



Final Report

A360 Process Evaluation

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Disclaimer

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List of acronyms

A360	Adolescents 360
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BMGF	Bill & Melinda Gates Foundation
CIFF	Children’s Investment Fund Foundation
HCD	Human Centered Design
HEW	Health Extension Worker
IRB	Institutional Review Board
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptive
LSHTM	London School of Hygiene & Tropical Medicine
MMA	Matasa Matan Arewa
MoH	Ministry of Health
MYE	Meaningful Youth Engagement
NGO	Non-Governmental Organizations
PSI	Population Services International
SFH	Society for Family Health
ToC	Theory of Change
UCB	University of California Berkley
USSD	Unstructured Supplementary Service Data
WHO	World Health Organization

Executive Summary

Reaching adolescent girls with modern contraception is a global health priority. This report presents the findings from a process evaluation of the Adolescents 360 (A360) program, which delivered modern contraception to over 400,000 girls across Ethiopia, Nigeria and Tanzania between 2017 and 2020. The process evaluation finds that A360's combination of Human Centered Design, meaningful youth engagement and adaptive implementation generated effective interventions that framed and combined youth-friendly activities in new ways, to substantially improve contraceptive access for girls.

A360 was a four-year (2016–2020), US\$31 million initiative to increase adolescent girls' access to and demand for modern contraception in Nigeria, Ethiopia and Tanzania. The program was co-funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, and implemented by Population Services International and the Society for Family Health Nigeria in collaboration with IDEO.org and other partners. A360 drew on six distinct disciplines, including human-centered design and meaningful youth engagement, to develop four novel 'solutions' (interventions) to reach adolescent girls across Ethiopia (Smart Start), Nigeria (9ja Girls and Matasa Matan Arewa) and Tanzania (Kuwa Mjanja). A second phase of the program began in 2020 and will run until 2025.



This report presents the findings of the A360 process evaluation. This was conducted by Itad between 2016 and 2020, designed to complement an outcome evaluation led by the London School of Hygiene and Tropical Medicine and a cost effectiveness analysis led by Avenir Health. The process evaluation used a theory-based approach to evaluate how the A360 approach and solutions were operationalized, experienced by participants, and replicated by external actors. The report draws on qualitative data from almost 700 interviews and 85 focus groups with girls, A360 staff and other key stakeholders, together with participatory research, structured observations, and an independent review of program documents and quantitative monitoring data. The findings of this report build on the [evaluation mid-term review](#) conducted in 2018.

Key findings

A360 has significantly exceeded performance expectations since the evaluation mid-term review. The program reached over 400,000 adolescent girls with modern contraception between 2017 and 2020 (compared to a target of 285,000), which is particularly notable given the impact of COVID-19 on service delivery in the final year of the program. Long-acting contraception accounted for 40% of all methods adopted, comparing favorably to national benchmarks. A360 has been more successful at reaching older girls (just under a third of adopters across all settings were under 18).

The human centered design process brought rigor and innovation to A360. It provided time and space to try out new ideas and bring them to fruition, created a mechanism to involve young people intentionally in design, and helped generate and iterate attractive brands that proved an important factor in the program's appeal to girls. HCD was seen as the prominent discipline throughout the design stage. While many of the concepts within the A360 solutions are not new in and of themselves (for example combining contraceptive service provision with skills training), the input of multiple disciplines has enabled A360 to tweak and combine these components in new and innovative ways.

While the other A360 disciplines contributed valuable insights and perspectives that strengthened the solutions, engaging a multi-disciplinary consortium led to challenges. Challenges arose from a lack of clarity in roles and responsibilities, and managing inputs and communication across a large team through a fast-paced design process. Existing evidence on best practice for AYSRH programming and national guidelines were not always given sufficient attention, and country teams were required to shoulder a very heavy workload as they balanced learning how to apply an HCD approach with the demands of program start up. Lack of budget, measurement and a clear strategy also constrained youth engagement and frustrated country teams. These challenges were largely resolved during the design phase by clarifying roles and responsibilities within the consortium, building understanding of the engagement required in the design process, and balancing out the use of different evidence sources. However, it is likely there would have been less frustration, especially for PSI country teams, and more efficient working if the parameters around these areas had been planned and communicated more clearly from the outset.

A360's use of adaptive implementation and meaningful youth engagement complemented the human-centered design process and added tangible value. An 'adaptive implementation' approach was introduced in 2018, to support continual iteration of the solutions in response to learning. Although time consuming to implement, the approach built on the skills and mindsets fostered through the design process to help country teams respond to variable performance, emerging challenges and opportunities, and COVID-19. This highlights the value of combining adaptive implementation lenses and tools with human centered design. Similarly, A360's commitment to meaningful youth engagement added valuable insight to A360's formative research, and also increased empathy for young people among implementers and provided young people with new opportunities and skills. However, lack of budget, measurement and a clear strategy at times constrained the extent and depth of youth engagement, and made it difficult to ensure a continued meaningful role for young people after the design stage.

A360's strong performance is underpinned by several common success factors across Ethiopia, Nigeria and Tanzania:

- **Life and vocational skills sessions and aspirational messaging** provide a 'hook' encouraging girls to participate, help contraception feel more relevant and valuable, and build girls' knowledge, confidence and ability to plan for the future. Aspirational components have also helped secure the support of government, service providers and community members, helping unmarried girls access services in a context of widespread stigma by framing the program as about more than contraception.
- **Flexible service delivery models supported by a diverse array of mobilization approaches** reach girls with free services at times and places that work for them. This has helped A360 overcome several common barriers affecting adolescent access to contraception – including cost, access and awareness.
- **Working through public health facilities and with public providers** has enabled A360 to scale up nationally, serve harder to reach girls, and build health worker willingness and capacity to serve girls in youth-friendly ways. On-the-job support from A360 staff has proved vital to embed new ways of working and mitigate the challenges of high public sector workloads and staff shortages. A360 has made most progress towards government ownership where solutions are more deeply integrated into health systems (in Ethiopia and to a lesser extent Nigeria), while sustainability in Tanzania is somewhat hampered by the reliance on A360 outreach teams.
- **Engaging government, trusted local stakeholders and husbands:** Across all countries, A360 has ensured health officials were involved as core partners in key activities, which has helped ease access to communities and lay the foundations for sustainability. In Ethiopia, the engagement of the Women's Development Army to support mobilization has been a major success story, highlighting the value of harnessing existing, trusted local structures to reach adolescents. Although light touch, A360's strategies to engage husbands have also seen success, with girls in Nigeria and Ethiopia significantly more likely to adopt contraception when their husbands were engaged by the program.

The following key gaps and challenges remain, and should be a focus for the program in its next phase.

- **Addressing sociocultural barriers to contraceptive access for girls** has been a consistent challenge. The program was not designed with a substantial social norms component, and pressures to prioritize adoption targets during scale up initially inhibited community engagement activities. While light-touch approaches to addressing social norms have, in most cases, helped A360 operate with the active or tacit acceptance of communities, A360 has struggled to reach key influencers in large numbers, or to engage them deeply. This potentially undermines long-term support for girls to continue accessing contraception once the program ends.
- **Ongoing challenges with service provider capacity and bias:** In most cases, training on the A360 approach is light touch and insufficient to address persistent service provider bias and capacity constraints. Service providers do not always counsel girls adequately about side effects and sometimes promote certain methods over others, which undermines freedom of choice and can reinforce girls' fears and misconceptions.
- **Reliance on A360 staff and intensive in-person mobilization approaches.** Across all three countries, A360 staff play a crucial role in supporting overburdened health workers and government officials. This poses challenges to sustainability, with the risk that quality and fidelity could drop when solutions are fully integrated into government health systems. There are also ongoing questions about how far government health systems will be able to absorb and manage A360's intensive mobilization approaches and outreach delivery models.
- **Supporting girls to continue using contraception in the longer term.** Continuation has been difficult to accurately monitor and measure. Mass engagement channels to support girls to continue method use (for example apps and Facebook groups) were explored but not widely adopted, although there has been some success with WhatsApp groups in Nigeria during the COVID-19 pandemic. A360 has made progress in the final years of the program through stepping up one-to-one follow up strategies, in the form of phone calls and in-person visits, but patchy phone ownership among girls limits the program's reach.

