Methodology Annex

A360 Process Evaluation Final Report

Date: February 2022

Submitted by Itad

This document contains further details on the A360 Process Evaluation methodology, supplementing the Process Evaluation Final Report. A separate Country Annex contains detailed analysis on each of A360 solutions, disaggregated by country.

Contents

List of acronyms

A360	Adolescents 360
AYSRH	Adolescent and youth sexual and reproductive health
CEA	Cost-Effectiveness Analysis
FGD	Focus Group Discussion
HCD	Human Centered Design
IDI	In-depth Interview
IRB	Institutional Review Board
LSHTM	London School of Health and Tropical Medicine
OE	Outcome Evaluation
PE	Process Evaluation

1 Outcome evaluation and cost-effectiveness methodology

Itad is working in collaboration with the London School of Health and Tropical Medicine (LSHTM) and Avenir Health to independently evaluate and distil lessons from the A360 program. The evaluation comprises three core components: an outcome evaluation led by LSHTM, a cost effectiveness analysis led by Avenir Health, and a process evaluation (PE) led by Itad. The evaluation components are designed to be complementary, with a view to providing a comprehensive snapshot of the impact of A360.

- **The Outcome Evaluation (OE)** aims to assess the impact of A360 on the modern contraceptive prevalence rate (mCPR) among sexually active girls aged 15 to 19 years in A360 target countries. It also examines fertility rates, age at first birth, unmet need for modern contraception, and girls' knowledge of modern contraceptives, agency to use them and attitudes towards them. The OE uses a pre-and-post-population-based, cross-sectional survey design, which includes a comparison group in Nigeria. A two-stage sampling design is applied in all three countries. The baseline survey was conducted in late 2017 before A360 solutions were scaled. The endline survey has been delayed by COVID-19, but is due to be complete in all countries by early 2021. Further information on the OE methodology is available here.

  By exploring how and why A360 has or has not achieved the intermediate outcomes in the A360 Theory of Change (see Figure 1), the process evaluation aims to provide evidence that can explain outcome evaluation findings.

- The **cost-effectiveness analysis (CEA)** examines the main cost drivers of the A360 approach, and the cost-effectiveness of A360 in relation to other approaches to designing interventions. The CEA provides information on what it costs A360 to achieve increases in use of modern contraception and associated measures of program effectiveness, including couple-years of protection and disability-adjusted life years averted. The final CEA results will be available in 2021, following the completion of the OE endline survey. Further details on the CEA methodology is available here.

2 A360 Theory of Change

The process evaluation utilizes a theory-based approach, whereby the evaluation design and application are explicitly guided by theory about how A360 leads to change. At the heart of the evaluation is the Theory of Change for A360 (Figure 1), which was developed in 2017. In particular, the process evaluation focusses on understanding the intermediate outcomes from the Theory of Change which are referred to as the 'pathway to behavior change' (Figure 2). By exploring how and why A360 is (and is not) achieving these outcomes, the PE aims to provide evidence that can explain outcome evaluation findings.

As discussed in the main report, the Theory of Change is a high-level model and was not actively used by A360 to guide strategy or implementation. It also does not provide a detailed description of the country-level solutions. In 2019, the process evaluation team worked in collaboration with A360 to design global and solution-level 'User Journey' models: visual depictions of how girls are intended to experience A360 (see Figure 8 in Section 3.2 of the main report, and Figures 2, 7, 12 and 13 in the Country Annex). The User Journeys became the primary framework to structure process evaluation data collection and analysis in 2019.

