existing community platforms and gatherings such as forums to cascade information and reach husbands, for example vaccination and nutrition days.

> *"The community kick-off had a bigger impact than expected. It was not fair to call it 'silent'. It resonated with the community, they appreciated that we met with them, it resulted in them referring girls…so we shifted how we branded it…There was more appetite for this conversation than we thought, we didn't have to be as silent as we thought. We have not shifted to making a direct ask to speak out in favor of family planning… [our ask is] this is an important conversation, let us have it, so your young people can have the lives that they want." (A360 staff member, Ethiopia, 2019)*

Engaging kebele leaders, community elders, and increasingly WDAs has been key to securing support within communities. These stakeholders are viewed as important influencers on husbands. Kebele leaders help mobilize community members for the kick-off meeting, and generally work to share information about the program and build community buy-in. They also support mobilization, sometimes accompanying HEWs to reach girls at their homes. Smart Start directly engages these leaders right from the beginning of working in a new kebele,

drawing on the authority of woreda-level government officials to gain an entry point with them.

> *"As a community leader I support HEWs during meetings and during home-to-home counseling… I accompany them and participate in convincing family members by telling them that it is not by number of children you are blessed in front of God, but by the way you nurtured them during their childhood." (Community leader, Ethiopia, 2020).*

Through these mechanisms, Smart Start has succeeded in tapping into community concerns about resource availability and building on existing norms around family planning. Many community members mentioned concerns about lack of resources, land and economic opportunities, driving migration and a desire for smaller families. Smart Start messaging around financial planning has resonated strongly, tapping into the community aspirations for young couples to have a better life, and to ensure that children grow up strong and healthy through their parents having sufficient income to provide for them. Linking family planning to financial planning is thus helping A360 to widen the window of acceptability for family planning to include girls.

> *"Our family will encourage us to come attend [Smart Start]. Because our family don't want us to live the kind of life they are living. They want us to live a better life." – Adolescent girl, Ethiopia, 2019*

Connecting contraceptives to maternal health has also helped increase acceptance among husbands and mothers-in-law, with HEWs often emphasizing the dangers of maternal mortality and fistula when girls give birth at a young age.

In the final year of the process evaluation, almost every community stakeholder interviewed said that they believed Smart Start had increased community support for family planning practices – not just for girls, but also in general – and felt that this had increased use of contraception, decreased stigma and the need for women to hide contraceptive use, and led to greater openness in the community to discuss family planning and sexual and reproductive health. However, changing deep-seated attitudes is a slow process, and the program still faces resistance in some communities – in some cases staff are unable to stay in an area as a consequence, and WDAs and HEWs sometimes face hostility and abuse from girls' husbands and relatives. The program is beginning to reach pastoralist communities, which pose greater challenges for community engagement, due to high levels of stigma and difficulties sustaining engagement given that community members move frequently. Kebele selection criteria for pastoralist communities have been adapted to consider seasonal migration of community members.

> *"There is a big change compared to the past. Previously family planning use was perceived [to be for] those who are married, or some of them thought it is shameful when you talk about family planning. But now when you go to the rural area and talk about family planning everybody knows about it." (Woreda government official, Ethiopia, 2020)*

3.3.2. Girls' journeys through Smart Start

Mobilization

Engaging community structures has been central to helping the program reach girls through time-intensive house-to-house visits.

Married rural girls aged 15-19 in Ethiopia are a hard-to-reach group. There are relatively small numbers in any given community, often dispersed across large areas. This has made house-to-house mobilization essential in order to reach these girls, although it is very labor-intensive, and particularly challenging in the rainy season or where villages within a kebele are very dispersed.

Girls frequently expressed appreciation for being visited in their own homes given their heavy workloads. This approach also allows the program to attempt to reach husbands and other family members, which the process evaluation suggests can be a valuable opportunity to enlist the support of key influencers. However, husbands are frequently out of the house during visits, which has been a persistent challenge for A360. In the final stage of the program, implementers experimented with conducting house visits very early in the morning before husbands left for work, and attempted to improve reach through enlisting the support of WDAs who are able to reach husbands outside of work hours.

The Women's Development Army (WDA) has proved particularly critical to mobilization as Smart Start scaled.

The WDA is a national structure established by the Federal Ministry of Health in around 2011, consisting of (unpaid) volunteer women who support various government development programs in their communities.[33] WDA volunteers have taken on an increasingly central role within the program over time. This group was not initially part of the intervention design, due to fears that older married women may not be the right demographic to connect with younger married girls. However, during the prototyping and pilot stages, WDAs were often informally supporting HEWs with mobilization, and mediating with husbands to encourage them to attend counseling. Their knowledge of the community is frequently superior to that of HEWs (who are often from outside the area), and they can draw on this to identify girls who have recently got married or engaged, also supported by the decentralized structure which allows WDAs to focus on the small number of households within their designated area.

> *"You can consider the WDAs as our eyes and ears in the community! We would not have been able to do our jobs at all without them. How else would we have been able to reach the girls amidst seven thousand residents?" (Health Extension Worker, Ethiopia, 2020)*

In 2018, A360 formalized the role of WDAs in the program and developed low literacy materials to support them to talk to girls about Smart Start. The fieldwork suggests that WDAs are well known and respected in the communities, and are able to connect with girls through sharing their personal stories – their motivation for helping girls avoid the challenges they have faced themselves. As of October 2019, 37% of all girls counselled by A360 were mobilized by WDAs,[34] and A360 plans to further embed and expand the role of WDAs in the next phase of the program.

> *"When the girls aged fifteen to nineteen years get married at an early age I don't want them to go through the challenges I had faced before. I was very happy when I first heard about the program." (WDA volunteer, 2019)*

However, the WDA structure is more active in some locations than others, and there are significant variations in levels of motivation and understanding of A360. Several stakeholders

[33] Kiddus Yitbarek, Gelila Abraham, and Sudhakar Morankar, "Contribution of Women's Development Army to Maternal and Child Health in Ethiopia: A Systematic Review of Evidence," *BMJ Open* (BMJ Publishing Group, May 1, 2019), https://doi.org/10.1136/bmjopen-2018-025937.

[34] LSHTM independent analysis of A360 monitoring data (June 2017-October 2019)

have expressed concerns about dissatisfaction due to a lack of stipends, as WDA members are often used to receiving an allowance for supporting activities within other projects. The workload of WDA members is also increasing, as the government has been expanding their role to support the HEP and reduce HEW workloads, which raises some concerns for sustainability as the next phase of A360 relies heavily on WDAs. HEWs felt that WDA members could become significantly more committed to Smart Start if they were supported with training, leadership and a small transport or food allowance. There are also some gender and equity concerns given that the future of A360 relies heavily on the labor of overworked women who are often experiencing deprivation and hardship.[35]

Girls were convinced to attend counseling for a number of reasons – including curiosity about financial planning, interest in family planning, and general trust and familiarity with the HEW.

A PSI learning visit found that getting the WDAs to introduce Smart Start to girls during mobilization acts as a 'useful first touchpoint', allowing HEWs to 'jump right into a counseling session.' Interviews suggest that the financial planning messaging resonates with girls during their first contact, particularly the concept of building assets before having children. However, this is not always the main reason for girls agreeing to counseling – in many cases they are happy to accept an invitation to attend the health post to receive education from the HEW, as something they are used to in their communities, and given their existing trust and familiarity with the HEW.

> *"I first heard about Smart Start from the HEWs. They came to our place with a WDA and gathered us from our houses to attend the meeting held in a place next to me. When I heard it was regarding family planning I was amazed, found the conversation interesting and immediately talked to my husband about it." (Adolescent girl, Ethiopia, 2020)*

Youth mobilizers have been less successful in Ethiopia than in other countries – but word of mouth among young people has helped raise awareness of the program.

The 'youth champion' role has played a minor part in the program, mobilizing under 3% of girls as of October 2019.[36] The role is relatively informal – SSNs and HEWs identify young people who are particularly enthusiastic about the program and ask them to take up the champion role, helping to spread the word about the programme among other young people. There are generally only one or two champions per community, and the role is voluntary without any compensation or formal training. PSI staff felt that Champions are less successful at mobilization than WDAs because they are not a pre-established structure, and because they tend to move away for work.

Word of mouth in communities has also helped encourage couples to participate in the program. Several husbands interviewed for the process evaluation said that they actively discussed and promoted Smart Start and family planning with their friends and neighbors.

Aspirational engagement

[35] Kenneth Maes et al., "Volunteers in Ethiopia's Women's Development Army Are More Deprived and Distressed than Their Neighbors: Cross-Sectional Survey Data from Rural Ethiopia," *BMC Public Health* 18, no. 1 (February 14, 2018): 258, https://doi.org/10.1186/s12889-018-5159-5.

[36] LSHTM independent analysis of A360 monitoring data (June 2017-October 2019)

The Smart Start messaging is raising awareness and shifting attitudes towards contraception, through helping girls and husbands see how it can help them improve their financial security and reach their goals.

The process evaluation consistently found that the financial planning messaging resonates strongly with girls and their husbands, when they participate, and helps to show the relevance of contraception. Many girls and husbands described the counseling changing their minds about when to have a baby, through highlighting the importance of building assets and spacing pregnancies in order to increase economic security and give their children a better life. For some husbands, these messages tapped into existing concerns about financial security. The visual discussion aids, including goal cards and the 'baby calculator' (a visual that shows how much it costs to raise a child in terms of sacks of grain) have also resonated with girls, and helped them understand the concept of financial planning and its links to contraception.

> *"She showed us that the child who didn't get enough to eat got skinny and weak and the one who got enough to eat got bigger and healthy… I thought, I never want to go through that kind of thing. I was certain. So, I started using the three year [method]." (Adolescent girl, Ethiopia, 2019)*

Many girls and husbands discussed the financial plans they had made following the counseling, and in several cases talked about concrete changes they had made as a result – for example, starting new businesses, beginning to save, or continuing formal education. However, some stakeholders (including several girls) requested that Smart Start's aspirational education be connected to economic empowerment schemes such as livelihoods training, income generating activities or small-business grants.

> *"She taught me about family planning and how to plan for future life. Following that advice, I started using the implant, after that I am now saving 300 birr a month. After I save the money I want, I will start my own business breeding chickens. Then after I fulfil all this, I want to add one more child." (Adolescent girl, Ethiopia, 2019)*

HEW capacity to deliver the aspirational components remains a concern, with the fidelity of financial planning counseling at risk once SSNs transition out of kebeles.

The process evaluation has found that the SSN is often largely responsible for the financial counseling component of the intervention during the six-week launch period, while the HEW focuses on delivering the family planning education component. Interviews and observations suggest that HEWs often lack confidence in delivering the financial planning counseling component, after the relatively short training. This has raised some concerns that HEWs are not getting sufficient opportunities to build their skills and confidence before the SSN leaves, and about the fidelity and sustainability of the counseling in the longer term. Although there is limited process evaluation data from Amhara (where SSNs are not part of the model), a visit to one community in 2019 suggested that girls were less clear on the financial planning component, and less excited and motivated in achieving their financial plans – potentially reflecting a lower level of capacity among HEWs to deliver the counseling.

Contraceptive counseling and adoption

Counseling is helping to increase awareness of contraception and its benefits among adolescent girls, and to dispel fears and misconceptions to some extent.

Several girls interviewed for the process evaluation said they had never heard about family planning before attending Smart Start counseling, while others had not previously seen it as

relevant to them. As well as the strong connection between financial planning and contraception discussed above, some girls and husbands also mentioned learning about the health risks of giving birth at an early age, which influenced their decision to delay pregnancy.

Generally, girls described learning about a range of different methods, and being told about their advantages and disadvantages. Many girls and husbands reported that their fears about contraception causing infertility or other harmful side effects had been allayed by the counseling. However, after the counseling some misconceptions still remain, for example, fears about particular methods. Process evaluation research conducted in 2019 found that this can contribute to discontinuation, when girls experience side effects with their first choice of method and do not feel comfortable with any of the other methods available to them.[37]

> *"I was also very happy when I hear[d] that the family planning will not affect our fertility in the future though we start taking it before having a child." (Adolescent girl, Ethiopia, 2017)*

HEWs are not always counseling girls accurately about side effects, and often express bias towards or against particular methods.

The process evaluation has found that girls are not always fully informed about side effects by the HEW, and sometimes were told that some methods have no side effects. This can cause particular concern to girls who adopt a method and then experience changes to their menstruation, potentially leading to discontinuation.

Other girls were provided inaccurate information about particular methods that perpetuated fears and misconceptions. For example, some girls reported being warned that the injection would 'dry their blood' or affect their bones, or that condoms would affect the uterus.