Finally, there are several examples of external actors adopting or replicating aspects of A360 in Tanzania, Nigeria and Ethiopia. This reflects the program's extensive efforts to generate global public goods and share learning through publications, conferences, and active engagement in national platforms. A360 has also successfully leveraged external funding to expand the reach and scope of the program. However, although there is significant curiosity about A360 within the global community, there are few examples of adoption or replication as yet beyond the three A360 countries.

In the final year of its first phase, A360 focused efforts on health system integration for sustainability. Progress has varied substantially across countries, influenced by the degree of existing integration into health systems, as well as the broader political context and level of national and regional commitments to adolescent sexual and reproductive health. The biggest success story is the decision of the Ethiopian Federal Ministry of Health to roll out the A360 Smart Start solution nationwide, aiming to reach one million married girls by 2025. However, across all contexts, a key challenge for the next phase of the program will be ensuring fidelity and quality of core intervention components, while reducing program complexity to facilitate government ownership.

Recommendations

Following on from the key findings, there are six recommendations organized into two sections.

Three recommendations for A360 to take into account in the next phase of implementation:

1. **Manage, monitor and regularly feedback learning from the integration of A360 into public health systems. This will help to manage tensions and trade-offs between quality implementation, reach and government ownership.** Doing this requires adequate resources to build strong government relations and ownership. It also requires a shift in focus for the A360 team from implementation to technical assistance. A360 will need to have realistic expectations of potential loss of fidelity to the solutions when they are integrated into the public health system. The components where it is

acceptable or inevitable that fidelity will not be maintained should be identified up-front, in coordination with government counterparts. Components which are considered essential to ensure quality will need to be prioritized by A360 for focused support, capacity building and phased handover. The process will need to be closely documented to monitor performance and learn from government integration.

2. **Develop clear goals and indicators around adoption and replication to guide communication and engagement activities.** Lack of clarity around the extent to which core components could be adapted while still maintaining fidelity to the A360 model (e.g. youth engagement, roles and responsibilities, adoption and replication, adaptive implementation), and shifting expectations over time (e.g. around social norms and government integration) created frustrations and inefficiencies. Space to adapt and evolve needs to be accompanied by clear parameters to ensure time and resources aren't wasted.
3. **Systematically plan, monitor and learn from processes to engage young people in design and implementation phases.** Both young people and the adults who worked with young people during A360 reported that this added value both to the program and personally. For young people, it was an opportunity to learn and develop new skills. For adults, it positively shifted their mindsets around the value of young people being engaged in a program for young people. In order to get the most out of this, we recommend clearly defining the expected outcomes of MYE, putting in place a plan upfront for how those outcomes will be achieved and developing indicators to track progress against this plan.

Three recommendations related to the HCD approach and empowerment activities for funders and implementers to take into account when designing and delivering programs future programs:

1. **Structure HCD programs to harness the benefits of multiple disciplines without the cost and complexity of large consortia.** A360's use of HCD, in combination with other disciplines, has been an important factor in its success, but introducing a new and complex approach brought challenges and tensions. The Process Evaluation team recommends a core consortium composed of the partners expected to have the greatest influence and engagement on design and implementation. For example, a consortium led by the implementing organization (PSI) in close partnership with the design partner (IDEO.org) during the design phase, with the other disciplines represented on an advisory group which would both provide advice and hold PSI accountable to excellence in elements of the program which relate to the group's areas of expertise.
2. **Harness the value of empowerment components, while being alert to the risks of light touch approaches that attract more than empower.** The process evaluation demonstrated multiple advantages of life skills, vocational sessions and aspirational messaging to AYSRH programs. However, this component needs to be a core focus of future programming rather than an add-on, and have sufficient resources attached to it, to have an impact on girls' empowerment. This requires either bringing expertise of economic empowerment into the consortium, partnering with organizations who specialize in this or a combination of both. It will also be important to define success upfront and periodically track progress and review learning.
3. **When applying HCD or design processes, build in sustainability considerations from the outset,** by adequately resourcing time to build strong relationships with government at multiple levels and building them into joint activities and data collection; considering tradeoffs between reaching high numbers of adopters and integrating into health systems; engaging actively in national and sub-national forums to influence thinking, policy and practice on AYSRH.



Introduction & Methodology

1. Introduction

Adolescents 360 (A360) was a four-year (2016–2020), US\$31 million initiative to increase adolescent girls' access to and demand for modern contraception in Nigeria, Ethiopia and Tanzania. A360 used human-centered design (HCD) alongside other disciplines to develop country-specific interventions through an iterative process of research and prototyping with girls and other stakeholders. A360 is implemented by Population Services International (PSI) and works in partnership with IDEO.org, the Center on the Developing Adolescent at the University of California at Berkeley, and the Society for Family Health Nigeria (SFH). It is co-funded by the Bill & Melinda Gates Foundation (BMGF) and the Children's Investment Fund Foundation (CIFF).

Itad is working in collaboration with the London School of Hygiene & Tropical Medicine (LSHTM) and Avenir Health to independently evaluate and distil lessons from the A360 program through an outcome evaluation, a cost-effectiveness analysis and a process evaluation. This report presents results from the process evaluation, synthesizing data collected between 2016 and 2020 to evaluate how A360 has played out in practice.

1.1. Overview of A360

The A360 approach drew on six disciplines: HCD, public health, adolescent developmental neuroscience, sociocultural anthropology, meaningful youth engagement and social marketing. The program hypothesis was that this fusion of disciplines would catalyze novel approaches to reaching adolescents that could be replicated by adolescent and youth sexual and reproductive health (AYSRH) partners around the world. A360 is defined by PSI, BMGF and CIFF as a multidisciplinary project where HCD was used as an ingredient, alongside other disciplines, rather than as an HCD 'end-to-end' project where HCD is aligned with the full program cycle from design to implementation¹. A360 was set up in such a way that HCD had a prominent role as compared to the other disciplines, particularly in the design phase, with the other disciplines supporting the process at specific points and in specific ways.

A360 was implemented in four phases: Inquiry, Insight Synthesis, Prototyping and Adaptive Implementation. The Inquiry and Insight Synthesis phases took place in 2016, involving formative research and analysis conducted by a team of design experts, implementers and young people. In 2017, insights were used to develop country-specific prototypes, which were tested and iterated to give rise to four distinct A360 'solutions' (interventions) for Ethiopia, Tanzania and Nigeria (north and south). The solutions were piloted in late 2017, before being rolled out, scaled up and further iterated between 2018 and the end of the program in September 2020 during the Adaptive Implementation phase.



¹ <https://www.designforhealth.org/understanding-design/why-does-design-matter>

A second A360 program began in October 2020 and will run until 2025. A360 Amplify, with continued funding from BMGF and CIFF, will focus on refining the solutions to continue improving effectiveness, integrating them into health systems for scale and sustainability, and supporting the adoption and replication of A360-inspired approaches through contributing to the global evidence base. A360 Amplify will work to further scale the existing solutions in Nigeria and Ethiopia, and introduce the program into Kenya.

The A360 solutions

**JALQABBII
GAARII
SMART START**

In Ethiopia, **Smart Start** uses financial planning as an entry point to discuss contraception with newly married couples. It leverages the nationwide Health Extension Worker (HEW) network, supported by A360 Smart Start Navigators and the volunteer Women's Development Army. It aims to help young couples view contraception as a tool that can help them achieve financial security and raise healthy children. HEWs are trained to host conversations about financial planning and provide contraceptive services in an approachable way to rural, married girls and their husbands, using a visual discussion guide.

**9JA
GIRLS**

In Southern Nigeria, **9ja Girls** combines walk-in contraceptive counseling with life-skills sessions for unmarried girls. Walk-in counseling is provided alongside Saturday sessions on the Life, Love, Health curriculum, which features vocational skills, future-planning exercises, and discussions about love, sex and dating. The aim is to make contraception relevant by helping girls tap into their aspirations and see contraception as a tool to reach their goals. 9ja Girls is delivered through public health facilities, where A360 Young Providers work alongside government providers to deliver classes and contraceptive counseling. 9ja Girls has a permanent presence at some facilities ('Hub' sites) and provides regular outreach services through more remote facilities linked to each Hub ('Spoke' sites).