Figure 1: A360 theory of change

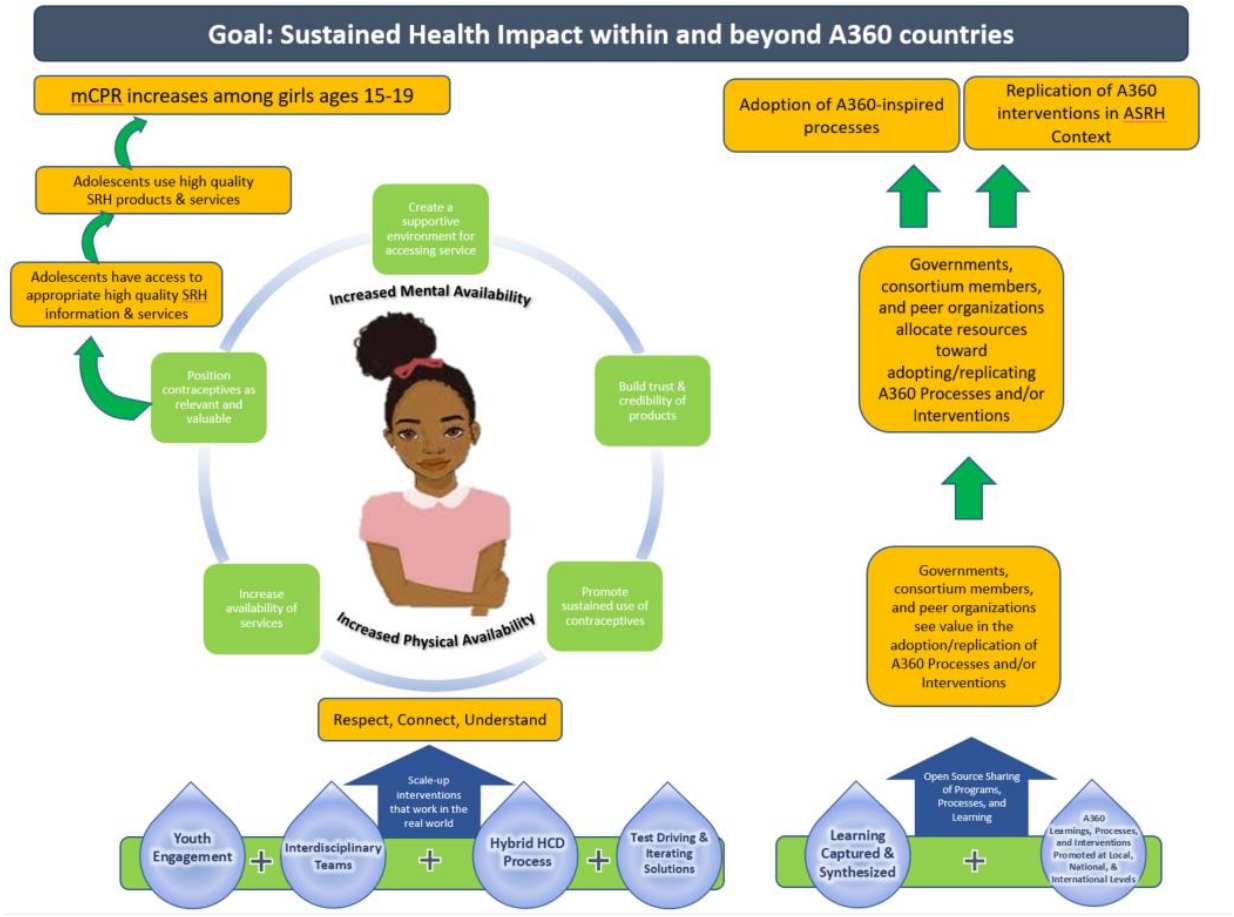
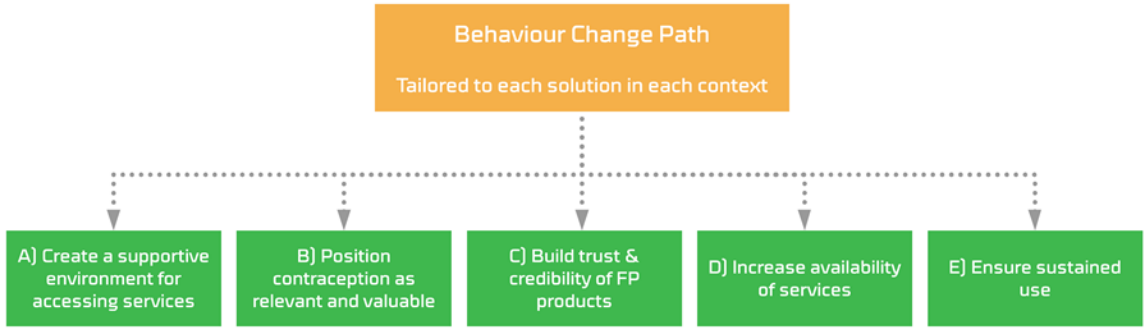