> *[Interviewer] "Did she tell you about the side effects?" [Girl] "No, but she told me if you forget to get the implant removed on time it might change it to cancer." (Adolescent girl, Ethiopia, 2019)*

The process evaluation has also found that girls are sometimes encouraged by the HEW to adopt specific methods over others, particularly the implant, which is sometimes positioned as 'the least harmful' method, or the best to avoid unintentional pregnancy. One driver of this appears to be the concern that the injection can delay return to fertility. Another factor may be the continued influence of previous quota system (now discontinued) put in place by the Government of Ethiopia to boost LARCs, in which HEWs were rewarded for providing certain methods including the implant.

The process evaluation has found that husbands' fears and concerns around side effects are a driver of discontinuation in Ethiopia, with some husbands encouraging their wives to stop using a method given concerns about their health. A360 have been prototyping husband engagement tools for the A360 follow on program and have found that misconceptions and fears among husbands can be alleviated by helping husbands better understand contraceptive methods. This includes providing the methods for husbands to see and touch.

Girls generally feel safe and comfortable during counseling, and trust the information provided by the HEW. However, there are some concerns about privacy and confidentiality when counseling takes place in groups or in the presence of relatives.

[37] Punton, Gebremedhin, and Lagaay, "The A360 Journey: How Are Girls in Nigeria and Ethiopia Experiencing A360, and What Factors Affect Whether They Continue or Discontinue Contraception?"

Most girls interviewed for the process evaluation were happy with the counseling and felt safe and supported by the HEW as they knew and trusted her and felt comfortable to ask questions. When interviewed for the process evaluation the husbands who did take part in counseling stated that they also trusted the HEW and appreciated learning new insights about the benefits of contraception.

Smart Start counseling is delivered flexibly, in girls' homes or at the health post or another community location; sometimes one-to-one and sometimes delivered in groups. Many HEWs prefer to provide counseling in groups to allow them to reach more girls at a time. Most (but not all) girls interviewed for the process evaluation were happy to receive counseling in groups, and said they were comfortable asking questions in the presence of other girls and liked the opportunity to hear about their experiences. However, the process evaluation has also found that that (contrary to guidance) contraceptive counseling as well as financial counseling sometimes takes place in group settings or in the presence of in-laws, which violates girls' privacy and raises concerns around confidentiality and consent. The odds of adoption were slightly greater among girls counselled one-to-one or in couples, compared to those counselled in groups.[38]

Where girls are counseled away from the health post or without their husbands present, they do not always access contraception 'on the spot.'

The initial intention was for girls to be able to access methods 'on the spot', whether or not counseling took place in a health post. However, in practice this does not always happen, presenting some barriers to adoption.

When conducting education in the community, SSNs and HEWs reported that they sometimes take short term methods with them so they can be delivered straight away, particularly the injectable. However, girls are often instructed to attend the health post, particularly to receive long-term methods. In general, this was not viewed as a problem by girls interviewed for the process evaluation, who were used to attending the health post and happy to do so; but girls who live further away may face more serious obstacles.

Where girls are counseled without their husbands contraception is often not provided on the spot, as they often wish to consult with husbands before deciding to adopt. In kebeles where husbands frequently migrate for work, many girls are not willing to adopt a method in their husband's absence, due to the prevalent belief that girls who do so are unfaithful or more at risk of sexual assault. This puts girls at risk of unwanted pregnancy, especially when their husbands return at short notice, and is also a driver of discontinuation. Some girls mentioned that they had not returned for their follow up appointment because their husband was now away.

The method mix in Ethiopia skews heavily towards injectables (see Figure 9), influenced by familiarity, myths and misconceptions, and availability of stocks at the health post.

Interviews with girls and service providers suggest that many girls choose the injectable because they are already familiar with it and know others who use it in their communities. Availability and stock-outs also affect method choice, and girls are sometimes referred to health centers to receive an implant, as not all HEWs are qualified to insert them (and removals must take place at a health center). In 2020, the proportion of implants adopted increased from 8% to 21% between April and June, which staff attributed to the consistent

[38] Odds ratio of adoption through an individual or couple counseling session vs a group session: 1.2 (95% confidence interval: 1.1–1.3). Results of a logistic regression mixed model, adjusted for data dependency between observations from the same health facility (random effect). Continuing users and pregnant girls not considered. Data from LSHTM independent analysis of A360 monitoring data (June 2017-October 2019)

restocking of LARCs in A360 sites, before declining again due to stockouts and medical supply shortages in some regions.[39]

> *"What we are finding is that the method choice is so limited, it is more a question of contraception or not (injection or implant) and what they pick is more dependent on what is popular in the community…We could do a lot more about explaining methods, but we know that they had to go far to access different methods." (A360 national staff member, Ethiopia, 2019)*

Follow-up

Most girls interviewed for the process evaluation felt comfortable returning to the health post and reaching out to the HEW with questions or concerns. In many cases, HEWs and WDAs follow up in person, enabled by their consistent presence in communities.

Girls reported being encouraged by HEWs to return to the health post if they have questions, concerns, or require additional contraception, and were aware that support and advice was readily available. This ongoing relationship is possible because of HEWs' permanent positions in communities, where they are known and trusted. The health post is a familiar and consistent point of contact in kebeles, and several girls interviewed for the process evaluation had returned to ask about concerns they had about side effects. Goal cards with next-appointment information help encourage girls to return, and in general HEWs felt that girls were committed to attending appointments. The process evaluation did not flag any concerns about stigma in relation to girls attending the health post, as being seen by others to visit the health post is very commonplace.

HEWs often check their registers to see which girls have come for follow-up appointments, and phone or visit girls to check in. HEWs also frequently give girls their phone numbers for girls to call if they have questions. Several girls interviewed for the process evaluation felt encouraged by this support and supervision. However, this personal follow-up does not always happen due to HEW's busy workloads, girls' distance from the health post, and migration as girls often move away. Couples who live further away from the health post with less exposure to the HEWs may not have the same degree of knowledge and confidence to return.

WDA volunteers have also increasingly been drawn on to support follow up, with HEWs sometimes asking WDAs to check in with girls living in their clusters. This role is intended to be further formalized in the next phase of A360.

> *"We follow up simply by checking our register for who has come and who has not come. After that, if they have not come for the appointment, we ask the WDA why she has not come and why she has stopped. If she says she wants to have a baby, the WDA discusses with her - she can't force her not to have a baby, but she will discuss with her." (HEW, Ethiopia, 2019)*

HEWs are continuing to implement the program after Smart Start officially transitions out of communities, but there are gaps in capacity and support.

The process evaluation and program learning visits suggest that Smart Start continues to be implemented in kebeles after SSNs transition out, with HEWs making efforts to identify newly married girls in the area and continuing to provide counseling. However, there are gaps in implementation due to their busy workloads, particularly during the dry season.

[39] Overall Ethiopia performance data, 2020.

Several HEWs interviewed for the process evaluation felt they were not receiving sufficient support from either woreda officials or A360 Adolescent Health Officers stationed at the woreda level, after SNNs had transitioned out of communities. The intention was that A360 staff would support HEWs through weekly meetings for the first month, with monthly meetings thereafter. However, there is only one Adolescent Health Officer per woreda, so as the program rolled out to more kebeles they were spread more thinly. This also appears to have contributed to challenges in ensuring HEWs have the latest Smart Start materials to support counseling, with several HEWs interviewed for the process evaluation continuing to work with the older, longer counseling guide some time after the new guide was introduced.

4. Nigeria

4.1. Introduction to 9ja Girls and MMA

A360 developed two solutions in Nigeria: 9ja Girls targeting unmarried girls in the South; and Matasa Matan Arewa (MMA) targeting married girls in the North. Both are delivered through public health facilities, leveraging partnerships with the Ministry of Health (MoH). Contraceptive counseling is delivered by A360 Young Providers, who are recruited and paid by A360 and work full time in public health clinics, or by government health workers. All providers are trained in youth-friendly service provision and use counseling protocols that focus on issues that are of most concern to girls.

9ja Girls

As of 2020, 9ja Girls worked across six states in Southern Nigeria and in parts of Northern Nigeria (on a smaller scale). Girls hear about the program through community mobilizers, their friends or their mothers, and can choose to go directly to a nearby public health clinic for a walk-in appointment or drop in to a Life, Love and Health (LLH) Saturday class. The curriculum features vocational skills demonstration and practice sessions, future-planning exercises, and discussions about love, sex and dating. The aim is to make contraceptives relevant by helping unmarried girls tap into their aspirations and see contraception as a tool to reach their goals. Classes also include an 'opt-out moment' in which all girls get the chance to see a service provider one-on-one, in order to reduce stigma. After girls adopt a method (for free and on-the-spot), service providers follow up with phone calls to check how girls are doing and to remind them of future appointments.

In addition to providing the LLH classes to girls, 9ja Girls also aims to involve mothers through regular Moms' sessions to help mothers understand that contraception can be a tool to help girls achieve their dreams and how they can support their daughters to achieve their goals, and dispel myths and misconceptions around contraception.

More information about 9ja Girls is available on the A360 website.[40] See the 9ja Girls User Journey (Figure 12 below) for further details on the key touchpoints within the solution.

Matasa Matan Arewa (MMA)

Matasa Matan Arewa (MMA) targets married adolescent girls in Kaduna and Nasarawa states in Northern Nigeria. It uses maternal and child health as an entry point, and employs two separate mobilization streams. In the first stream, female mentors use door-to-door counseling to reach married adolescent girls and invite them to take part in the program. Girls

[40] https://www.a360learninghub.org/cause/southern-nigeria/.

are then mentored in groups of 12 through four classes on Life, Family and Health (LFH). The curriculum focuses on nutrition, life skills and vocational skills and offers an 'opt-out' counseling session at the end of each class, which aim to provide girls with multiple opportunities to engage with providers and reduce the stigma associated with talking to a provider. In the second stream, male Interpersonal Communicators (IPCs) start conversations with groups of men in public spaces, using the health of the baby and mother to encourage married men to refer their adolescent wives to a female mentor or to a clinic for counseling. Girls referred by their husbands then attend a health clinic for a one-to-one appointment with a provider.

More information about MMA is available on the A360 website.[41] See the MMA User Journey (Figure 13 below) for further details on the key touchpoints within the solution.

Design and evolution

The Nigeria team conducted two Inquiry and Insight Synthesis processes simultaneously, for the North and the South. IDEO.org led the process in the South, while SFH led the process in the North.

In the South, insight synthesis generated six initial prototypes, which aimed to connect girls to SHR at relevant moments in their life trajectories; inform and empower girls through skills training, enlisting the support of mothers, and online platforms; and leverage young providers able to relate to and inspire girls. These initial concepts were tested in early 2017, and iterated into five refined prototypes. Further testing in March-April 2017 gave rise to the 9ja Girls program, which consisted of the 9ja Girls brand, a set of digital platforms, a private, girl-only clinic space, a skills class, and a youth provider network to deliver counseling.

In the North, insight synthesis generated ten initial prototypes, including a mentorship model, digital platforms, activities to engage mothers and husbands, and provider training. In 2017 it was decided to focus on married girls in the North, and further prototyping and testing gave rise to the MMA mentorship channel and husband mobilization channel described above.

The 9ja Girls Youth Provider Network concept, although initially promising, did not prove successful during pilot. The idea was to recruit recent university graduates with medical or a related background to spend their National Year of Service Corps (NYSC) as a 9ja Girls Young Provider Fellow, posted at a 9ja Girls clinic. A360 reached an initial agreement on the concept with the NYSC, but challenges around allowances led the idea to be shelved.

Donors had concerns around 9ja Girls' performance in early 2018, given relatively low conversion rates (40% in the first quarter of 2018), and a method mix highly skewed towards short term methods (83% of methods adopted in Q1 2018).[42] This led to the decision to delay scaling A360 in Nigeria, to allow time for further optimization of the solutions. Various adaptations were tested to reduce costs and improve performance in 2018. These included:

- Removing the standalone branded 9ja Girls facility spaces, instead integrating 9ja Girls services into public facilities. This proved successful, with no reduction in performance and a significant cost saving.
- Removing the A360 Young Provider from the model, with service delivery entirely led by government providers. This did not prove successful due to the high workloads of government health workers, which led to reduced service delivery.

[41] https://www.a360learninghub.org/cause/northern-nigeria/

[42] Overall Nigeria performance data, 2018.

- Reducing the frequency of vocational skills classes from once a week to twice a month. This was successful and resulted in cost savings.
- Introducing a 'Reach Out' model to increase program reach to girls living outside the catchment areas of A360 static facilities. This involved pop-up outreach events held at more remote facilities for two days per month, delivering an abridged LLH/LFH curriculum alongside contraceptive service provision. Government providers received youth-friendly capacity building, and A360 engaged Reach Out providers and mobilizers an ad hoc basis to run the events, and also provided commodities if needed. Reach Out replaced the initial 'Cluster+' service delivery model, which involved rotating mobilizers and providers across more geographically dispersed clinics to deliver classes and services in each facility once per week.
- Introducing the PSI youth-friendly Counseling for Choice book to help providers counsel girls in an accurate and youth-friendly way on a range of methods, leading with long-acting rather than short-acting methods to attempt to address the skewed method mix.