**MATASA MATAN
AREWA**

In Northern Nigeria, **Matasa Matan Arewa (MMA)** targets married adolescent girls and their husbands using maternal and child health as an entry point. MMA uses a two-pronged approach to reach married girls. Female mentors recruit girls to take part in four Love, Life and Family classes, which incorporate life and vocational skills sessions, as well as an opportunity for one-to-one contraceptive counseling with a provider. Meanwhile, male mobilizers start conversations with husbands, to encourage them to refer their adolescent wives to a clinic for walk-in counseling. As with 9ja Girls, MMA is delivered by A360 Young Providers working alongside government providers through public health facilities, in a Hub-and-Spoke model.

**Kuwa
Mjanja**

In Tanzania, **Kuwa Mjanja** reaches unmarried girls with life and entrepreneurial skills sessions alongside youth-friendly contraceptive counseling. Out-of-clinic pop up events aim to provide a safe, non-medicalized space for girls to access contraceptive services. Events are framed as wellbeing rather than contraceptive events, incorporating targeted messaging on body changes or 'achieving dreams' depending on girls' life stage and priorities, and entrepreneurial skills sessions designed to inspire girls and enlist the support of communities. In-clinic events provide dedicated times and spaces for girls to access counseling at local facilities, with contraception linked to their goals

and dreams. Kuwa Mjanja is delivered through A360 outreach teams. Teams rotate districts each month and work with local government service providers who deliver contraceptive counseling and services.

See the Country Annex for further details on the solutions and how they evolved over time.






1.2. Context

Reaching adolescent girls with modern contraception is a global health priority to meet the United Nations Sustainable Development Goals on maternal and child mortality (Li *et al.*, 2020). Adolescent pregnancy is associated with complications during pregnancy and childbirth – a leading cause of death amongst girls worldwide (World Health Organization, 2016) – as well as increased risk of neonatal mortality (Ganchimeg *et al.*, 2014) and a decrease in girls' earning potential by up to 30% over their lifetimes (Chaaban and Cunningham, 2011). High adolescent fertility also results in significant economic losses – for example in Tanzania girls dropping out of school due to pregnancy costs around US\$5.2 billion annually (UNFPA, 2013).

A360 has been implemented in countries with high rates of adolescent pregnancy and early marriage,² and with large gaps between sexual debut and first contraceptive use particularly in rural areas.³ In Tanzania, adolescent pregnancy rates increased by four percentage points from 2010 to 2016 (MoHCDGEC Tanzania *et al.*, 2015). In Nigeria, while modern contraceptive use has tripled overall among women 15-49 in the past 30 years, contraceptive use among adolescents has remained stagnant (PMA, 2019). 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 (CSA Ethiopia, 2016; UNFPA, 2020).

Adolescent girls face many barriers to accessing contraception. These include social norms that promote early marriage and child bearing (McCleary-Sills, Stoebeu and Hollingworth, 2014; Challa *et al.*, 2018; Prata and Weidert, 2020), while condemning pre-marital sex (Williamson *et al.*, 2009; IPPF, 2014), and low levels of agency and self-efficacy which limit girls' autonomy to choose contraceptives if they wish (Chandra-Mouli *et al.*, 2017; Prata and Weidert, 2020). Girls often fear modern contraception due to cultural taboos, knowledge gaps and misconceptions around possible side effects, and face many barriers to access including cost, distance, health system constraints, and stigma and judgement on the part of service providers and communities (WHO, 2011; McCleary-Sills, Stoebeu and Hollingworth, 2014).

1.3. Overview of the report

INTRODUCTION & METHODOLOGY	FINDINGS	SPOTLIGHT 1	SPOTLIGHT 2	CONCLUSIONS AND RECOMMENDATIONS
		 How has A360 engaged young people?	 How sustainable is A360??	
Page 1	Page 12	Page 20	Page 54	Page 57

The diagram above depicts the structure of the report. Our findings are presented in three sections:

- **Section 3.1** describes how the A360 approach was applied to design the four solutions and draws out lessons from the design stage, including on the use of HCD, the input of multiple disciplines, and the adaptive implementation approach.

² As of 2016, the adolescent fertility rate was 117 births per 1000 girls (aged 15-19) in Tanzania, 69 in Ethiopia and 109 in Nigeria, compared to 43 globally. (World Bank, 2020). Median age of first sex and first marriage are 17.7 years and 18.1 years respectively in Ethiopia; 17.8 years and 18.6 years in Nigeria; and 17.4 years and 19.6 years in Tanzania (FP2020, 2020a).

³ Nigerian women experience a gap of nearly 8 years between first sex and first contraceptive use and by time of first contraceptive use they have on average 3.4 children (UNFPA), while in rural Tanzania the total fertility rate is 6.1. (DHS)

- **Section 3.2** synthesizes insights from across the A360 countries to tell the story of how implementation has unfolded and highlight key successes and challenges.
- **Section 3.3** describes how A360 has promoted the adoption and replication of the approach and solutions, and evidence of progress towards these aims.

The Country Annex presents further data and analysis for each of the four A360 solutions, disaggregated by country.

2. Methodology

2.1. A360 evaluation

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

- Provide timely data to help A360 course correct during implementation, and to maximize the effectiveness and impact of the program.
- Assess the impact of the program in reducing the number of unintended pregnancies among adolescent girls.
- Provide a robust evidence base on what does and does not work to reach adolescent girls at scale, cost-effectively, and assess to what extent the program is replicable.

The evaluation comprises three core components: an outcome evaluation led by LSHTM, a cost effectiveness analysis led by Avenir Health, and a process evaluation led by Itad (see Figure 1). At the heart of each evaluation component is a cross-cutting engagement and research uptake strategy, outlining how the learning will be shared with internal and external stakeholders. The evaluation components are designed to be complementary, with a view to providing a comprehensive snapshot of the impact of A360. More details on the outcome evaluation and cost effectiveness analysis are provided in the Methodology Annex, and on the Itad website.⁴

Figure 1: The A360 Evaluation Components



⁴ <http://www.itad.com/knowledge-and-resources/adolescents-360/>

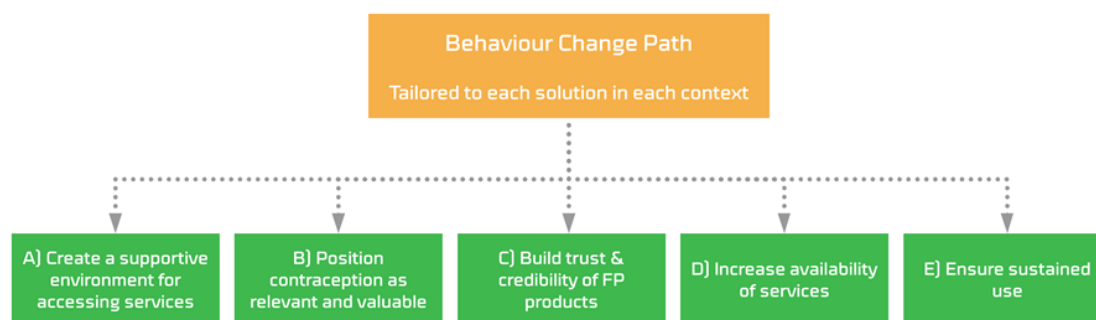
2.2. Process evaluation approach

The process evaluation was conducted by Itad between 2016 and 2020. It aimed to:

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

The process evaluation approach is theory-based, designed to investigate how the A360 Theory of Change (ToC) played out in practice (see Methodology Annex for ToC diagram). By exploring how and why A360 has or has not achieved the intermediate outcomes in the ToC (see Figure 3), the process evaluation aims to provide evidence that can explain outcome evaluation findings.

Figure 2: Intermediate outcomes in the A360 ToC: the 'behavior change path'



The A360 ToC 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 PSI and SFH to design global and solution-level 'User Journey' models, depicting how girls were intended to experience A360 (see Figure 7: below, and solution-level diagrams in the Country Annex). This approach builds on 'journey maps' from health research – a systematic approach to documenting service-user touchpoints with an intervention, capturing both the physical and emotional journey of the user including behavior, feelings, motivations and attitudes (McCarthy *et al.*, 2016).