Figure 2: A360 'behavior change path'



3 Process evaluation questions and framework

Table 1 below details the evaluation questions, sub-questions and data sources for the process evaluation. The evaluation questions were updated in 2018, to reflect the shift from the design phase of A360 to the implementation phase. The revised questions incorporated a greater focus on understanding the implementation of A360 solutions, in line with the pathway to behavior change. Additional sub-questions were added in 2019 to help unpack evaluation question 3.7, drawing on the UK Medical Research Council guidance for process evaluation[1] and Steckler and Linnan's key process evaluation components,[2] and linking the evaluation questions to the User Journeys.

Table 1: Process evaluation framework

	Evaluation question	Evaluation sub-questions	A360 documents and data	Primary data

Process	1.1. What makes the A360 process different to traditional ways of designing and implementing interventions?[3]	• What is the theory behind A360?
		• How is the theory playing out during implementation?
		• How have the public health, development neuroscience, youth-adult partnership, social marketing and sociocultural anthropological lenses influenced the implementation of A360?
		• To what extent have there been synergies or tensions between disciplines?
			• Strategy and design documents, meeting and workshop notes and slides, documents describing A360 approach and experiences	• In-depth interviews (IDIs) with:
				  ○ A360 country staff
				  ○ A360 global staff
				  ○ Consortium partner staff
				  ○ Donor staff
				• Group reflection exercises with consortium and A360 country staff

	1.2 How has the A360 approach adapted over the course of the program and why?	• How have the role and approaches of different partners (including donors) evolved and why? • How has the approach adapted over time and why? • What has driven adaptations?		
	1.3 How has the design and implementation of A360 been managed and with what implications and effects?	• What organizational and consortium factors have enabled or inhibited success? • What capacities and processes are needed to effectively introduce and implement a program such as A360?		
	1.4. What is the evidence of the adoption of the A360 inspired approach to design programs in A360, consortium members,	• How has the A360 approach been adopted internally in A360? • How does the A360 approach influence how the wider adolescent and youth sexual and reproductive	• # learning and comms resources created • # A360 advocacy events	IDIs with: • A360 country staff • A360 global staff

[1] Moore, G., Audrey, S., Barker, M., Bonell, C., Hardeman, W., Moore, L., … Baird, J. (2013). *Process evaluation of complex interventions: UK Medical Research Council (MRC) guidance*.
[2] Steckler, A., & Linnan, L. (2002). *Process Evaluation for Public Health Interventions and Research*.
[3] "Traditional ways of designing and implementing interventions" is framed subjectively, based on respondents' experience.

	Evaluation question	Evaluation sub-questions	A360 documents and data	Primary data
	governments and peer organizations?	health (AYSRH) community design programs aimed at adolescents?	• # Downloads from learning hub / A360 site • # A360 and external entities exposed to A360 approach / concepts • Qualitative replication and adoption stories	• Consortium partner staff • Donor staff • Partners who may have been influenced by A360: including national government and AYSRH stakeholders, and stakeholders in the global Human Centered Design (HCD) / AYSRH community
	1.5 What is the evidence of replication of the A360 developed solutions by A360, consortium members, governments and peer organizations?	• How has the process of replication worked in other contexts, including Northern Nigeria? • How do key national stakeholders perceive the A360 solutions? • What is the evidence that the solutions or components of the solutions are being replicated by other partners at country level? • What is the evidence that the solutions or components of the solutions are being replicated beyond the solution geographies?		
Context	2.1. How does the context in each country enable or inhibit the A360 approach and its implementation?	• What are the contextual enablers and barriers to implementation? ○ *Considering enablers and barriers for each stage of the User Journey* • What else is happening in the ecosystem that is influencing implementation?	• Qualitative monitoring data • Strategy and design documents, meeting and workshop notes and slides, documents describing A360 approach and experiences	• IDIs and Focus Group Discussions (FGDs) with all stakeholders • Observations of solution activities, and exit interviews with girls • Workshops with A360 teams *Mapping of significant contextual factors noted in the process evaluation used to structure data collection tools*