A360 also made several adaptations to the mobilization model in 2018, in order to address intensive human resource requirements and difficulties reaching girls who lived further away from the health center. The criteria for site selection and mobilizer recruitment were revisited, a modified job aid rolled out, and performance-based pay introduced.

These adaptations were successful in improving performance while reducing costs, with the conversion rate for 9ja Girls reaching 75% in the fourth quarter of 2018, and a shift towards adoption of long-acting methods.[43] In October 2018, 9ja Girls was scaled up to 31 facilities across nine states. MMA was scaled much later, in part due to a donor decision to reallocate budget to other countries. It was scaled from two permanent facilities to ten (with additional funding from CIFF) in July 2019. The success of the MMA pilot also led UNFPA to fund a pilot of government-led implementation across three further facilities in Kaduna state.

In summer 2019 the Reach Out strategy transitioned to a Hub and Spoke model. This aimed to intensify A360's presence at Reach Out sites (which became Spokes) and formalize the role of static facilities (Hubs) to provide ongoing support and supervision. The model involved more frequent events at Spoke sites, and more intensive supervision and training to government providers at those sites. By September 2019, the model had been fully rolled out – with MMA operational in ten Hubs and 37 Spokes across two states, and 9ja Girls in 26 Hubs and 72 Spokes across six states.

In 2019-20 A360 pursued several further adaptations in Nigeria, including introducing a follow-up process and call center to support continuation, and a network of 'Big Sistas' (satistified users, some of whom are Community Health Workers) to support girls at a community level particularly around self-injection. A360 also made tweaks to the MMA model, including introducing mentorship sessions at Spoke sites, and adjusting the language used in activities to better reflect issues that resonated in the Northern context (e.g. emphasizing 'child spacing' over 'family planning.'

Figure 11 below displays a visual timeline of key evolutions in 9ja Girls and MMA over the course of the A360 program.

Adaptations due to COVID-19

The onset of the COVID-19 pandemic led to restrictions on movement and social gatherings. State level lockdowns were initiated on March 30, 2020, however, government designated SRH

[43] Overall Nigeria performance data, 2018.

an essential service. A360 Nigeria was able to quickly respond with a wide variety of adaptations to continue delivering services, including:

- Placing sanitization stations at entrances, establishing physical distancing protocols during counseling, providing COVID-19 awareness/protection information during counseling, and sourcing PPE and distributing it to girls, providers, mobilizers and other A360 staff.
- Moving to WhatsApp for program and team management: this allowed for daily briefings and the easy dissemination of information, including feedback and cascading specific COVID-19 training and materials to team members at all levels.
- Modifying mobilization to take place on a one-to-one basis only, due to restrictions on social gatherings. This approach was first adopted in Hub sites in April 2020 and generated a steady in-flow of girls for one-to-one counseling while avoiding large crowds. In June 2020 a similar mobilization model was rolled out for Spoke facilities in all nine states.
- Adapting classes to take place virtually through WhatsApp groups. During mobilization, girls with an Android phone were invited to the online class, while girls without an Android phone were invited directly to the facility for one-to-one counseling. Virtual classes involved daily activities and a weekly stock-take of key issues. Questions could be asked in the group chat, or by messaging or calling the provider directly. Girls interested in adopting a method could privately message a provider, who then arranged for the girl to visit the facility.
- Revamping the 9ja Girls and MMA Facebook pages to include content on awareness creation, life-planning, vocational skills (e.g. DIY videos) and COVID-19. The A360 communications strategy was modified to engage girls on a daily basis using different weekly topics.
- Sending bulk SMS messages to girls with either Android or feature phones. These messages included information on COVID-19 and life, love, relationship and health skills. A contact phone number was shared so girls could contact a provider.

Figure 11: **A360 Timeline: MMA and 9ja Girls (Nigeria)**

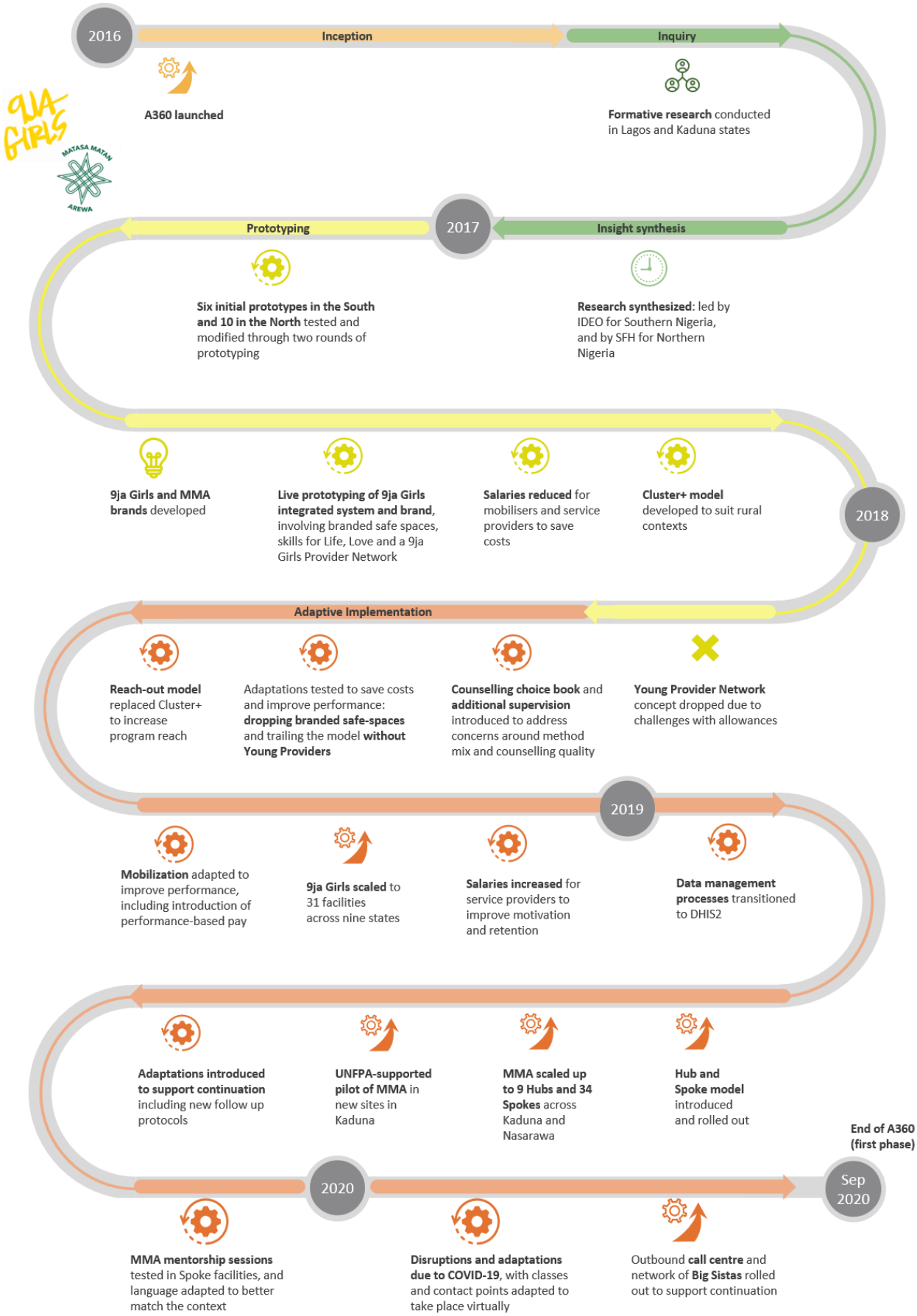


Figure 12: **9ja Girls User Journey**

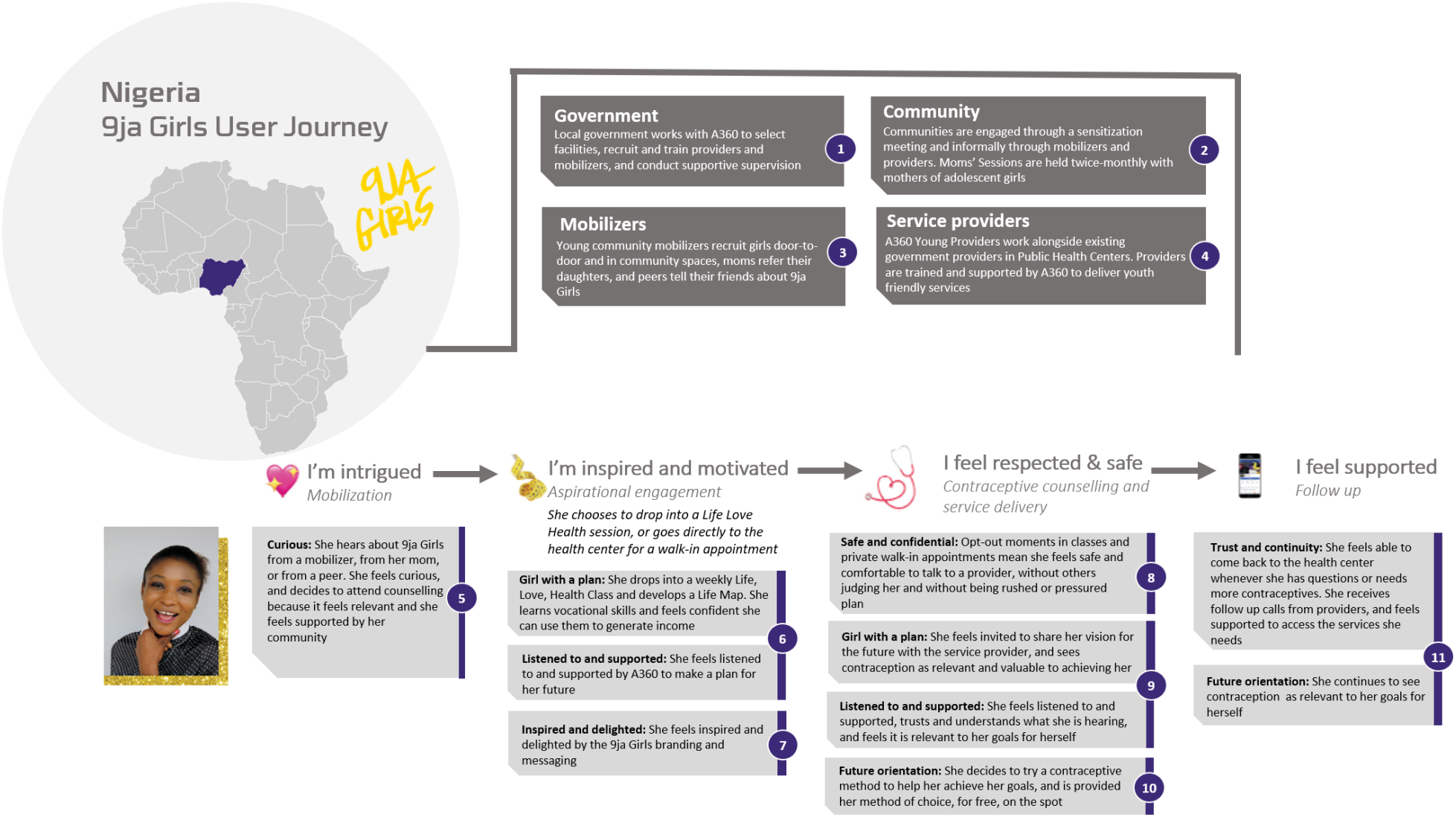
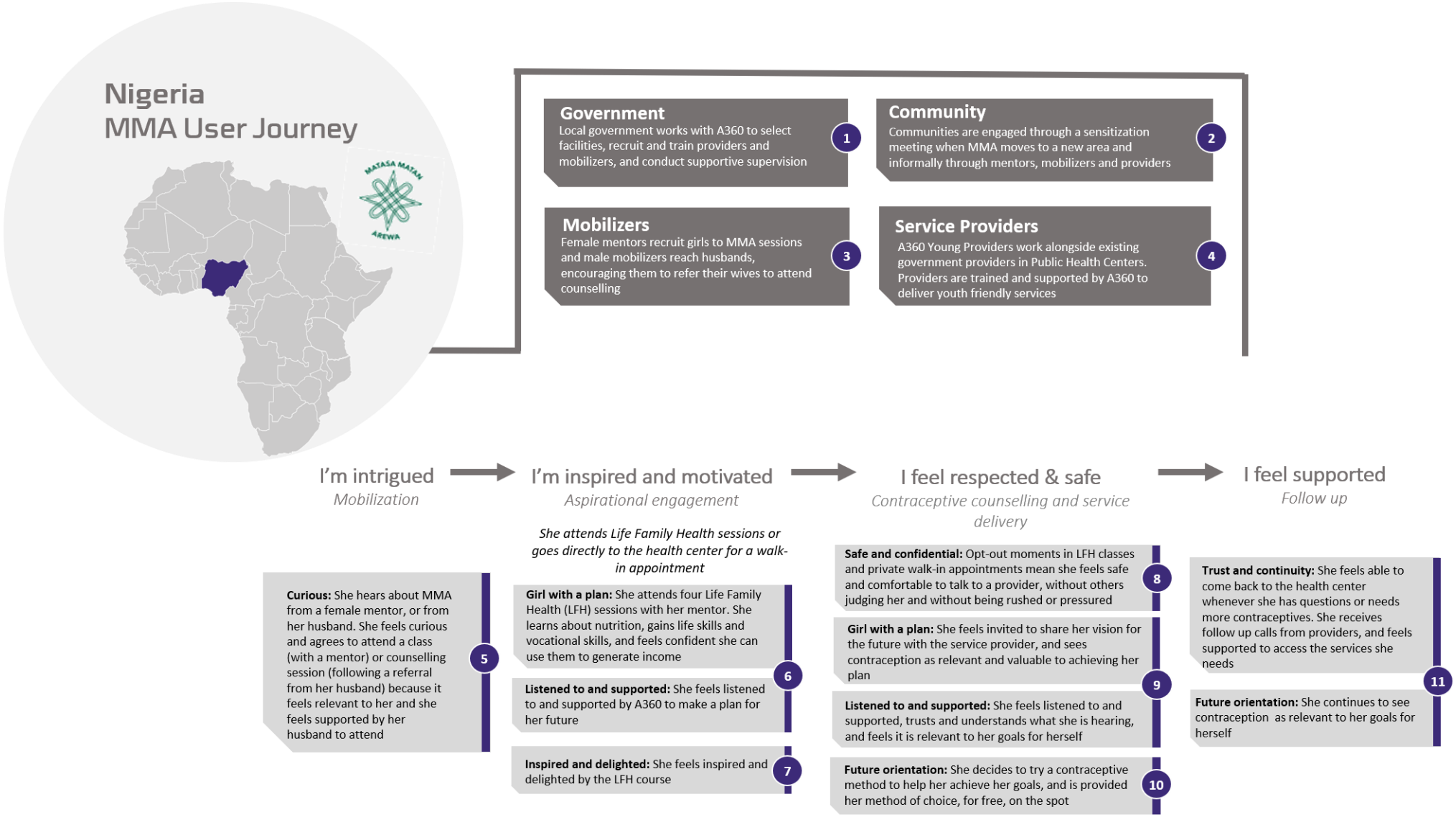