The User Journeys were designed to help the evaluation investigate three dimensions outlined in the UK Medical Research Council framework for process evaluation (Moore *et al.*, 2013):

- **Implementation factors:** how A360 was delivered (through which structures, resources and processes); how implementation unfolded and whether this was faithful to the intended User Journey; and how A360 solutions adapted over time.
- **Mechanisms of impact:** how A360 activities, and participants' interactions with them, triggered change.
- **Context:** how external factors influenced the delivery and functioning of A360.

The User Journeys became the primary framework to structure process evaluation data collection and analysis in 2019, and explore implementation factors, mechanisms of impact and context. They have therefore been used to structure the country-level insights in Section 3.2. and the Country Annex.

Evaluation questions

Table 1 lists the process evaluation questions and indicates where each evaluation question is addressed in the report. The Methodology Annex contains the full evaluation framework.

- **Process questions** explored the A360 approach and how this played out in practice during implementation.
- **Context questions** considered the contexts in which A360 operates, including the enablers and barriers to implementation.
- **Solutions and experience questions** looked specifically at the interventions, considering how they were operationalized and experienced by girls, community members and other stakeholders.

The Country Annex contains further analysis and insights across the evaluation framework, particularly in relation to Context and Solutions and Experience questions.

Table 1: Process evaluation questions

Process	1.1. What makes the A360 process different to traditional ways of designing and implementing interventions?	Section 3.1
	1.2. How has the A360 approach adapted over the course of the program and why?	Section 3.1 and 3.2
	1.3. How has the design and implementation of A360 been managed and with what implications and effects?	
	1.4. What is the evidence of the adoption of the A360 inspired approach to design programs in PSI, consortium members, governments, and peer organizations?	Section 3.3
	1.5. What is the evidence of replication of the A360 developed solutions by PSI, consortium members, governments, and peer organizations?	
Context	2.1. How does the context in each country enable or inhibit the A360 approach and its implementation?	Section 3.2
Solutions and experience	3.1. Do the A360 solutions create a supportive environment to access services for adolescent girls in the communities they are operating in?	Section 3.2.1 and 3.2.2
	3.2. Do the A360 solutions position modern contraception as relevant and valuable to adolescent girls?	Section 3.2.3 and 3.2.4
	3.3. Do the A360 solutions build the trust and credibility of family planning products among adolescent girls?	Section 3.2.5
	3.4. Do the A360 solutions increase availability of services to adolescent girls?	Section 3.2.1 and 3.2.5
	3.5. Does the solution promote ongoing interaction between the adolescent girl and the service provider/health system?	Section 3.2.6
	3.6. How have the solutions been operationalized at scale in each country?	Section 3.2

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 **Error! Reference source not found.** above, aligned with the phases of A360 (see Figure 1).

2. **‘Global rounds’** encompassed interviews with PSI Global staff, A360 donors, consortium members, and external stakeholders within the AYSRH and HCD communities.
3. **Participatory Action Research 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 program 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 program. Case studies were published as standalone reports and are available on the Itad website.⁵

In total, the process evaluation conducted five full rounds of data collection in each country, four global rounds and three participatory action case studies (see Methodology Annex for further details).

2.3. Data collection, analysis and synthesis

Data collection

Data collection involved national and state / regional level interviews (with A360 staff, government officials and external AYSRH actors), alongside data collection in a sample of A360 implementation communities. Communities were purposively identified by the process evaluation team in collaboration with the country A360 team, considering the start date and duration of implementation in the area, as well as logistical factors such as security and access. Community-level data collection was focused in outcome evaluation states / regions, in order to complement the outcome evaluation findings (Oromia region in Ethiopia; Nasarawa and Ogun states in Nigeria; and Mwanza region in Tanzania). The process evaluation obtained Institutional Review Board (IRB) approval prior to data collection in each country (see Methodology Annex for more details on evaluation ethics).

The process evaluation primarily utilized qualitative methods and tools, to elicit perspectives and insights on experience, attitudes and behaviors in line with the evaluation questions in Table 1. Study participants were recruited with the support of program mobilizers and implementing staff, guided by purposive sampling criteria aiming to identify participants with some knowledge or experience of A360 activities (see further details in Methodology Annex). Table 3 summarizes the total data collected through the process evaluation.

Table 2: Process evaluation data collection methods

Semi-structured in-depth interviews and focus group discussions	697 in-depth interviews were conducted with A360 staff and donors, adolescent girls, community implementers, government officials, community members (including husbands, mothers, and local leaders), and external AYSRH stakeholders. 85 focus group discussions were conducted with girls and community members. Semi-structured guides were tailored to each stakeholder group and used to structure discussion.
Structured observations and exit interviews	The process evaluation team observed 66 key events and process points during the A360 design period and beyond. This included workshops, annual review meetings and solution activities (e.g. counseling sessions and events – in 2019 these observations were also accompanied by short exit interviews with participating girls).
Participatory research	Participatory ethnographic research was conducted in Ethiopia and Tanzania in 2017 and 2018, drawing on principles of Participatory Ethnographic Evaluation and Research (PEER). ⁶ Girls were trained as peer researchers and engaged in co-creating interview questions, before interviewing their peers about their

⁵ See <https://www.itad.com/project/evaluation-of-adolescents-360/>.

⁶ PEER was developed by Options Consulting Ltd in collaboration with Swansea University.

	<p>experiences of A360. Group reflection, roleplays and visual storytelling were used to help girls discuss and reflect on their findings.</p> <p>While these exercises generated rich insights into girls' perspectives and experiences, the nature of girls' interactions with A360 (often one-off) meant the ethnographic approach was challenging to apply. In 2019, it was replaced with lighter-touch sensemaking workshops with girls who took part in interviews and focus groups, using participatory drawing and group reflection to encourage girls to reflect on emerging findings and help research teams deepen understanding of the issues raised.</p>
Document review and review of A360 monitoring data	<p>Each data collection round included a review of key implementation documents, including A360 reporting and strategy documents, and solution materials such as curricula and implementation guidelines. From 2019, each full round also involved an independent analysis of program monitoring data (conducted by Itad in 2019 and LSHTM in 2020), in order to triangulate national-level quantitative data on performance with qualitative insights from the process evaluation study sites.</p>

Adaptations due to COVID-19

The final round of data collection in 2020 took place during the COVID-19 pandemic, requiring major changes to methods. The same stakeholders were consulted as in previous rounds, but all data was collected through remote interviews (273 in total across the three countries), over the phone or using Microsoft Teams. Topic guides were shortened, and all community stakeholders were reminded about how to prevent the spread of COVID-19, in line with government guidance. Different approaches were used to identify and interview girls in each country, based on the status of A360 implementation at the time of data collection.

- In Tanzania, COVID-19 had completely halted all A360 activities during the data collection period. Girls were therefore recruited and interviewed entirely remotely, with the help of A360 Tanzania's 'call center database', and with the support of peer mobilizers (Kuwa Mjanja Queens), who recruited acquaintances whose phone numbers they had access to.
- In Ethiopia and Nigeria, service provision was ongoing and so it was possible to conduct interviews with the support of implementers on the ground. This enabled the process evaluation team to interview girls who did not have access to a phone. Health Extension Workers (HEWs: in Ethiopia) and paid mobilizers (in Nigeria) were trained on the mobilization process and provided with personal protective equipment. HEWs and mobilizers then scheduled interviews in line with process evaluation sampling criteria, which were conducted in health facilities using HEW's and mobilizers phones, following a strict physical distancing and sanitization protocol designed to protect girls' confidentiality and health.