Solutions	3.1. How do the A360 solutions create a supportive environment to access services for adolescent girls in the communities they are operating in?	• How does exposure to the solutions affect the perceptions and opinions of co-habiting adults (mothers and/or husbands) of adolescent girls' use of modern contraception?
		• How does the implementation of the solution in a community impact wider community view/acceptance (e.g. community leaders) of adolescent girls' use of modern contraception?
		• How are the 'supportive environment' mechanisms of impact in the User Journey playing out in practice?
			• Qualitative monitoring data (e.g. exit interviews)
			• A360 meeting / workshop / adaptive implementation notes
				• IDIs with:
				  ○ Girls
				  ○ Husbands
				  ○ Community members (mothers in law; Religious / community leaders)
				  ○ Service providers
				  ○ National and sub-national government stakeholders

	Evaluation question	Evaluation sub-questions	A360 documents and data	Primary data
				• Observations of solution activities, and exit interviews with girls
	3.2. How the A360 solution position modern contraception as relevant and valuable to adolescent girls?	• How does exposure to the solutions affect the perceptions and opinions of adolescent girls about modern contraception? • How are the 'relevant and valuable' mechanisms of impact in the User Journey playing out in practice?	• Qualitative monitoring data (e.g. exit interviews) • A360 meeting / workshop / adaptive implementation notes	• IDIs with: o Girls o Husbands o Community members (mothers in law; Religious / community leaders) o Service providers • Observations of solution activities, and exit interviews with girls
	3.3. How do the A360 solutions build the trust and credibility of family planning products among adolescent girls?	• Does exposure to the A360 solution dispel myths and misconceptions around modern contraceptive methods among adolescent girls? • How do adolescent girls perceive their interaction with service providers and other associated implementers of the solution? • How are the 'trust and credibility' mechanisms of impact in the User Journey playing out in practice?	• Qualitative monitoring data (e.g. exit interviews) • A360 meeting / workshop / adaptive implementation notes	• IDIs with: o Girls o Husbands o Service providers • Observations of solution activities, and exit interviews with girls
	3.4. How do the A360 solutions increase availability of services to adolescent girls?	• How does the solution address availability of services to adolescent girls? (e.g. sites, providers) • How does the solution improve access to services for adolescent girls? (e.g. financial, logistical, informational) • How does the solution facilitate uptake should an adolescent girl choose to use a contraceptive method? (e.g. reduce referrals) • How are the 'increase availability' mechanisms of impact in the User Journey playing out in practice?	• Monitoring data: o # new service delivery points o Attendance figures • A360 meeting / workshop / adaptive implementation notes	• IDIs with: o Girls o Husbands o Service providers • Observations of solution activities, and exit interviews with girls
	3.5 How do the A360 solutions promote ongoing interaction	• How does the solution support girls to access follow-up support and services?	• Monitoring data: Any available data on follow up	• IDIs with: o Girls