Figure 13: **MMA User Journey**



9ja Girls and MMA Mechanisms of Impact

This section presents the intended 'mechanisms of impact' underlying the 9ja Girls and MMA User Journeys (numbers relate to the diagrams above). These explain how and the solutions are intended to lead to change. Section 4.3 discusses whether these mechanisms were observed in practice through the process evaluation.

1 **Working with local government** ensures MMA and 9ja Girls seamlessly integrate into the existing health system, leveraging what works and filling gaps for adolescent girls' access. Ongoing engagement with the Federal Ministry of Health and State Health Management Board helps ensure government support of A360 as it scales.

2 **Engaging and enlisting communities** through community sensitization meetings and the ongoing presence of mobilizers, mentors and youth-friendly providers helps 9ja Girls and MMA reach girls efficiently and helps build community support by positioning contraception as a tool to help girls and families live better and healthier lives.

Positioning A360 as about life, family and health (MMA) and life, love and health (9ja Girls), means that girls can access services without the fear of being judged by onlookers, helping girls feel safe and comfortable and helping avoid community stigma.

Involving mothers in 9ja Girls through Moms sessions helps mothers understand that contraception is one of many tools that can help her daughter achieve her goals and dispels myths around contraception. Sessions help mothers understand how they can support their daughters to achieve their goals.

3 **Engaging community mobilizers and mentors makes use of existing community structures and peer networks to reach girls.** The mobilizers and mentors are young people from the area who girls can identify with, are known respected in the community, can build community support, know which girls are eligible for the program and are able to reach them where they are.

Engaging male IPC Agents uses existing community structures and peer networks to inform married men about MMA, building buy-in to the program and encouraging them to refer their adolescent wives to MMA services. Involving husbands increases girls' participation and acknowledges the husband as an important decision maker, encouraging joint decision making and using the health of mothers and babies to create a new value for contraception among men.

4 **Training government providers and other facility staff in youth-friendly service provision** and **providing ongoing support through Quality Focal Persons** supports providers to build empathy and address biases, helping them to see adolescents as in need of family planning, and giving them the skills to counsel them in a youth-friendly way.

Working with existing service providers and recruiting mentors and IPC agents from the local area leverages their position in communities as known and trusted local actors whose legitimacy and qualifications are highly valued.

Recruiting and training new Youth Providers to deliver youth-friendly contraceptive services to girls expands the pool of providers able to effectively serve girls.

Placing Youth Providers alongside government providers in existing facilities enables MMA to maximize reach to married girls in rural and semi-urban areas, utilizing the public health system to support scalability.

5 **Entrepreneurial and life skills components provide a 'hook' that makes girls curious** and encourages them to attend classes – and also makes parents and husbands more likely to support girls to attend.

Informal, youth-friendly mobilization helps girls feel the program is relevant to them.

6 **Delivering entrepreneurial skills sessions and aspirational messages alongside information about contraceptives** acknowledges contraception as a taboo subject, and helps girls see contraception as key to help them achieve their goals

Using a tailored curriculum to deliver information on life skills, love, family and health gives providers a new, compelling and youth-friendly way to discuss contraception with married and unmarried girls. The curriculum and materials ensure consistent delivery of information and help providers put girls at ease, address girls' fears, and provide information in a way they understand.

- The 9ja Girls curriculum uses the life map tool to help girls see contraception as key to help them achieve their goals. The curriculum helps build life skills, including around how to engage in healthy relationships, and also helps girls learn practical skills they can use to gain income that can help them gain greater control over their lives. Introducing and positioning contraception as a key asset for the future leverages key life moments of need to help contraception feel relevant to girls.
- The MMA curriculum and materials are designed to resonate with married girls. Life skills delivered by the mentor over the course of four sessions helps build girls' confidence as well as be prepared to raise healthy children, while vocational skills help them gain income to achieve greater control over their lives.

7 **The 9ja Girls brand, anthem and messaging** focuses on building girls' confidence that they can achieve their goals. Girls internalize the messaging and take it into future relationships: her life is hers to make and her body is hers.

Using elements of the 9ja Girls brand in the delivery of MMA focuses on building girls' confidence.

8 **Conducting opt-out counseling sessions at the end of each LFH / LLH session** provides girls with multiple opportunities to engage with providers and reduces the stigma associated with talking to a provider.

Ensuring youth friendly providers are always available at the public health center ensures girls can drop in and access contraceptive counseling whenever they wish.

9 **Using a counseling protocol** to deliver contraceptive counseling helps ensure counseling feels relevant to girls by ensuring the issues girls care about are front and center – including questions about how secret the method needs to be and the impact of different methods on menses.

10 **Delivering girls' method of choice on the spot, for free,** reduces barriers to uptake for girls and delivers contraception when a girl wants it.

11 **Follow up calls and visits** by providers, mentors and mobilizers ensures A360 builds continued relationships with girls and helps build ongoing confidence in contraception among girls. Regular follow up ensures providers can continue to meet girls wherever they are in their journeys to help girls access desired services, and ensure continued use.

4.2. Performance data

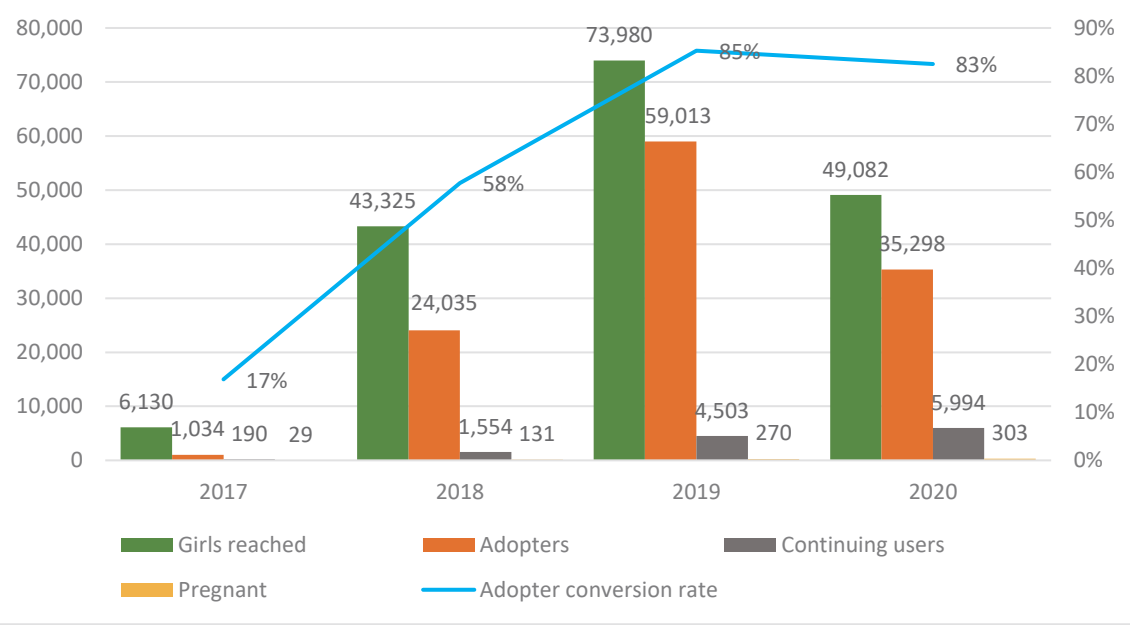
9ja Girls

By the end of September 2020, 172,517 adolescent girls had been counselled through 9ja Girls, and 119,380 of these had adopted a modern contraceptive method. Overall, 75% of eligible girls (i.e. those not already using contraception or pregnant) adopted a method after counseling.

Adopter numbers for MMA are lower because it was developed later and was not scaled until 2019, at which point it was rolled out in only two states (compared to 9ja Girls' six) – see Figure 15. Overall, 45,371 girls were counseled through MMA, with 35,641 adopters (a conversion rate of 84%).[44]

The introduction of the Hub and Spoke model in 2019 incorporated over 100 new 'Spoke' facilities, allowing A360 to reach significantly more girls. Across both solutions conversion rates improved significantly over time (Figures 14 and 15), attributed to improvements in mobilization and counseling quality (discussed further in Section 4.3).

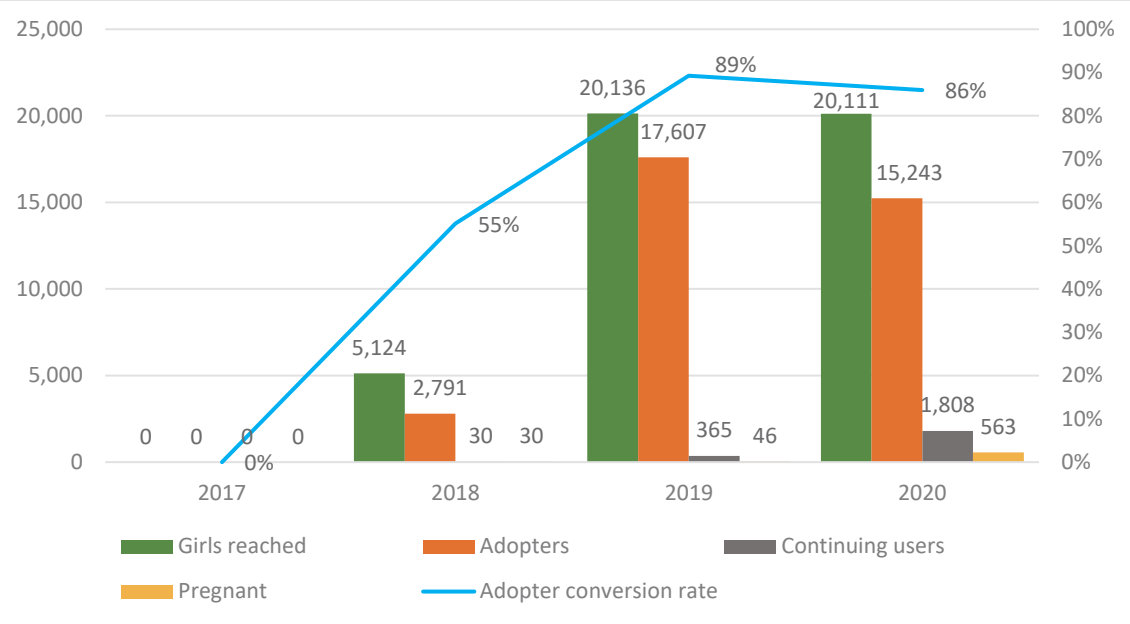
Figure 14: **9ja Girls performance data (Oct 2017 – Sept 2020)** [45]