Table 3: Total data collected through the process evaluation

Data	Ethiopia	Nigeria	Tanzania	Global	Total
In-depth interviews	245	172	198	82	697
A360 staff	58	56	68	15	197
Donors				4	4
Adolescent girls	58	78	30		166
Community implementers <i>Including service providers, mobilizers, and skills facilitators</i>	55	67	37		159
Government	28	26	23		77
Community members <i>Including boys, husbands, mothers, and religious and community leaders</i>	27	16	18		61
External AYSRH stakeholders	19	16	22	7	64
Focus group discussions	26	32	26	1	85

Adolescent girls	12	15	12		39
Community members <i>Including husbands, mothers and adolescent boys</i>	14	17	14		45
Observations	17	29	20		66
Participatory youth researchers (2017-2018)	12		15		27
Sensemaking workshops (2019)	4	2			6

Data analysis

Data analysis was conducted approximately annually for each country and workstream (more frequently during the design stage). Following each round of data collection, transcripts from primary data collection were coded thematically by the Itad country lead using qualitative analysis software Dedoose and later MAXQDA. Coding was primarily deductive, using a framework structured according to the evaluation questions and later the User Journeys, with new codes added iteratively to capture emerging themes. Secondary documentation was reviewed for insights relating to the evaluation questions and (from 2019) the User Journeys.

Data sources were synthesized thematically, through reviewing all data relating to a particular evaluation question or area of the User Journey, and triangulating insights from different sources and stakeholder groups to draw out key themes. Internal ‘analysis narratives’ were created, linking each finding to the raw data to ensure insights were well-triangulated. These were quality assured by the process evaluation team leader before finalizing.

In 2019 and 2020, quantitative monitoring data collected by A360 was independently analyzed using Stata 16 statistical analysis software to generate descriptive and analytical results. Analysis explored data relating to key ‘touchpoints’ between adolescent girls and the program (in line with the User Journeys): mobilization, counseling, adopting a method, and follow up. Results were triangulated with qualitative findings and incorporated into the relevant analysis.

From 2018, draft analysis reports were shared with A360 prior to participatory one-day ‘sounding workshops.’ These brought A360 and process evaluation teams together to review and discuss draft findings, verify insights, and collaboratively identify implications. Finalized insights were then developed into slide decks, reports, case studies and webinars and delivered annually or in line with data collection rounds to A360 donors, implementers and external audiences.⁷

Final report synthesis

The final process evaluation report draws on 38 analysis documents, including country-level and global analysis from across the workstreams, as well as synthesis reports and slide decks. All sources were coded using MAXQDA using both deductive coding (aligned with the A360 evaluation questions and User Journeys) and inductive coding (drawing out emergent patterns and themes). Thematic synthesis was applied to identify common descriptive themes, contradictions and nuances, and inductively group insights to generate new explanations and hypotheses. The report also incorporates the following secondary data sources:

- Insights from an internal literature review conducted by Catarina Krug (LSHTM Research Fellow) for the evaluation in 2020.
- Independent analysis of A360 monitoring data conducted by Catarina Krug in mid-2020.
- Overall A360 performance data from October 2017 to the end of the program in September 2020, provided by A360 in November 2020.

This final process evaluation report highlights cross-cutting and critical issues from across the four phases of A360 and the four solutions. As it draws on existing analysis – subjected to a rigorous process of

⁷ Externally published resources are available on the Itad website: <https://www.itad.com/project/evaluation-of-adolescents-360/>

triangulation, review and revision as described above – we have not cited primary evidence sources extensively. Where we have drawn on secondary data, full citation is provided. The draft report was reviewed by the country evaluation leads and quality assured by the evaluation Project Director before finalizing.

2.4. Limitations

The main limitations of the process evaluation are as follows:

- **Limited generalizability of community-level findings:** Community level data collection was conducted in a small number of sites (1-4 per round), and with a relatively small number of respondents each round (see Table 3), meaning that insights may not be generalizable across all implementation areas. This challenge was mitigated to some extent by triangulating findings with a comprehensive review of key A360 documents, national level monitoring data, and interviews with national stakeholders and staff.
- **Reliance on program monitoring and performance data:** While the process evaluation drew on A360 monitoring data, it was not within the evaluation team's remit to conduct data verification or quality checks on this data. The independent analysis was also restricted by some data gaps and did not include the final months of the program.
- **Keeping abreast of a fast-paced, iterative and adaptive process:** As the process evaluation team was independent from A360 this presented challenges in documenting how the design and implementation processes played out, as the evaluation was not present for many key decision points and adaptations during the fast-paced process.
- **Measuring adoption and replication:** Through interviews with A360 staff, national level government officials and global AYSRH stakeholders, the process evaluation has been able to generate some insights on where A360 has been adopted and/or replicated, both globally and nationally. However, it is not within the scope of the process evaluation to investigate this issue in depth or verify claims of adoption and replication.
- **COVID-19:** While remote interviews in 2020 generated substantial rich and valuable data, there were several limitations. Topic guides were shorter in order not to overburden respondents with long phone calls, meaning some interviews were less in-depth. There was also greater reliance on A360 staff to connect the process evaluation team with girls and community stakeholders, introducing some risk of bias. In Tanzania, the need to locate adolescent girls with access to a phone potentially biased the sample, given the overall low levels of phone ownership among adolescents in Tanzania



| Findings

3. Findings

3.1. The A360 approach

This section describes the A360 approach and how it was applied to design and implement the four solutions, drawing out key successes and challenges.

Headline findings

The **multidisciplinary A360 approach** represented a novel approach to design for the consortium partners, and added value in several ways:

- The **HCD process** provided time and space to try out new ideas and bring them to fruition, created a mechanism to involve young people more intentionally in design, shifted the mindsets of implementers to inspire more empathy for adolescent girls and enable them to work in more flexible, responsive ways, and helped generate attractive brands that were rigorously tested and iterated.
- **Youth engagement** ensured young people were core to the design process from the outset, making valuable contributions to research and prototypes.
- The **other disciplines** contributed to learning and generated insights that strengthened solutions during the design stage.

However, managing the complex approach and large consortium was challenging. Challenges arose from a lack of clarity in roles and responsibilities, and managing inputs and communication across a large team through a fast-paced design process. There were concerns that existing evidence on best practice for AYSRH programming and national guidelines were not given sufficient attention, and unclear expectations of the heavy workload required by country teams. Lack of budget, measurement and a clear strategy also constrained youth engagement and frustrated country teams. Disciplines other than HCD and youth engagement had less explicit influence after A360 scaled and in practice, A360 was multidisciplinary rather than transdisciplinary.

Earlier clarity around the parameters for scalability and feasibility could have helped to avoid tensions. The HCD approach focused on the desirability of concepts to girls, but not all ideas were practical to implement. Providing more explicit space for the public health perspective from the outset would have also helped ensure that early ideas were better grounded in evidence and context.

Adaptive implementation was introduced to facilitate continuous improvements as solutions scaled. This built on the skills and mindsets fostered through HCD to provide a framework for understanding and addressing variable performance, introducing adaptations in response to learning and changes in context, and supporting country teams to respond to COVID-19 – although was not always easy to apply in practice.

The A360 approach incorporated expertise from multiple disciplines: HCD, public health, developmental neuroscience, cultural anthropology, meaningful youth engagement and social marketing.

Human Centered Design (HCD) is an approach to intervention design increasingly applied in public health projects (Bazzano *et al.*, 2017). There is no single definition of HCD, and its tools and principles overlap with user-centered design, participatory design, and design thinking (Bazzano *et al.*, 2017; Holeman and Kane, 2019; Chen *et al.*, 2020). At its core is the idea that design should be a reflective practice employing a specific mindset to engage in creative problem solving and generate innovative solutions, with the end-user integral to the process (Björgvinsson, Ehn and Hillgren, 2012). It differs from more ‘traditional’ social-behavioral research in its focus on users’ desires and aspirations, not just their needs. HCD also employs flexible, rapid and iterative data collection and analysis, with an emphasis on story-telling and creative insights over scientific research approaches (IDEO, 2015; Tolley, 2017). The HCD approach applied in A360 and described here reflects the HCD practices of IDEO.org, the design partner in the A360 consortium. The evaluation did not consider how this may have differed if the HCD support was provided by a different design firm. For the purposes of this evaluation, references to HCD as applied in A360 are specific to the IDEO.org approach.

A360 aimed to augment HCD with several other disciplines, drawing on expertise from multiple consortium partners (see Box 1) to unlock innovative approaches to reach adolescent girls. The approach was variously described as multidisciplinary, transdisciplinary or ‘HCD plus.’ This represented a shift for PSI – away from what was characterized as an “assembly line” model where each partner works autonomously on a different element of a project.