	Evaluation question	Evaluation sub-questions	A360 documents and data	Primary data
	between the adolescent girl and the service provider/health system?	• How are the 'follow up' mechanisms of impact in the User Journey playing out in practice?	• A360 meeting / workshop / adaptive implementation notes • Qualitative replication and adoption stories	○ Husbands ○ Service providers • Observations of solution activities, and exit interviews with girls
	3.6. Have there been any unintended consequences of the solutions (either positive or negative)?		• Qualitative monitoring data (e.g. exit interviews) • A360 meeting / workshop / adaptive implementation notes	• IDIs and FGDs with all stakeholders • Observations of solution activities, and exit interviews with girls • Workshops with A360 teams
	3.7. How have the solutions been operationalized at scale in each country, and how have they been integrated into the existing health system to support sustainability?	• How is A360 implementing the solutions with other partners? • What were the successes and challenges in the scale up of the solutions in each country?	• Documentation on partnership • Documentation on integration into health system • Documentation on successes and challenges	IDIs with: • A360 staff • Government and other partners
	Fidelity *(the quality of what is delivered)*	• How far are the solutions being implemented as per the User Journeys? *Investigating whether each 'box' in the User Journey played out as planned* • How far is recruitment, training, support of implementers being delivered as planned? • How far are adolescent girls, community members, solution implementers, and A360 staff satisfied with the solution?	• Guidelines / manuals for solution implementers • Event set-up guides • Solution strategy / reporting documents • Adaptation guidelines • Site supervision tools / exit interviews • Recruitment, training plans and training curricula for providers and mobilizers	• Interviews with A360 staff and solution implementers • Observations (conversations with providers at events – no observations of training) • Interviews, FGDs, participatory research etc with girls and community members
	Adaptations *(whether these improve the intervention's*	• What has been adapted since the previous round of PE data collection, and why? • Are the adaptations in line with the adaptation guidelines?	• A360 adaptation tracking tool • Site Supervision Tools • Programme reporting • Minutes from adaptive implementation meetings	• Interviews with A360 staff and solution implementers • User Journey workshops • Observations

	Evaluation question	Evaluation sub-questions	A360 documents and data	Primary data
	contextual fit, or compromise its functioning)[4]	• What have the consequences of the adaptations been?		
	Reach / coverage *(the extent to which / proportion of the target group that came into contact with the intervention)*	• How many adolescent girls are participating in project activities? • Who is participating in project activities (age, marital status, geographic areas, number of children etc)? How representative is this of the population of adolescent girls? • What proportion of adolescent girls in targeted communities who have an unmet need for contraception are being reached?	• Monitoring data: event attendance and adoption data • A360 estimates of unmet need satisfied	• Qualitative indications from interviews, FGDs participatory research – perceptions on who is participating and not. Where possible, insights to be triangulated with monitoring data
	Dose *(the amount or proportion of the intervention actually delivered to and received by the target group)*	• How many and how intensive are the touchpoints for girls within the solution? • What proportion of participants access each touchpoint (including follow-up support or services after A360 events)? • To what extent are the solution components being delivered in the planned numbers, districts, sites? • What elements of the solution are understood best by the participants? (e.g. messaging, brand, contraceptive information)	• Event set-up guides / guidelines / manuals detailing nature of touchpoints • Monitoring data • Reporting data (progress against plans) • Client exit interviews	• User Journey workshops and interviews with A360 staff • Qualitative indications from interviews, FGDs participatory research – perceptions on what is being delivered and how many girls are accessing the touchpoints

4 Bumbarger and Perkins argue that fidelity and adaptation are not opposites. Evaluators need to be able to distinguish between 'innovation' (implementers actively and skilfully attempting to make an intervention better) and 'drift' (unintentional shortcomings). Bumbarger, B., & Perkins, D. (2008, April 12). After randomised trials: issues related to dissemination of evidence-based interventions. *Journal of Children's Services*. Emerald Group Publishing Limited. https://doi.org/10.1108/17466660200800012.

4 Process evaluation workstreams

The process evaluation was operationalized through three interconnected workstreams:

1. **'Full rounds'** involved data collection in each country designed to address the full set of evaluation questions in Table 1 above, aligned with the phases of A360.
2. **'Global rounds'** encompassed interviews with A360 Global staff, A360 donors, consortium members, and external stakeholders within the global AYSRH and HCD communities.
3. **Participatory Action case studies** were introduced in 2018 to provide a mechanism to answer implementers' 'burning questions' in a rapid way. Case studies were conducted on an ad-hoc basis, in line with the needs of the implementing teams. Research questions were co-developed with A360 programme staff, with rapid, light touch data collection and analysis conducted independently by the evaluation team. Participatory sounding workshops provided a space to discuss findings with implementers and co-create implications for the programme. The case studies were published as standalone reports, and are available on the Itad website here: https://www.itad.com/project/evaluation-of-adolescents-360/.