[44] Adopter 'conversion rate': percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

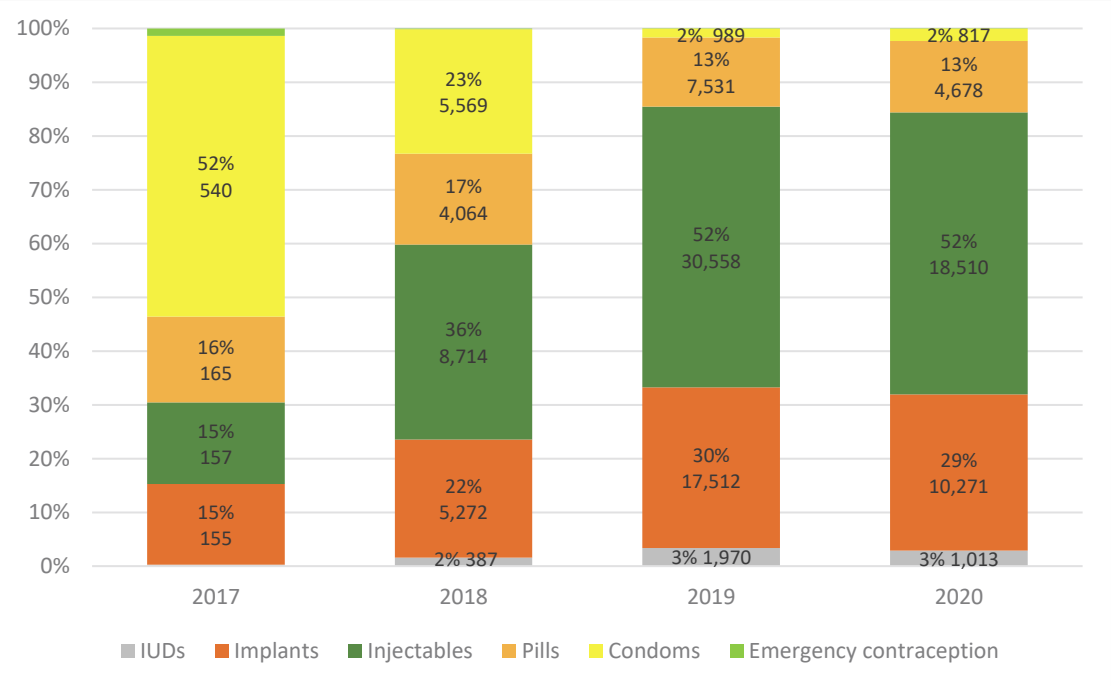
[45] Girls reached: girls registered at a 9ja Girls clinic or event. Adopters: girls under 20 who had never used a modern method of contraception or were discontinued users, who took up a method at the clinic/event. Continuing users: girls who were already using a method. Adopter conversion rate: percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

Figure 15: **MMA Girls performance data (Oct 2017 – Sept 2020)** [46]



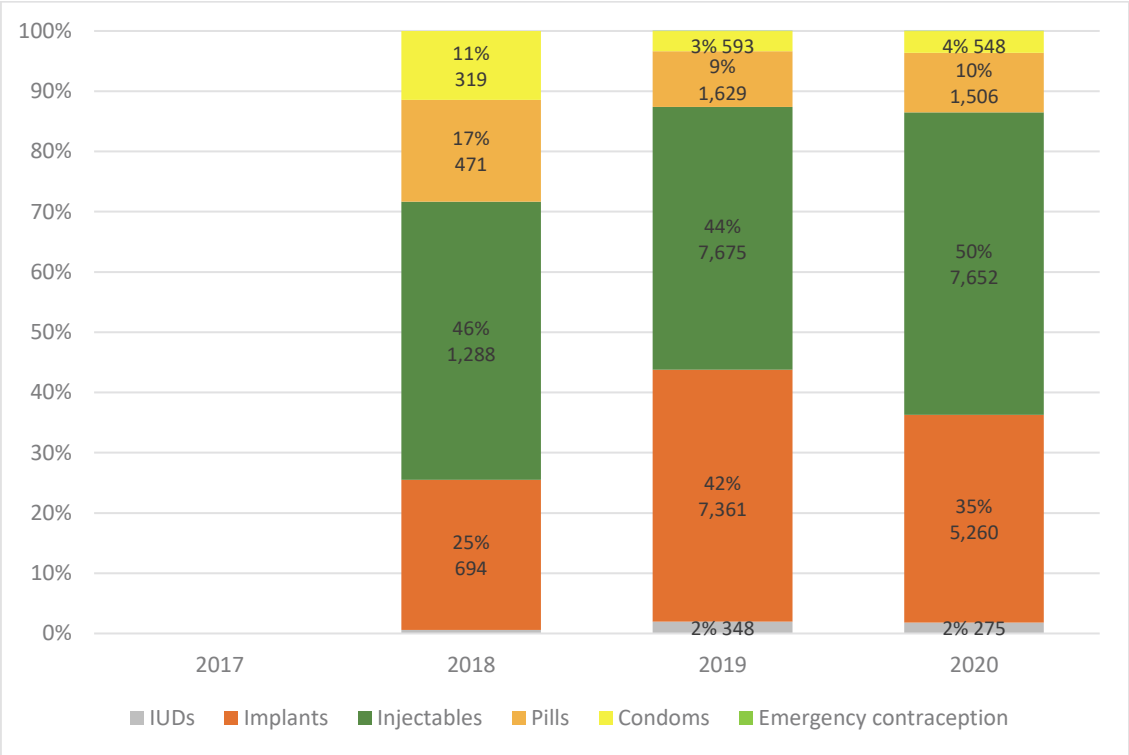
Long-acting reversible contraceptives (LARCs) accounted for 31% of methods adopted in 9ja Girls, and 39% of methods adopted in MMA (see Figures 16 and 17). The differences between the models can be attributed to the target audiences, with married girls more likely to take up long-acting methods. LARC uptake increased in 2019 across both solutions, again attributed to improvements in counseling quality.

Figure 16: **9ja Girls method mix (Oct 2017 – Sept 2020).** *Note: values under 100 not included*



[46] Girls reached: girls registered at an MMA clinic or event. Adopters: girls under 20 who had never used a modern method of contraception or were discontinued users, who took up a method at the clinic/event. Continuing users: girls who were already using a method. Adopter conversion rate: percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

Figure 17: **MMA method mix (Oct 2017 – Sept 2020).** *Note: values under 100 not included*



Just 13% of 9ja Girls adopters were aged 15-17, and 19% of MMA adopters. The proportion of younger adopters in 9ja Girls decreased from 26% in 2018 to 10% in 2019 (see Figure 18). This is due to a strategic decision to focus mobilization on older girls in 2018, to help meet adoption targets.

Figure 18: **Age disaggregation of 9ja Girls adopters by year (Oct 2017 – Sept 2020)**

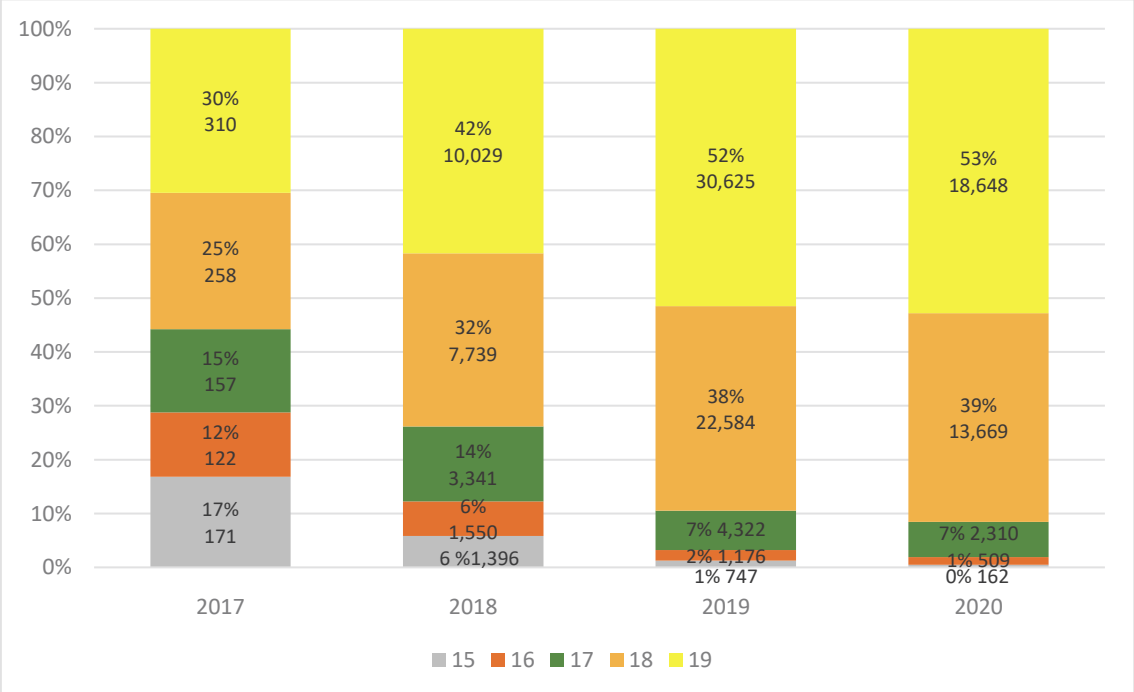
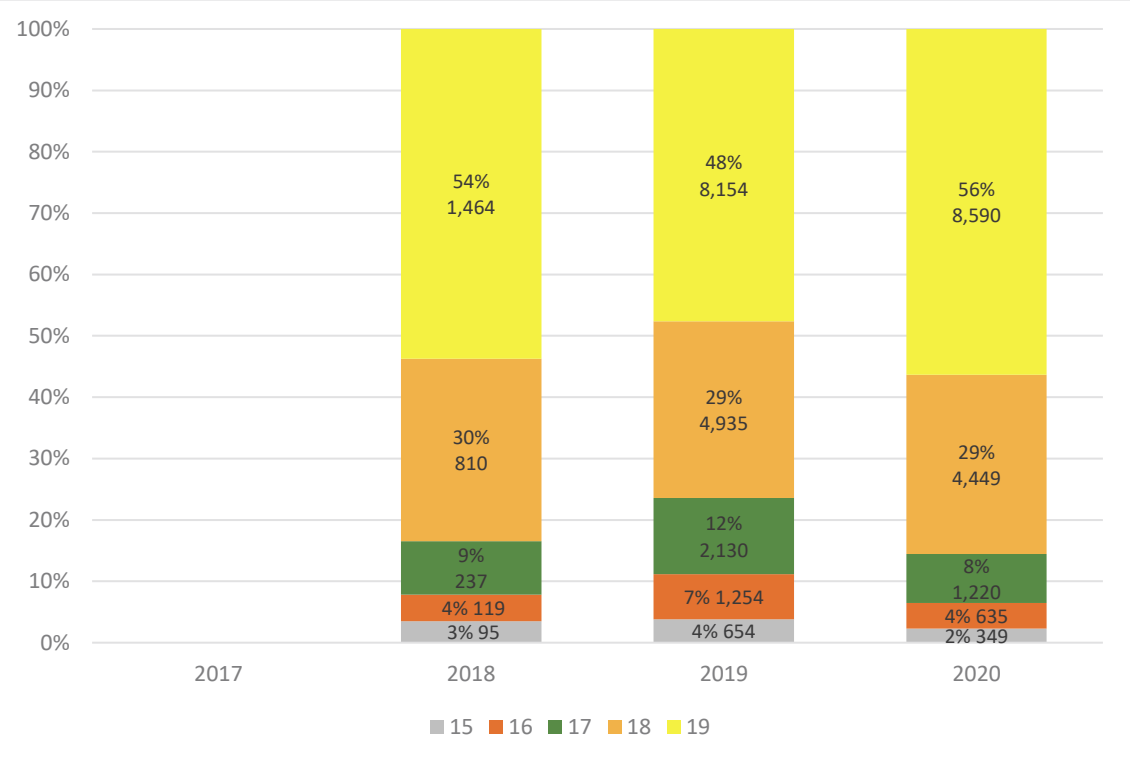


Figure 19: **Age disaggregation of MMA adopters by year (Oct 2017 – Sept 2020)**



4.3. Process evaluation findings

This section presents key findings on the 9ja Girls and MMA solutions from the process evaluation, structured according to the User Journey model above. The findings reflect on how far the solutions are playing out as per their User Journeys, highlighting successes and challenges, and discussing how broader contextual factors are affecting the program.

4.3.1. Engagement with government, the health system, and key influencers

Government

Early and sustained engagement with government has been key to A360's success in Nigeria, driving high levels of support. A core strength of A360 Nigeria has been regular and active engagement with government at all levels, especially through key policy coordination groups such as the national and state level Technical Working Groups on adolescent health and development. Government support and ownership has been driven by regular data sharing and effective communication of program results. This has helped fill gaps in government health data while demonstrating how A360 objectives connect with existing government priorities and commitments, such as FP2020. For example, some state-level government officials said they supported A360 due to evidence that the program has increased the state contraceptive prevalence rate. Others highlighted that A360 data played a significant role in addressing a gap in state health service provision.