“Everyone is tinkering and bringing their own experience to create something that is better than the sum of its parts to generate health impact.” (A360 consortium member, 2017)

A360 was implemented through four phases. The Inquiry, Insight Synthesis and Prototyping phases represent the ‘design stage’ of A360, (see Box 2) after which the program moved into the Adaptive Implementation phase as it scaled.⁸ The evaluation mid-term review (Newport *et al.*, 2019) describes how the first three of these phases played out in detail.⁹

HCD was viewed as the driving force during the A360 design process and added value in several ways.

HCD provided tools and a structured approach that drove the A360 design stage, with youth engagement integrated through bringing young people into design teams, and other disciplines providing tailored

Box 1. A360 consortium partners

- **PSI:** Consortium lead, with dedicated teams in Washington, Ethiopia and Tanzania.
- **SFH:** Lead implementing organization in Nigeria, with dedicated national and state level teams.
- **IDEO.org:** Dedicated HCD support through the inquiry to prototyping stages, and support to ad hoc design sprints during adaptive implementation.
- **University of California Berkley (UCB):** represented by one or two experts throughout the design process, bringing expertise on adolescent developmental neuroscience and youth engagement.
- **A sociocultural anthropologist** provided consultancy support to all countries and supported data collection in Nigeria.
- **Triggerise*** played a role in the inquiry and insight synthesis stages, bringing expertise in digital solutions.
- **Ogilvy & Mather*** played a role in the inception phase, bringing expertise in social marketing.

*Ogilvy & Mather and Triggerise both left the consortium as it as mutually agreed that their inputs were less relevant to A360 than originally envisioned. Ogilvy & Mather left before the design phase; Triggerise left after prototyping; The sociocultural anthropologist joined prior to the start of insight gathering.

⁸ A360 initially referred to the phases using language from IDEO.org’s approach to HCD: Inspiration, Ideation, Pilot and Scale. The terminology was adapted in 2019 to improve clarity to wider audiences. The Inspiration phase is now termed ‘Inquiry and Insight Synthesis’; the ‘Ideation’ and ‘Pilot’ phases are now known as ‘Prototyping’, and ‘Scale’ became ‘Adaptive Implementation.’

⁹ The evaluation mid-term review is available on the Itad website here: <https://www.itad.com/knowledge-product/midterm-review-of-the-adolescents-360-program/>

inputs at specific points (discussed further below). HCD added value to the A360 design in the following ways:

- **Giving implementers permission to try out new ideas and bring them to fruition.** A360 staff described the process as ‘deeper’ than a typical program design experience, with HCD providing space for new ideas to be developed, tested and iterated from the bottom-up.

“Typically, with other projects, we go to the donor with a solution, but in this case it is very different. We don’t know where we’ll end up.” (A360 staff member, Tanzania, 2016)

- **Shifting the mindsets and attitudes of implementers.** A360 staff from all three countries consistently reported that the HCD process had changed their attitudes to designing programs for adolescents, providing new ways of thinking and new behaviors that they took forward into implementation. Staff felt their exposure to HCD had inspired more empathy for adolescent girls, as well as fostering an attitude of humility and curiosity that they would take into future programming.

“HCD changed my way of thinking in the sense that it is not about prescribing your thoughts but thinking of things from the perspective of the adolescent.” (A360 staff member, Nigeria, 2017)

- **Providing a process to involve young people intentionally and meaningfully.** Prior to A360, country teams reported that they had not typically engaged young people in design, or where they had, young people had not been involved as much or as consistently as they were in A360. Working with young people as core design partners to help ‘put girls at the center’ was a new way of thinking. This added value in several ways – discussed in more detail in Spotlight 1 below.
- **Helping A360 ‘land the brand.’** HCD provided a way to engage girls in the branding process. Support from IDEO.org was credited with anchoring the A360 brands (encompassing not just solution names and logos, but also broader intended user experience) in design principles and mindsets. These included ‘thinking outside of the box’, and subjecting brands to intense testing and iteration during prototyping. In Tanzania this was viewed as a game changing moment by the country team, highlighting the contribution that a design lens can bring. The value of the A360 brands is discussed further in Section 3.2.5.

Box 2. The A360 design stage

- The **Inquiry** phase in 2016 involved experts in each of the disciplines working together to conduct qualitative formative research with adolescent girls, key influencers and other community members. Consortium members contributed expertise from their various disciplines through orientation sessions, remote support, and participation in data collection.
- The **Insight Synthesis** phase (late 2016) synthesized the research to generate sets of ‘insights’ for each country, which were used to design prototypes for testing.¹⁰
- The **Prototyping** phase took place in 2017. It involved PSI and SFH working together with IDEO.org to test and iterate ideas and generate tangible interventions. Testing took place through several stages – including ‘rough’ and ‘live’ prototyping followed by a short pilot of the refined solutions. At this point, decisions were made to narrow the target audience to specific sub-population groups in order to consolidate resources and focus solutions, prioritizing married girls in Ethiopia and Northern Nigeria, and unmarried girls in Tanzania and Southern Nigeria.

¹⁰ Insights are summarized on the A360 website here: <http://a360learninghub.org/open-source/insight-synthesis/irrelevant-dangerous/>

The A360 design stage was challenging, as the consortium struggled with a new and complex process and a large consortium.

Bringing a new process for program design together with a large consortium presented a range of challenges. These led to various tensions and frustration in the early stages – some of which could potentially have been avoided if ways of working had been planned at the start. Issues included:

- **Initial lack of clarity in roles and responsibilities.** One major source of tension arose due to Insight Synthesis being led by IDEO.org from San Francisco without on-the-ground engagement from country teams, leading to concerns that important public health and contextual issues were not sufficiently considered when developing the insights. This issue was resolved over time as roles became more clearly defined and collaboration strengthened within the consortium. During Prototyping, the balance of ownership shifted with decision-making primarily driven by country teams in collaboration with IDEO.org.

“We’re co-creating knowledge and yet we’re doing it in separate places. I don’t see how that is ideal...you build knowledge through local knowledge, not through a separate process” (A360 Consortium respondent, 2016)

High demands on staff, with risk of burnout. The high volume of work and irregular hours required to learn how to apply an HCD process at the same time as co-leading the HCD process were not made clear to the PSI country teams from the outset. At times the high level of pressure on relatively small core teams, and the frequently evolving priorities and demands, led to a risk of burnout. Country team members sometimes felt that the global team did not fully recognize the expectations placed on them and the burnout faced by some staff. Ultimately, the dedication and commitment of the individuals within A360 have been fundamental to the success of the program – for example their commitment, expertise and passion for A360, and willingness to work in new ways and have difficult conversations when needed. Flexibility and open-mindedness were flagged as critical, especially given the complexity of the process and the introduction of multiple new lenses and tools over the course of the program.

“We wouldn’t be moving so quickly if we didn’t have such fiercely determined people, who like each other, and are willing to go to couples counseling when things get hard.” (A360 Consortium member, 2016)

- **Insufficient consideration of relevant evidence:** Several consortium members expressed concerns that the focus on bottom-up insights from HCD formative research had crowded out consideration of the wider evidence base during the early stages of the design process, leading to missed opportunities to draw on existing AYSRH evidence about what works to engage adolescents. Literature reviews, stakeholder mapping and gender analysis were conducted during the Inquiry phase, but there was no systematic triangulation with the insights emerging from data collection. This was seen as a risk to A360 as it made initial choices about which concepts to prototype. This was addressed to some extent during the Prototyping phase, as consortium members fed in expertise from various lenses to inform iterations to the solutions – for example, UCB helped develop ‘opt-out moments’ to enable girls to access contraceptive counseling without stigma (see Section 3.2.6), and PSI drew on evidence on peer engagement to inform the Kuwa Mjanja Queen role in Tanzania.