Table 2 provides details of the timing of each round of data collection.

Table 2: Timing of A360 data collection by workstream

Inquiry and Insight Synthesis	Full round 1 (Ethiopia, Nigeria, Tanzania)	August-Dec 2016
	Global round 1	August-Dec 2016
Prototyping	Full round 2 (Ethiopia, Nigeria, Tanzania)	Feb-August 2017
	Full round 3 (Ethiopia, Nigeria, Tanzania)	Oct-Dec 2017
	Global round 2	Oct-Dec 2017
Adaptive implementation	Full round 4 (Ethiopia, Nigeria, Tanzania)	June 2018-Sept 2019
	PAR 1 (Ethiopia)	April-May 2018
	PAR 2 (Nigeria)	June-July 2018
	Global round 3	May 2019
	PAR 3 (Nigeria and Ethiopia)	July-Nov 2019
	Full round 5 (Ethiopia, Nigeria, Tanzania)	May 2020-Sept 2020
	Global round 4	June 2020

5 Sampling and recruitment

The process evaluation used a purposive sampling approach, in which study participants were selected based on their role on the A360 program or in implementation and/or because of their socio-cultural relevance to the adolescent girl (see Table 3).

Study participants were recruited primarily through working with program mobilizers and field staff to support the identification of service providers engaged in the interventions and adolescent girls and other community members who had been exposed to the interventions. Through mobilizers, A360 field staff and meetings with government representatives, the process evaluation identified other key community influencers appropriate to the context, for example kebele (village) leaders in Ethiopia.

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

Stakeholder type	Inclusion criteria	Recruitment method	Tool and approx. sample size, per country, per full round
Adolescent girls	• Girls 15-19 who have been exposed to A360 • Sample included girls who participated in A360 events and a) adopted a method and b) did not choose to adopt a method	• Where possible, monitoring data was used to identify a sample of girls through unique identifiers • Where this was not possible, PE team asked for referrals from A360 staff / solution implementers	• 3-6 FGDs • Up to 30 peer conversations from 15 youth researchers • 6-15 IDIs (from 2019)
Adolescent boys / husbands of adolescent girls	• Individuals 15–19 years of age (both married and unmarried) / husbands of adolescent girls from communities with A360 activities	• PE team asked for referrals from A360 staff / solution implementers • PE team asked youth peer researchers to identify adolescents in their community • PE identified adolescents through observations (i.e. those visiting an A360-supported site, attending a community moment, etc.)	• 3-6 FGDs
Community influencers (e.g. community and religious leaders)	• Influential community member (e.g. religious leaders, local chiefs and government officials, teachers, women's leaders, representatives of community-based organizations, etc.) • Aware of and/or engaged in A360	• PE team asked for referrals from A360 staff / solution implementers	• 4-8 IDIs
Community members (e.g. parents, mothers'-in-law)	• Individuals from communities with A360 activities • Where possible, individuals whose children / daughters-in-law have been exposed to A360	• PE team asked for referrals from A360 staff / solution implementers / local partners, based on engagement with A360	• 3-6 FGDs
Service providers and mobilizers	• Individuals engaged in implementing A360 solution (e.g. health workers and mobilizers)	• Purposively selected from sampled ward / kebele, based on involvement in A360	• 5-10 IDIs • Up to 6 observations per round
Government	• Government officials working with A360, at a national and sub-national level	• PE team asked for referrals from A360 staff / solution implementers	• 3-6 IDIs
A360 Consortium staff, CIFF, the Gates Foundation	• Working with one of the A360 Consortium organizations or the Foundations	• Purposively sampled based on role and involvement in the relevant phase of A360 implementation	• 10-15 IDIs
External AYSRH stakeholders	• Staff in organizations working on AYSRH programming who have had some exposure to A360	• PE team asked for referrals from A360 staff / donors, based on engagement with A360	• 3-5 IDIs