At a national level, sustained and effective government engagement has helped ensure consistent support from the Federal Ministry of Health and has driven national government stakeholder interest in key aspects of the A360 approach, including the HCD process and the involvement of young people in the program. Government stakeholders have been particularly attracted to the skills acquisition and vocational components of the solutions.

> *"Another good aspect of the program is the skills acquisition [that aims] to empower the girls, to take them off the street, by giving them the ability to fend for themselves so that they will not be easily deceived with a token to lure them into having sex with men." (Government stakeholder, Southern Nigeria, 2018)*

Local and state-level government engagement has been particularly important given the decentralized nature of health provision in Nigeria.

State governments play a crucial role in ensuring support from local officials and ensuring sufficient commodities are available for A360 activities. Because of substantial variations in the governmental and policy environment across different states, A360 has needed to be adapted to the idiosyncrasies of different state environments. This has required extensive effort to ensure that processes are embedded in state structures and that government officials are closely involved through multiple touchpoints in the implementation process. The focus on state-level engagement has generally been highly successful, with government stakeholders in both Southern and Northern Nigeria consistently expressing strong support and ownership for both programs. During interviews with the process evaluation team, state government officials highlighted several channels through which they continually engage with A360, including training sessions, regular meetings, assisting with community engagement and by ensuring government facilities are working and stocked with commodities.

> *"Whenever SFH have any issue, they come to us and we try to solve it at the state level. I know that they have been very very supportive. So SFH has*

been a partner and they have been so good in this area." (State government official, Southern Nigeria, 2018)

A360 have also focused more on local government over time, leveraging strong state government support as an important enabler of local ownership and engagement. This has taken place through, for example, community meetings sponsored by state health educators in partnership with local government health educators and community members, and working closely with Local Government Authority Medical Health Officers and other key staff.

A360 has enjoyed a hospitable policy environment in Nigeria, with AYSRH considered a priority by the Federal Ministry of Health – but a lack of inter-ministry cooperation has created challenges.

Before A360 began the government of Nigeria had already begun to promote access to AYSRH services, including through integrating youth friendly services into public health clinics. The prioritization of adolescent health has since been reflected in multiple policies which address youth and contraception. The new National Policy on Young People's Health 2020–2024 includes ambitious targets for adolescent contraceptive use, which reflects growing government recognition that declines in national birth rates can only be achieved through work with adolescents.

However, a key challenge to government engagement and ownership has been the fact that AYSRH does not sit within a single government ministry or department. Services are spread across multiple ministries and departments, including the Ministry of Health's Reproductive Health unit and Gender, Adolescent, School Health and Elderly Care (GASHE) unit; the Department for Public Health; and the Federal Ministry of Education, which deals with SRH education and awareness and which currently promotes abstinence. This presents challenges for targeting, coordinating and sustaining government engagement efforts.

The AYRSH policy environment is also complicated by the fact that policies aimed at youth and contraception are often ambiguous.

AYSRH policy is developed at federal level but applied by state governments. The ambiguity of policies means that there is some variation in how states interpret policy, which makes for an uneven implementation landscape. Although a law exists which supports youth access to contraceptive services regardless of age, some state directives (e.g. in Lagos) require under-18s to seek parental permission before adopting long-acting forms of contraception. This has created challenges in serving younger girls, further exacerbated by instances where State Ministry of Health views on consent have not been cascaded down to the level of facilities and health providers. For example, although the state MoH in Ogun took the position in 2018 that girls could access long-acting methods without parental consent, this was not communicated to providers.

Despite a range of policies, government funding for adolescent health remains limited, and specific budget lines for AYSRH services are often lacking.

From early on in the program, government stakeholders – particularly at the state level – have tempered support for 9ja Girls and MMA with cautions about budget limitations. In 2019 there was a federal budget cut in the national family planning commodity counterpart budget. Federal health funding was further reduced in 2020. The proposed 2021 federal budget suggests a small increase in overall health funding, but it is unclear how much will find its way to SRH and adolescent health. The problem of limited funding is compounded by the fact that the funds allocated for AYSRH tend to be subsumed in budgets for other health areas. Although the new national policy on adolescent health includes ambitious targets for contraceptive uptake, respondents indicated that the implementation of the policy is

significantly limited by the fact that the Federal MoH does not have a specific line of funding for adolescent health issues.

> *"I think the major thing is just for government to put more funding beyond the political commitment." (External AYSRH stakeholder, Nigeria, 2020)*

The health system

A360 is well integrated into government health facilities in Nigeria but concerns remain about sustainability due to the dependence on A360 staff.

Both 9ja Girls and MMA are delivered through public health facilities where SFH Young Providers work alongside government service providers to implement the program. Before beginning work on A360, Young Providers and government service providers receive six days of training on youth-friendly service provision, and seven further days of training on contraceptive counseling methods and the A360 curriculum. Young Providers are able to provide on-the-job support and capacity building for government providers, who are often burdened with a heavy workload and multiple responsibilities across different areas of public healthcare, which makes it harder for them to adjust to the additional requirements of A360. Service providers also receive support from state-level A360 Quality Focal Persons**,** who provide supervision and additional training.

Young Providers thus play a key role in ensuring quality youth-friendly service delivery, but the dependence of the program on A360 staff raises questions about sustainability. The Nigeria team trialed delivering A360 without a Young Provider in 2019, but this was found to be unfeasible without a significant drop in service quality and productivity. The heavy workload of providers meant they were forced to pick one particular day during the week to serve girls, which meant that many girls would simply not be able to access the service. The limited capacities of government providers are also likely to have an impact on correct and consistent data management.

> *"Government providers have so many responsibilities; most are overstressed, they're understaffed, so it's always a challenge for them to have time to always be around to listen to how we attend to girls. That is one of the major challenges with working with government facility providers." (A360 Regional Staff, Southern Nigeria, 2020)*

Capacity building has been expedited by the shift to the Hub and Spoke model.

In 2019 the 'Reach Out' (outreach) model was replaced with a 'Hub and Spoke' model. Hub sites, staffed with A360 Young Providers and Quality Focal Persons, provide capacity building, equipment and technical support to enable government providers to offer services in more remote Spoke sites, increasing reach into rural communities. Quality Focal Persons provide supportive supervision and on-the-job training to providers at Spoke sites, and bring consumables to ensure girls can access the service for free.

Investments in training and supportive supervision have paid dividends in improving the quality of service provision, promoting youth-friendly services and reducing provider bias.

In 2018 A360 identified a number of counseling weaknesses and quality issues. In order to improve the quality of counseling, A360 introduced additional mentoring, on-the job training and supervision through its regional Quality Assurance team, and the PSI youth-friendly Counseling for Choice book to support providers during contraceptive counseling. Process evaluation interviews conducted in 2019 and 2020 suggest this approach has paid off, with few issues identified in the counseling process. Feedback from providers has consistently highlighted that A360 training and support has addressed personal biases and clinical

misinformation, shifting provider attitudes (for example, the belief that contraception is only for older women or negative judgments about unmarried adolescents who are sexually active).

> *"Initially, it wasn't easy but with time I have improved, in making [girls] open up, I have become friendlier with them, because I allow them to explain everything, listen to them, ask them about their worries, their personal issues" (A360 Young Provider, Northern Nigeria, 2019)*

However, MoH and SFH staff have expressed concerns about government providers continuing to hold biases and lacking the same degree of commitment as A360 Young Providers.

> *"One nurse was telling me one day: 'how can we be giving contraceptives to teenagers? Giving what is meant for the adult to teenagers may spoil their womb.'" (A360 staff member, Northern Nigeria, 2019)*

A key challenge for A360 Nigeria has been the attrition of service providers.

Feedback from stakeholders has regularly highlighted that providers often suffer from lack of motivation because of low remuneration, late payments and deductions for public holidays. The steady attrition of providers and the subsequent need to recruit and train new staff has consistently been identified as a core challenge which demands significant program resources and can impact the quality of service delivery. Provider attrition has meant that sometimes service providers working on A360 have not undergone the training curriculum.

> *"We have a lot of attrition of staff, when SFH have trained them for quite some time…before we know it, they have gone. It is a big challenge to get a new person and get them trained." (A360 staff member, Southern Nigeria, 2020)*

Infrastructure weaknesses and stock-outs have presented challenges to the quality and consistency of service delivery.

The program has faced challenges in some delivery sites – especially Spoke sites – relating to poor quality facilities, a lack of equipment, erratic supply of electricity and limited space. This can lead to overcrowding and issues with privacy and confidentiality, making it difficult to provide quality of care or ensure services are delivered in youth friendly spaces. Providers have expressed concerns about not being able to sterilize equipment needed to provide long-acting methods.

In addition, shortages of contraceptives and other medical supplies have been a continual challenge for continuous service delivery. The primary issue is structural: the Nigerian contraceptive supply chain is disorderly, poorly regulated and prone to stock-outs. The supply chain is heavily supported by donor funding but government authorities have not always been able to maintain steady supply of contraceptive commodities and consumables. In 2020 Nasarawa state experienced a four-month stock-out of LARCs, especially implants. Temporary stock-outs of LARCs affect method choice, in some cases leading girls opting for condoms until the LARC becomes available. In order to mitigate this issue, A360 Nigeria has maintained a strategic partnership with Marie Stopes International (MSI) which provides access to MSI-sourced commodities acquired at the federal level which are not available through normal SFH state-level delivery channels.

Communities and influencers

Deeply held sociocultural norms around adolescent use of contraception pose many obstacles to girls participating in the program.

In Northern Nigeria, girls face significant social and familial pressures which enforce established norms around marriage, childbearing and the control of adolescent girls' decision making by husbands and parents. Although A360 has had some success in providing AYSRH counseling and services for married girls in Northern Nigeria, there are serious socio-cultural barriers which make it extremely difficult to offer these services to unmarried girls.

In Southern Nigeria, pre-marital sex is highly stigmatized and the use of contraception among unmarried girls is linked to promiscuity, with a prevalent belief that providing access to information about contraception and SRH will encourage girls to have sex. Girls' attitudes often mirror those of the community at large, with girls holding very negative attitudes towards premarital sex and girls who engage in it.

In both Northern and Southern Nigeria, deeply entrenched fears and misconceptions about contraception – especially fears of infertility – generate distrust of AYSRH interventions and opposition to contraception use.

> *"Some of us young girls will not come to take up family planning services at the regular clinic, because people will be many and they will be looking at us somehow." (Girl, Southern Nigeria, 2019)*

Community acceptance has increased over time, with engagement efforts successfully generating increased support for both 9ja Girls and MMA.

Given the entrenched sociocultural barriers to contraceptive access for girls in Nigeria. community engagement has been recognized as crucially important from the outset of the program. However, the engagement activities initially implemented during the prototyping phase did not prevent some community resistance and backlash, including the closure of a 9ja Girls site and a service provider taken into police custody.

This led to further time and energy being invested in community engagement activities and a conscious reorientation to focus more centrally on engaging community leaders who act as key influencers and decision makers. On entering a new community, government-supported sensitization meetings are carried out with key community leaders and gatekeepers who in turn mobilize their local sphere of influence. The process of bringing local leaders on board has been facilitated support from state Ministry of Health officials. As the program scaled, the ongoing presence of community mobilizers and the greater involvement of community leaders in regular program meetings was seen to be instrumental in securing increased community support, with community leaders expressing strong support for the program, highlighting their appreciation at being engaged early on in the process.

Although instances of outright backlash have become rarer, A360 continues to face a degree of community resistance as the programs move into new areas. Resistance varies by location, with some communities easier to work with than others. In some instances, the program has been forced to pull out of certain communities. For example, A360 tested the 9ja Girls model in Northern Nigeria. However, there was significant resistance given the focus on unmarried girls, with a local leader demanding that the program be discontinued in his community. As a result, 9ja Girls was pulled from the entire state. Support from local government officials has helped A360 deal with instances of community resistance by addressing issues as they arose before they resulted in major problems for the program.

Vocational and life skills components have been helpful in building community buy-in and support.

The vocational components of 9ja Girls and MMA have resonated with communities in both Southern and Northern Nigeria, facilitating community acceptance and helping reduce the social stigma associated with contraception. In Northern Nigeria, offering vocational and life

skills has helped ensure that MMA is seen as a 'community-based complete wellness' program rather than a contraception program 'imposed from outside,' which would have been less acceptable to girls and communities.

> *"The community realizes that adolescents go [to A360] to learn skills that could help them become engaged in activities that are economically viable…the community will not stigmatize someone that goes to facilities supported by A360 because they know that there are other activities that are going on there." (Federal Ministry of Health Official, Nigeria, 2020)*

A360 Nigeria has tapped into existing community concerns and increasing community acceptance of family planning.