“It’s an ongoing tension with the design process that there’s no review of existing best practices.” (A360 Consortium respondent, 2017)

- **Tensions between desirability, feasibility and scalability.** HCD focuses on the ‘desirability’ of solutions to users, and this consideration initially took precedence during the design stage. Considering the feasibility and scalability of concepts at an earlier stage may have helped establish clear parameters for prototyping. The solutions in Ethiopia and Nigeria were designed to integrate into public health systems, which face major challenges in relation to contraceptive availability, human resources for health and infrastructure, and management and leadership capacity (see Section 3.2.2). In some cases, this led to tensions between what was ideal and what was practical. For

example, in Nigeria a standalone branded space for girls in vacant government facilities was included as part of the design despite concerns about cost; while in Ethiopia the Discussion Guide designed for Health Extension Workers proved too onerous given their busy schedules, requiring significant revision at a later stage.

- **Documenting the process.** The HCD literature recommends documenting the tools, mindsets and methods used, and the new ideas and actions that arise through the process (Bazzano *et al.*, 2017). However, A360 struggled to systematically document all aspects of the complex, iterative and fast-paced design process. Decisions were often made quickly and ideas and prototypes evolved organically in meetings and workshops. This process was described as ‘both an art and a science,’ with prototypes selected based on teams having ‘internalized’ the design standards rather than formally scoring different concepts. While the process evaluation was able to capture some of this evolution, the evaluation team was not always present for key activities and decision points.

Box 3. What value did adolescent developmental science, public health, social marketing, sociocultural anthropology and meaningful youth engagement bring to A360?

- **Adolescent developmental neuroscience** helped teams in all countries think beyond simple categories (girls’ age and marital status) to consider how adolescents develop, their life trajectories, and how they think about and make decisions about sexual relationships, childbearing and contraceptive practices. Insights fed into the development of aspirational content for A360 (see Section 3.2.5). It also informed a segmentation analysis in Tanzania, which led to different models targeting girls at different life stages.
- The **public health lens** brought PSI and SFH understanding of context, clinical requirements and AYSRH evidence to the design phase. This drove the decision to obtain Institutional Review Board (IRB) approval prior to formative research. The IRB process helped A360 strengthen its research design and approach to ethics, and was viewed as important to ensure the resulting solutions were credible in the public health community. However, it was also seen to constrain the less structured and exploratory nature of the HCD research process, limiting the ways in which the research teams could interact with young people – for example, being unable to ask about young people’s personal experiences or having to follow scripted conversations. PSI and SFH country teams also drew on their public health expertise and understanding of the context to inform evolving solutions during the prototyping stage, and build quality assurance processes into the program as it scaled.
- **Social marketing** expertise from PSI contributed to the well-defined A360 brands and messaging in all three countries, drawing on insights from behavioral change communication. However, efforts to use adolescent segmentation models from social marketing provided limited value in terms of data needed to make decisions, and teams struggled to find the time and resources to complete a rigorous analysis of segmentation research in order to build insights into solution. Whilst social marketing was seen to contribute to A360 in specific ways at the country level, its influence was often considered to be ‘overshadowed’ by HCD.
- **Sociocultural anthropology** was considered the ‘least influential’ discipline as of 2018, with consortium members reflecting that the anthropologist was not engaged early enough in the design process to inform research protocols. This meant that a sociocultural perspective was not well integrated, and cultural belief systems and social norms were not always explicitly addressed. Some A360 staff felt that sociocultural anthropology had provided useful foundational insights around the importance of working with community structures, and helped to surface the importance of context and country team knowledge. It is possible that this discipline could have provided more support on addressing social norms if it had been engaged from the start of the design phase and with a more prominent role in the consortium.
- **Meaningful youth engagement (MYE)** aimed to ensure that young people were involved throughout the design and implementation of A360. While there were challenges with this from operational and organizational culture standpoints, it was widely seen as integral to A360 being able to understand and

address the needs of the target populations, and led to a positive recognition by PSI staff who engaged with young people of the value they added to A360. See Spotlight 1 for a further discussion of MYE and the definition of MYE that guided PSI's engagement with young people.

While all the disciplines contributed to learning and generated insights that strengthened solutions, A360 operated as a multidisciplinary rather than transdisciplinary or interdisciplinary program.

All disciplines added value by bringing new insights and ways of thinking that influenced the design of country solutions (see Box 3). Discipline experts helped mediate key decisions, validate some components of the solutions and provide strategic input at a global level. However, the influence of the disciplines was not equal across the team. Disciplines had less influence where they lacked expert representation on the A360 team, or where budgets were smaller (as was the case with social marketing and sociocultural anthropology).

HCD and youth engagement continued to play a significant role in A360 during the Adaptive Implementation phase, with mini design sprints held in some countries to help adapt solutions as learning grew, and new approaches to youth engagement trialed. However, the influence of the other lenses was less clear after the design stage, and consortium partners other than PSI and SFH played minimal roles in the program from 2018 onwards.

A360 has been variously described as multidisciplinary, interdisciplinary and transdisciplinary. As most disciplines contributed in a complementary rather than a joint way, and most inputs were fairly specific and narrow, this suggests that A360 operated as a multidisciplinary program, with the disciplines adding value individually and complementing each other but not integrated in a truly 'transdisciplinary' way.¹¹ Some stakeholders raised questions about whether a complex, multidisciplinary approach was in fact necessary, as HCD is intended to draw on multiple, relevant perspectives as part of the approach.

A360 struggled with shifting donor expectations and pressure to reach scale quickly while managing a complex design process.

Over the course of the program, A360 struggled with tight timelines, shifting priorities and the pressure of learning and implementing a complex design process while also working towards scale and achieving high adoption targets. While the strategic inputs of donors were valued, shifting expectations at times caused anxiety and demoralized country teams.

"There have been a lot of changes and we have had to adjust our strategy approach to meet donor expectations which just slows things down... having clear expectations for deliverables [would have helped]." (A360 staff member, Tanzania, 2016)

For example, pressure from donors to stay on schedule during Prototyping led to a rushed process as A360 moved towards scaling solutions without having all the necessary systems and staff in place. The final stage of Prototyping aimed to pilot solutions in 'live conditions' before scaling. Under pressure from the donors to make up for time lost during Inquiry (a result of delays to the IRB processes), the pilot was shortened from the planned six months to three months. This was generally felt to be too short to rigorously test the solutions and effectively use data and learning to course correct.

As the project moved from Prototyping into the Adaptive Implementation phase at the start of 2018, donor expectations for country teams to meet targets and rapidly scale up at the same time as driving down costs created further pressure. A360 was encouraged to identify the 'minimum viable product' for each solution – focused on cost-efficiency as defined by cost per adopter – while also achieving country-specific adoption targets. Country teams identified ways to decrease the costs of the solutions through local procurement, using less expensive materials and modifying or eliminating various program components that did not have a direct impact on adoption figures. This led to some successful adaptations

¹¹ A transdisciplinary approach is defined as '...an integrative process in which researchers work jointly to develop and use a shared conceptual framework that synthesizes and extends discipline-specific theories, concepts, methods, or all three to create new models and language to address a common research problem' (Stokols et al., 2008).

that drove down costs – for example removing the standalone branded clinic model in Nigeria, after A360 found that integrated service delivery rooms were equally successful and considerably more cost-effective. However, the drive for efficiency and emphasis on adoption numbers over other objectives also created incentives for A360 to strip back activities focused on community engagement and continuation, which was flagged as a concern in the evaluation mid-term review (Newport *et al.*, 2019).

After the evaluation mid-term review, these concerns helped drive a shift in focus from ‘minimal’ to ‘recommended’ viable product in 2019. A360 adapted or re-introduced various program components to more holistically respond to girls’ needs and ensure quality. This was accompanied by a greater focus on supporting continuation and stakeholder engagement, and meaningfully engaging youth.

Box 4: Unidisciplinary, multidisciplinary, interdisciplinary or transdisciplinary? Levels of integration among disciplines:

Unidisciplinary:

- Researchers from a single discipline work together to address a common research problem.

Multidisciplinary:

- Researchers from different disciplines work independently or sequentially, periodically coming together to share their individual perspectives with the goal of combining efforts to address a common research problem.
- Participants in multidisciplinary teams remain firmly anchored in the concepts and methods of their respective fields.

Interdisciplinary:

- Greater sharing of information and closer coordination among researchers from various fields than occurs in multidisciplinary projects.
- Participants remain anchored in their respective disciplinary models and methodologies but work more intensively to integrate their divergent perspectives.