6 Research ethics

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

- **Submitting process evaluation study designs for approval by Institutional Review Boards (IRBs)** in Ethiopia, Nigeria and Tanzania.
- **Ensuring independence of the data collection teams** from policymakers and program implementers so that they were free of any pressure to present findings in a good light.
- **Ensuring that potential conflicts of interest were disclosed and properly addressed** through mitigation plans. Individuals or organizations who were significantly conflicted were not permitted to work on this evaluation.
- **Respecting cultural differences** such as local norms, religious beliefs, gender, age, ethnicity, disability and other social differences when planning and undertaking the evaluation, including the need to avoid over-burdening particular groups.
- **Recognizing the risk that research participants may experience psychological discomfort** in being asked to discuss culturally sensitive topics, such as sexual activity or the use of contraception, and putting in place risk and mitigation measures accordingly. These included ensuring that participants felt free to abstain from answering questions which cause discomfort; orientating the PE team to signs of post-traumatic stress; and establishing a protocol to deal with distress and/or disclosures of violence, abuse or coercion.
- **Ensuring confidentiality of information and the privacy and anonymity of participants.** Field researchers were trained in study procedures and research ethics to ensure they were sensitized to risks and respectful of privacy. All identifying information needed for recruitment of study participants, whether adults or adolescents, was destroyed at the completion of data collection. Participants were not asked for their own personal views or behaviours during FGDs or other group data collection activities; instead, participants were asked about the general situation or attitudes in the community.
- **Ensuring verbal informed consent of all participants**. Community-level participants were provided with an information sheet about the process evaluation (this information was provided verbally to national and regional staff, government and AYSRH stakeholders). Informed consent was obtained verbally by researchers, who signed consent forms for each participant. Signed forms were stored in a locked box and destroyed within one year of the completion of data collection.

In 2020, the process evaluation moved to remote data collection in response to the COVID-19 pandemic. Revised IRB protocols were submitted, and an additional risk assessment was conducted (see Table 3)

Table 3: COVID-19 risks and mitigations

Potential risk of remote data collection	Mitigation strategy
Girls taking part in telephone interviews do not have audio-privacy, therefore confidentiality is at risk	The researcher conducting the telephone interview will ask a series of questions at the beginning of the interview to ensure that the girl is situated somewhere private. If she is not, the interview will not take place. Girls will also be advised that they do not have to answer any questions if they do not want to, or if they feel someone might over-hear their answer. As part of our standard consent procedure, girls will also be advised that they can terminate the interview at any time

Girls are not provided with an information sheet about the study which outlines its purpose and where to go for support or further questions after taking part in an interview	Since it will not be possible to share a physical copy of an information sheet about the study, the interviewer will provide girls with information about the study verbally at the start of the interview. This will be done slowly and clearly with opportunities for questions. The interviewer will also provide a contact number for girls to call if they have any further questions. Girls will also be advised that they can contact A360 staff with any follow up questions.
Building a rapport between the interviewer and the participants could be more challenging, and reading body language through non-verbal communication will not be possible. This could cause a risk to the integrity of the data if participants do not feel as comfortable sharing their experiences	A script will be provided to the researcher to encourage building a rapport over the phone at the start of the interview. The interview will start with simple questions about the girls life to encourage her to speak freely. The interview script will also include moments to pause and check that girls are happy to continue with the interview, or whether they are happy to answer particular questions.
Management of emotional distress during a telephone interview, or disclosure of abuse	We will make clear at the start of the interview that girls can cease the interview at any time, or skip any questions that they find distressing. If a girl self-discloses that she is in a situation where her safety is at risk, we would note the main details, and refer her on to a social protection agency. We would make clear at the start of the interview that there are limits to confidentiality and that in the case of disclosed harm or risk, we will inform relevant support agencies. If a girl becomes distressed during the interview, we will cease questions and advise her where she can seek support.
Disclosure of COVID-19 symptoms during telephone interview	In the case of an interviewee disclosing symptoms that may mean an active COVID-19 infection, we would request A360 staff to follow-up with a phone call to discuss their state of health and self-isolation practices in the household. All interviewees will be provided with some short, high quality information on COVID-19 at the end of each interview.

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