In Southern Nigeria community stakeholders – particularly mothers – have been motivated to support 9ja Girls out of concern about teenage pregnancy, desire for girls to complete their education, and fears about unsafe abortions. In Northern Nigeria, MMA resonates with concerns about the health, nutrition and physical wellbeing of mothers and children, as well as worries about household financial stability. In MMA, mentors and LFH classes shifted from discussing "family planning" to using language around child spacing, which has resonated strongly with husbands and community leaders.

Contraceptive use is becoming more familiar to some communities, such as in Kaduna state where there has been significant focus on family planning and reproductive health programming in recent years. Increased community understanding of family planning in general makes it easier to begin conversations about AYSRH.

Engaging mothers in Southern Nigeria has been an effective mechanism for community engagement but has not significantly contributed to mobilization.

Parents – mothers in particular – can play a key role in facilitating unmarried girls' access to the program. Because mothers' resistance to contraception is often linked to a lack of knowledge, 9ja Girls has used 'Moms' sessions" to help build their understanding. The monthly sessions have been popular but relatively small-scale. However, they have largely been regarded as a success in leading to greater community support.

> *"Getting mothers to participate and support the program is a major achievement. It has really helped a lot because mothers have great influence on their daughters. We have seen some mothers having heard about this program, they invite us into their community" (A360 staff member, Southern Nigeria, 2020)*

Mothers interviewed for the process evaluation were largely positive about the sessions, with many highlighting how much their perspective on adolescent contraceptive use had changed, particularly around no longer seeing contraception as encouraging promiscuity. A key message from mothers was that the sessions helped them improve their relationships with their daughters, encouraging greater openness, less conflict, greater trust and an increased willingness by girls to confide in their mothers and ask for advice. However, the sessions have not proved a significant mobilization channel.[47]

> *"This program has brought unity between we parents and our children. I have learnt a lot…I am now better in my relationship with young girls including those who are not my daughters, I counsel them on how they can*

[47] LSHTM analysis of A360 monitoring data found that 2.5% of girls were referred by their mothers for 9ja Girls (June 2017-April 2020)

live their lives without jeopardizing their future." (Mother, Southern Nigeria, 2020)

Increased focus on engaging husbands in Northern Nigeria has contributed to greater community acceptance and support but raises concerns about replicating gender norms of control.

In Northern Nigeria, married girls' access to contraception is heavily determined by the support or opposition of their husband. MMA adopted a male engagement strategy that uses IPC agents to directly mobilize married men. IPC agents work in their own communities, approaching groups of men on the street, at mosques and churches, and other places where married men gather, focusing on identifying and engaging men with wives who are in the target age group.

"Since their husbands are involved in the program, we don't have issues with them because sometimes we see their husbands bringing them themselves, so we don't have issue with community backlash." (A360 staff member, Northern Nigeria, 2020)

The strategy has generally been successful in increasing involvement by husbands, facilitating girls' access to A360 services and reducing community resistance and backlash. This channel also increases adoption rates: girls referred by husbands in Nigeria were 1.4 times more likely to adopt a method than those referred by a mobilizer.[48]

However, a key challenge is the risk of unintentionally reinforcing social norms of control. Although most husbands described making decisions about contraception jointly with their wives, a number of stakeholders –including husbands, IPC agents, girls and SFH staff – talked about husbands making decisions for their wives after speaking with IPC agents. There is therefore a risk that although MMA's focus on husbands is helping girls access contraception and SRH services, it may also be unintentionally undermining girls' free decision making. A360 is aware of this challenge and has tried to address it with further IPC training; as well as engaging a gender consultant to review this aspect of the program. However, evidence from the in-depth interviews suggests the issue remains.

"There are times that...the husband dictates the method that the girl should take…She wants something different, but she can't take what she wants because her husband has given an instruction." (A360 regional staff member, Northern Nigeria, 2020)

4.3.2. Girls' journeys through 9ja Girls and MMA

Mobilization

In both Southern and Northern Nigeria, mobilization has resonated with girls and reaches girls where they are.

In both Southern and Northern Nigeria, the status of community mobilizers as known and trusted members of their community has helped build trust with girls and husbands and has increased community support for A360.

Girls consistently reported that they became interested in A360 because of the friendly and engaging approach of mobilizers and the program messaging, which intrigued them and made

[48] 95% confidence interval: 1.2–1.7. Results of a logistic regression mixed model, adjusted for age as well as for data dependency between observations from the same Facility (random effect) and districts within the same State (fixed effect). Data from LSHTM independent analysis of A360 monitoring data (June 2017-April 2020)

them want to continue the conversation. Girls said they were motivated to attend 9ja Girls for a range of reasons, including curiosity about the program, interest in the program's focus on adolescent girls, the opportunity to learn vocational skills, a desire to learn about SRH and pregnancy prevention, and the opportunity to receive guidance on how to manage love-life relationships. The 'multi-pronged' approach of the program enables it to appeal to a number of areas interest to girls, increasing the chances of their participation. In Northern Nigeria, girls who attend MMA are more likely to cite a desire to access contraception, which to some degree reflects the target population of married girls, most of whom have already had one child. Girls who attend MMA also say that the opportunity to learn vocational and life skills and accessing contraception appeals to them.

> *"I gave the mobilizers audience when they met me on my way because they were friendly in their approach. I decided to follow them because they assured me that there is no problem, that 9ja girl is just to help girls, and they showed me the program card, so I became a bit more relaxed." (Adolescent Girl, Southern Nigeria, 2020)*

> *"I was wondering what MMA means when it was explained to me that it is about birth spacing for those who want to 'rest' (delay having a child), many options of contraceptives are offered and for free. I have a baby, and I wish to 'rest' for a while, so I went home to inform my husband about it." (Adolescent Girl, Northern Nigeria, 2020)*

Community mobilizers are an integral part of the success of the A360 solution in Southern Nigeria, while peers and mothers are less significant channels.

9ja Girls mobilizers target unmet need 'hot spots,' approaching adolescent girls on the street and engaging them using a variety of tools, including a flip chart and risk assessment protocol. Mobilizers talk about the life skills and vocational sessions in order to 'sell' the program to girls, which has been particularly effective in sparking girls' curiosity and appealing to girls who are keen to learn new skills. The effectiveness of 9ja Girls community mobilization model has led to the Ogun state government showing interest in adopting this component of the A360 solution.

Most girls across both models are reached through paid mobilizers. Peer mobilization also accounts for only a small proportion of girls who attend 9ja Girls sessions (2.8%).[49] Interviews with girls reveal that most girls are not comfortable talking about the services offered by 9ja Girls, which means they tend not to bring their friends to the facility. Girls say lack of trust and prevalent social stigma about contraception and SRH meant that they felt embarrassed, ashamed or afraid to discuss the program openly with their friends. As noted above, socio-cultural barriers such as these remain a key obstacle to girls accessing contraception.

Saturation around health centers combined with the push for cost-effectiveness has affected 9ja Girls community mobilizers, who have been demotivated by having to carry out a demanding role while facing issues around remuneration.

As areas around health centers become saturated, mobilizers have been forced to work in communities further away from the facility. But girls are much less likely to travel long distances to attend sessions, which makes work more difficult for mobilizers. The move to the Hub and Spoke model helped alleviate this to some extent, providing A360 services across a greater geographic range of facilities. However, the issue of saturation combined with a move to a performance-based payment system in late 2018 led to some mobilizers failing to earn the

[49] LSHTM analysis of A360 monitoring data (June 2017-April 2020)

minimum wage because of overly high targets. Mobilizers also had pay deducted for public holidays and were sometimes paid late.

In Northern Nigeria, the MMA mentorship model has been highly effective not only at mobilizing girls but in offering girls an ongoing touchpoint with the program.

Girls interviewed for the process evaluation have consistently emphasized how they trust and respect the mentors and are able to speak to them openly and with confidence. Mentors approach girls at their home, utilizing a variety of tools (flip chart, icebreakers and a screening tool) to customize messaging to girls' individual situations. As members of the community in which they work, mentors are able to help girls navigate community sensitivities and play a key role in facilitating girls' continuation of contraception by providing a trusted point of contact with the program. A key challenge has been the need to recruit and train mentors as saturation lead the program to move to new areas. A360 have tested mentorship sessions in spoke facilities but this was not viable due to the required resources and cost.

The use of IPC agents to engage men in Northern Nigeria is generally viewed as a success, leading to high numbers of referrals while helping to build community acceptance and support.

IPC agents are able to leverage their status as known and trusted members of the community to reach husbands. The IPC mobilization channel has proved effective for demand creation, with 47% of MMA participants referred by their husbands.[50]

> *"The referrals from the husbands are amazing. When the male IPC agents interact with these husbands in the community, and the community get a sense of what the program is all about, the husbands are the ones encouraging their wives to join the A360 program." (A360 staff member, Northern Nigeria, 2020)*

A challenge with using IPC agents is that asking husbands to relay information to their wives risks them sharing incomplete or distorted secondhand information. In addition, some issues appear to remain around inconsistencies in IPC agents' knowledge and understanding of MMA. More fundamentally, the husband engagement strategy raises concerns about replicating norms of social control and reinforcing husband authority over their wives, as discussed above. In late 2020, SFH had begun prototyping new husband engagement materials to address these gaps, and introduced further training to IPC agents to ensure they do not provide advice on contraceptive methods to husbands (which can result in girls arriving for counseling with a method already decided by her husband).

The final round of process evaluation data collection found that as MMA is becoming better known within communities due to mobilization, this leads to greater participation as girls become aware of the services through word of mouth.

Aspirational engagement

Exposure to aspirational content varies according to the different entry points through which girls access 9ja Girls and MMA – and a large proportion of girls do not access it in depth.

In Nigeria girls can access A360 through two different pathways: via walk-in counseling or through attending the 9ja Girls LLH or MMA LFH classes. The different entry points provide greater or lesser exposure to A360 aspirational content. In Southern Nigeria, girls are able to drop in to weekly 9ja Girls LLH classes which take place at public health facilities. During the classes, girls learn life skills – including how to navigate relationships – and participate in

[50] LSHTM analysis of A360 monitoring data (June 2017-April 2020)

conversations about how contraception might enable them to realize their dreams and goals. Two classes a month involve vocational skills sessions. The classes contain an 'opt-out moment' in which all girls get the opportunity to see a provider one-on-one.

Girls can also decide to go directly to a clinic to access A360 services through a walk-in appointment. These do not provide girls with the same degree of aspirational content as the LLH classes, but service providers draw on the 9ja Girls messaging to help connect contraception to the girls' dreams and objectives.

In Northern Nigeria, girls who are recruited by mentors attend four weekly LFH sessions which offer structured progression culminating in "graduation" from the class after the fourth session. Girls are taught vocational and financial planning skills as well as information about health and nutrition. In contrast, girls who do not attend classes but instead access MMA through a walk-in appointment (including girls referred by their husbands) do not experience the aspirational dimensions of the program.

Overall most girls in Nigeria (69% in the South and 51% in the North) access A360 through walk-in appointments rather than skills classes, and so do not receive most or any of the aspirational content.[51] In both Southern and Northern Nigeria, staff reported that classes appeal more to younger girls – older girls tend to prefer walk-in appointments (many are apprentices or working and so the classes have less appeal).

The aspirational components of 9ja Girls and MMA play a central role in the success of the solutions.

The process evaluation has consistently shown that the life skills and vocational skills components of both solutions encourage girls to attend and facilitate engagement and acceptance from key community stakeholders despite high levels of stigma around contraceptive use and family planning. There is some evidence to suggest that these components are helping girls expand their horizons by equipping them with skills, increasing their confidence, and making them more aware of their potential and life-opportunities. Mentors reported that although many girls who attend the MMA classes initially lack the confidence to speak and express themselves, they generally develop their voice as the classes progress.

> *"Girls are beginning to know that they have a voice... Most of them see their husband as high and mighty; once he says something, they can't do anything besides what he says. And then they go through the MMA class and they begin to realize, 'okay I can actually say I don't want something when I don't want it.'" (SFH staff member, Northern Nigeria, 2020)*

LLH and LFH classes function as safe spaces where girls are able develop their voice and agency and can raise issues they do not feel comfortable discussing with family or friends. Formative research during the inquiry stage in Nigeria found a clear need for safe spaces for girls to discuss topics around SRH. In Southern Nigeria, girls who attended LLH classes reported feeling safe, comfortable and free from judgement. Girls also welcomed the opportunity to speak about how to manage romantic and sexual relationships.

> *"I gained a lot from my coming that day…I was having issues with my lover. And the way my question was answered, it was just as if the person that answered my question actually knew what I was going through. Her*

[51] LSHTM analysis of A360 monitoring data, June 2017-April 2020

response was so precise and helpful." (Adolescent Girl, Southern Nigeria, 2020)

In Northern Nigeria, mentors play a key role in ensuring girls feel at home in the LFH classes. More than half of the girls interviewed said the thing they enjoyed most about the class was the friendly attitude and respectful demeanor of the mentors, who made them feel welcome and took time to answer all their questions. The continuity of the personal relationships girls have with mentors is an important foundation for girls' trust and confidence in the program, while girls also appreciated the opportunity to meet with their peers.

"The mentors really impressed me because if you are not clear about anything they will explain to you over and over again until you are clear. They treated us as if we were their friends, there was no stress, everything was done joyfully. If there is anything you did not understand then they will repeat it to you." (Adolescent Girl, Northern Nigeria, 2019)

Vocational skills sessions are extremely popular, but there have been regular complaints that the program does not do enough to economically empower girls.

Girls, mothers, husbands and government officials have all commented on the need to better assist girls in translating new skills into viable income generating activities. In Southern Nigeria girls often lack access to basic start-up capital for vocational activities. In Northern Nigeria fewer girls have had the opportunity to put their skills into practice. This gap is being addressed in A360 Amplify, where A360 has developed new partnerships to build and develop the economic empowerment component of the program.

In Northern Nigeria there is a risk that the LFH classes may unintentionally reinforce inequitable gender norms. MMA has less focus on goals or dreams than other A360 solutions, focusing more on decision making and managing relationships with husbands. Girls who were interviewed talked about learning to be 'obedient' and how to take better care of their families. This is not part of the MMA curriculum, which raises questions about how the material was being interpreted and delivered by mentors, but these findings have led to some concerns that sessions may be unintentionally reinforcing harmful gender norms. LFH classes tread a delicate balance between promoting empowerment, and using messaging that is acceptable to communities and husbands in a setting where husbands hold most of the decision-making power.

Contraceptive counseling and adoption

Substantial investments in tools, training and supervision have improved the quality of contraceptive counseling over the course of the program.

In the early years of A360 process evaluation analysis, and external quality assurance, found a number of issues relating to the quality and consistency of counseling. This included some service providers and facility managers exhibiting bias towards or against particular methods due to persistent myths and misconceptions about LARCs and injectables, and preconceived notions about abstinence counseling being more suitable for adolescents. In Northern Nigeria service providers sometimes counseled girls against LARCs and injectables because they worried they would cause harm or lead to infertility. In Southern Nigeria, some service providers and facility managers introduced messaging about abstinence and "self-control" as part of both LLH sessions and counseling. This appears to have had an impact on the overall method mix, which was initially heavily skewed towards condoms.

As discussed in Section 4.3.1, the program subsequently sought to improve the quality of counseling through new tools and investment in supportive supervision and on-the-job

training. The move to the Hub and Spoke model in 2019 allowed for greater supportive supervision and training at Spoke sites.

These investments have helped improve counseling quality over the final years of the program. Interviews carried out in 2019–2020 found few examples of service provider bias or misinformation, with providers reporting they felt confident and comfortable delivering contraceptive counseling across all method types. Providers reported that the revised counseling materials – the algorithm and choice book – ensure that they ask girls all the relevant questions and are able to easily respond to girls' queries, concerns, worries and fears.

Girls interviewed in both the North and the South in 2019–2020 were overwhelmingly positive about the counseling process and reported feeling comfortable and safe**.** Despite occasional fears that the provider would be "harsh" or judgmental, girls were put at ease by the provider's friendly, respectful manner. In Southern Nigeria, a few girls remarked that they felt so comfortable with the provider they were able to open up and discuss aspects of their lives that they had been ashamed about or kept secret. In Northern Nigeria, girls felt confident in the medical knowledge and authority of the provider, reporting that the provider's patience and friendliness helped them speak easily.

> *"I was so comfortable with her, because as I entered, she assured me of confidentiality. When I first entered I was a bit reluctant, but she encouraged me to open up. I discussed all that was bothering me, I told her my family issues." (Adolescent Girl, Southern Nigeria, 2020)*

Despite being built into the Nigeria models from an early stage, 'opt-out moments' have not worked in the way they were initially envisaged, and girls are significantly more likely to adopt a method through walk-in appointments.

In 9ja Girls and MMA, 'opt out moments' were built into the structure of LLH and LFH classes, with each girl taking part in private one-to-one counseling during each class unless she opts out. This was intended to reduce stigma and ensure all girls had the opportunity to see a provider every session. However, this format often limits counseling time to only 10 minutes per girl, making it difficult to conduct a meaningful counseling session. In addition, the short time-period of the session has meant that some girls have been unwilling to adopt a method – particularly a long-acting method – in case their peers could tell due the time spent with the provider, reflecting the stigma girls often face from peers if they are known to be sexually active. This appears to have pushed some girls towards short-term methods in some cases.

Monitoring data shows that walk-in clients are significantly more likely to adopt a contraceptive method than girls who enter the program via LLH classes.[52] The reasons for this are not fully clear. Although many girls who attend classes are younger, analysis shows that there is still a significant difference in adoption rates even after age has been controlled for. This difference may be explained by the fact that girls who attend classes are less likely to be sexually active but are attracted to the life and vocational skills offered. Staff also report that girls who do not wish to adopt a method in the presence of their friends during class often return to the clinic later for a walk-in appointment. This potentially creates an additional hurdle to adoption.

Choice of method varies by age, marital status and number of children.

[52] Odds of adoption for girls entering via classes = 0.28 vs girls entering via walk-ins (95% confidence interval: 0.27–0.29). Results of a logistic regression mixed model, adjusted for age as well as for data dependency between observations from the same facility (random effect) and districts within the same atate (fixed effect). Data from LSHTM independent analysis of A360 monitoring data (June 2017-April 2020)

In 9ja Girls sites, condoms tend to be the preferred method across 15- and 16-year-old girls, while injectables are the preferred method for those aged 17-19 years. In MMA sites, injectables were the preferred method across all ages except for girls aged 19 years, for which implants were the preferred method. Overall, the data also shows that LARC adoption increases with age. Statistical analysis carried out in 2020 has shown that for both 9ja Girls and MMA, the odds of adoption increase with age and that girls with one or more children are twice as likely to adopt a method compared to girls without children. In the case of MMA, this reflects findings that there is pressure for married girls to have a baby before using contraception.

Girls' choice of method remains also heavily influenced by socio-cultural factors such as deep-seated myths and misconceptions, prevalent social stigma, and a lack of autonomy.

Most girls accessing 9ja Girls reported that the counseling process had changed their attitudes towards contraception, helping dispel prevalent myths and misconceptions about contraception and normalizing contraceptive use as a health issue rather than a moral one. However, misconceptions around side-effects – particularly fears about long-term infertility - continue to affect girls' choice of method. In Northern Nigeria, some stated that they were 'embarrassed' or 'ashamed' to use an intrauterine device. Other girls expressed a preference for an injectable because they were scared of having something inserted into their body and so they 'test' contraception to 'see if my body can tolerate it.'

> *"I told her that for now, I am more comfortable with [the injection] of 2 months…people used to say, that one may not be able to get pregnant again, if one take[s] those long term." (Adolescent Girl, Southern Nigeria, 2019)*

In both models, girls are also substantially influenced by fears about social stigma and social pressures. In Southern Nigeria, girls are influenced by a fear of opposition from their mothers, who remain key influencers of girls' decisions. A360 staff have hypothesized that the preference for short-term methods (injections) in south-west Nigeria is due to girls being worried about their mothers becoming aware they were using contraception – injections are preferred because they do not require removal and are more discrete.

Follow up

Throughout the program, monitoring data has consistently shown that the number of continuing users is low.

A360 made this a key area of focus from 2018 onwards, working closely with quality focal persons, providers, mobilizers, and young designers to intensify follow-up both by phone and in person. Because girls regularly report feeling more comfortable seeking follow up services if they have had a good experience through A360 counseling, the shift to provide greater capacity building and support in 'Spoke' facilities has helped support continuation by providing girls who live further away from A360 Hub facilities with better access to A360-trained youth-friendly providers. These changes have likely contributed to the small but steady improvements in the number of continuing users over time (see Figures 14 and 15 above).

However, the monitoring data may not present a true picture of continuation rates, as girls may opt to renew their methods from private vendors, pharmacies or private hospitals after initially receiving them via A360. In addition, monitoring continuing users is complicated by the fact that the indicator definition for adopters in Nigeria includes girls who previously adopted a method through A360 but have since discontinued. This definition is necessary to align to national public health indicators but means that some girls may be recorded as adopters multiple times, rather than as continuers.

In both Southern and Northern Nigeria, follow-up processes have developed over time to become more clearly defined and consistently applied.

During the prototyping stage, A360 Nigeria trialed a one-to-one follow-up model in which service providers noted down girls' telephone numbers to proactively follow up with them, and often gave girls their own telephone number along with an appointment card so that girls could contact them directly if they had questions. Girls have consistently indicated in interviews that having a personal relationship with a provider is crucial to them feeling comfortable and confident enough to ask questions and raise concerns about side-effects, resupply and other post-counseling concerns.

Over time, the one-to-one follow up process has become more formalized into structured protocols. Service providers give their contact details to girls, advise about when to return to renew their method, and phone girls to check in on them and remind them to return to the facility. This process is tracked by A360 using a follow-up log. In the most recent rounds of process evaluation data collection and analysis in 2019-2020, most girls said they felt confident about how renew their method and ask questions or raise concerns with a service provider.

In 2020, A360 introduced a call center, which is used to make a series of follow up calls to girls. This typically involves three calls: the first provides support on how to take the method, the second is to check for concerns about side-effects, and the third is to remind the girl to return to the facility. However, this process does have challenges, including the fact that many girls do not leave their own phone number, either because they do not own a phone or because they worried that being contacted by the facility may expose the fact they are accessing contraception. Interviews conducted during the 2020 end of program analysis found that some girls who had been contacted were not expecting a call and denied adopting a method, fearing their confidentiality had been compromised. In addition, because some girls give the number of a family member, boyfriend or friend, there are potential issues around confidentiality.

> *"For now, where we have a challenge is when it comes to repeat visit, continuation…when a provider is trying to do a follow up, she discovers that either a number is not going through, or the number belongs to either her husband or someone else. You know they give wrong numbers and that has been a challenge for us." (A360 Staff, Northern Nigeria, 2019)*

The role of community mobilizers and mentors is gradually shifting to support follow up and continuation.

Because many girls do not have phones, mentors and mobilizers have begun conducting follow-up visits to girls' homes. These individuals can also act as a community-based point of contact to help girls continue using contraception by helping answer questions and referring girls to the facility if they are due to renew their method or experience side effects. During the onset of the COVID-19 pandemic, mobilizers played a key role in advising girls that A360 facilities remained open, helping them access the service to renew their method or address problems. A360 staff have suggested that moving forward into A360 Amplify the mobilizers' position could potentially be re-designed to formalize their role in facilitating continuation.

A360 has recently established a network of 'Big Sistas' across two states – a network of satisfied users who are trained to provide mobile, community-based services and support for girls who adopt short-term methods, particularly self-injection. Big Sistas are able to act as link to program/facilities for girls facing access challenges such as lack of transport. Some Big Sistas are also Community Health Extension Workers, working as community-based distributors who can initiate self-injection methods with girls.

Virtual engagement channels were initially planned to support follow up but were not

widely used until COVID-19.

The 9ja Girls design initially included a virtual engagement component through Facebook groups, but this was dropped as the solution waned due to low levels of engagement. However, WhatsApp groups developed to share information and deliver LLH/LFH classes during the COVID-19 pandemic have in some cases helped facilitate follow up and continuation by providing girls with a discrete channel to contact service providers if they have questions, concerns or need to renew their method. Testimony from both girls and service providers indicates that some girls are more likely to seek follow up services and advice when they have a private channel to initiate contact.

> *"Since the program is now on social media, I will check from the group WhatsApp, and will visit the nearest center to me." (Adolescent Girl, Southern Nigeria, 2020)*

Social stigma and a lack of support from influencers continues to be a key barrier for girls, affecting the enabling environment for continuation.

Girls often lack support from their communities or key influencers to continue using contraception, and can face backlash if they experience side effects. This environment creates a barrier to girls renewing a method or accessing a clinic for a second time, and can lead to discontinuation.[53] A number of girls accessing 9ja Girls have reported keeping their use of contraception a secret. In Northern Nigeria, married girls' decisions about continuation or changing method remain highly subject to the decision-making authority of their husbands.

> *"I will feel bad [if people know I'm using contraception] because I am sure they will gossip about me. There is a woman in my neighbourhood, who called me one day and asked if I am taking any drug, I said no, then she asked, 'Why are you losing weight?' I answered nothing and she then said, 'If you are using any family planning method you better go and stop, you are becoming thinner every day.'" (Adolescent Girl, Southern Nigeria, 2019)*

[53] Punton, Gebremedhin, and Lagaay, "The A360 Journey: How Are Girls in Nigeria and Ethiopia Experiencing A360, and What Factors Affect Whether They Continue or Discontinue Contraception?"

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