Transdisciplinary:

- An integrative process where researchers work jointly to develop and use a shared conceptual framework that synthesizes and extends discipline-specific theories, concepts, methods, or all three to create new models and language to address a common research problem.

Stokols *et al.*, 2008

Adaptive implementation was introduced in 2018 to facilitate continuous improvements as the solutions scaled. This has proved a success, although challenging to implement.

In 2018, A360 introduced an adaptive implementation approach, with the support of an implementation scientist who joined the global team. This approach was intended to provide structure and tools to ensure the solutions continued to resonate with girls and that the core elements of A360 were preserved while pursuing adaptations to drive improvements as they were scaled. The process involved country teams regularly reviewing qualitative and quantitative monitoring data to identify learning and iterate solutions (see Box 5 below). Staff viewed adaptive implementation as complementary to the HCD process, and as a means of moving from design to implementation while still maintaining ‘curiosity and tinkering.’ The skills and new mindsets fostered through HCD (flexibility, curiosity and the ability to test and iterate) helped teams adjust to and apply an adaptive approach.

“HCD will shape your cornerstones. And then adaptive implementation gives you the bricks in between...it does not rely on big sprints, but rather smaller tweaks based on the needs that are there.” (A360 staff member, Tanzania, 2020)

Adaptive implementation was supported by opportunities for cross-country learning. Country-teams felt that regular peer-to-peer learning visits, co-creation meetings and shared quality assessment exercises were useful mechanisms to learn from other settings. However, the introduction of adaptive implementation was time consuming for the country teams and required significant support from PSI Global. Some country teams found the array of new materials and resources difficult to assimilate. The Tanzania team began with weekly performance review meetings, but eventually reduced these to monthly and limited the engagement of regional staff members due to time constraints. It was also difficult to embed adaptive ways of working into front-line implementation and challenging to roll out adaptations to multiple regions and teams after the solutions scaled. Although some adaptations arose from teams on the ground, most were centrally coordinated. In 2019, Tanzania managed to overcome some of these challenges by embedding ‘youth experts’ into outreach teams – see Spotlight 1 below.

Box 5. The value of adaptive implementation

PSI’s definition of adaptive implementation is grounded in the fundamental tenet of implementation science that no intervention is optimal prior to implementation (Chambers, Glasgow, and Strange, 2013). The adaptive implementation approach embraces the need for and encourages iterative, learning-based adaptations to program implementation. Adaptations aim to ensure the interventions’ continued “fit” for girls, and the health systems that own and sustain their implementation. Data systems and monitoring approaches are designed to allow for rapid reviews of qualitative and quantitative data to inform continuous program adaptation. In this way, programs can be supported to respond to girls’ experiences and needs and the possibilities and constraints of local health systems. The adaptive implementation approach has helped A360:

- **Understand and respond to variable performance.** Adaptive implementation has provided a process for regularly reviewing quantitative monitoring data alongside qualitative insights from site visits, enabling teams to identify higher and lower performing sites and the reasons behind the differences. This has resulted in adaptations that have further improved performance. For example, in Tanzania, the team observed high attendance and conversion figures in one region, which was linked to the use of Youth Development Officers to mobilize girls. This approach was then rolled out nationally (see Country Annex Section 2.3.1 for further details).
- **Identify critical and less critical elements of the solutions.** Country teams have trialed various adaptations over the course of the program, monitoring performance to understand whether certain aspects of the solutions were critical or not. In Nigeria, A360 trialed the 9ja Girls solution with and without branded girl-only safe spaces and found the branded safe-spaces were not necessary (see Section 3.2.5). However, a similar trial to test the necessity of the A360 Young Provider stationed in health facilities found that removing this role led to a significant drop in service quality (see Section 3.2.2).
- **Tweak the solutions to respond to emerging questions and challenges.** In Ethiopia, a central Learning Team conducted ad hoc learning visits to explore emerging questions and issues in more depth. This contributed to important adaptations including the increased role of the Women’s Development Army in the solution. In Tanzania, staff observed that many girls were leaving out-of-clinic events before seeing a provider for contraceptive counselling, as they were getting bored while waiting. A team of youth experts was brought in to help identify areas for improvement and roll out adaptations to outreach teams (see).
- **Rapidly respond to COVID-19.** In Tanzania and Nigeria staff felt they were able to understand girls’ needs and modify the solutions more quickly because of their experience with HCD and adaptive implementation. Nigeria responded in particularly innovative ways, moving skills classes to virtual platforms that enabled them to continue reaching girls with aspirational content. Throughout the pandemic, regional coordinators continued to carry out regular data-to-action review meetings virtually to reflect on challenges and successes in the new model with young providers, mobilizers and young designers. See Country Annex Section 4.1 for further details.



Spotlight 1: How has A360 engaged young people?

Young people made direct contributions to the A360 design process and shifted the mindsets of both designers and implementers in important ways.

In each country, young people were engaged in the Inquiry and Insight Synthesis phases as core members of the design team. They added value to the design stage through:

- **Helping ensure formative research was girl-friendly:** During the Inquiry phase, young designers supported formulation of questions in local languages using terms understood by adolescents, and were engaged as note-takers, translators and interviewers during data collection. Staff observed that young people helped girls feel more at ease during the research process.
- **Translating cultural insights.** During the Insight Synthesis phase, young designers helped design teams understand the cultural meanings of issues arising through research – explaining the connotations of particular findings and helping draw informed conclusions. In all three countries, young people were seen to add value during

formative research by ‘*explaining insights, layering on richness and bringing energy*’.

- **Supporting government buy-in.** In Ethiopia, a skeptical government representative became a champion of A360 after hearing about the program directly from young designers, emphasizing the value of youth advocacy.

Engaging young people in the design also helped to increased empathy for young people among adult members of the design team. As time went on, more adults came to value and advocate for the contribution of young people in design and implementation.

However, lack of budget, measurement and a clear strategy constrained youth engagement and frustrated country teams.

From the beginning of A360 the participation of young designers was limited by budget and resourcing constraints. This presented challenges in fully integrating young people into design teams, and ensuring they were fully supported to add value during research processes while recognizing their relative lack of research experience. For example, in Nigeria, a budget was not considered for young people to

stay at the hotel where the Inquiry workshop was being conducted, creating tensions. A360 did not budget for compensation for young designers during Inquiry, which created challenges with retention.

“For youth engagement to be truly meaningful [young people] would need to have equal involvement in the process. However, for A360...the young designers were brought in at key moments, rather than being consistently involved.” (A360 Consortium member, 2016)

A360 also did not incorporate clear mechanisms to measure the impact of youth engagement, above anecdotal evidence of their contribution. Country teams were frustrated by this as they wanted to be able to understand the impact of young people on the A360 solutions.

Finally, the young people engaged in the design process were not generally representative of the girls targeted by A360 – young designers were older, more educated and more urban. This was viewed as a pragmatic solution given resource constraints and the challenges of meaningfully engaging rural girls in the process.

A360 initially struggled with youth engagement after the design stage.

The shift to implementation in the Prototyping phase saw the country teams struggling to find a meaningful role for young people. It was challenging to retain youth in implementation teams, as they often did not possess the operational capacity and skills required. In some cases young designers were moved into operational roles, such as supporting monitoring and evaluation in Nigeria, or moving into core team positions in Tanzania. Although this role was a good fit for the skill-set of young designers, it also meant that youth engagement during implementation was somewhat more restricted than the idea of young people as 'core partners' as was earlier envisaged. However, many young designers left the program at this stage, and there are questions about the extent to which hiring young people as core staff represented ongoing meaningful youth engagement.

Youth mobilizers were also incorporated into the solutions in Ethiopia and Tanzania, with mixed success. In Ethiopia, 'Youth Champions' are recruited by identifying particularly enthusiastic participants in Smart Start counselling. They are asked to support mobilization through spreading the word among their friends and peers, but no formal training or orientation is provided. In Tanzania, Kuwa Mjanja Queens are recruited through networks of local government officials. They are paid a small stipend and trained to visit

girls door-to-door to invite them to upcoming events.

The peer mobilization approach has been more successful in Tanzania than in Ethiopia, likely due to the greater investment in training and support. In 2019 a team of youth experts identified opportunities to engage Queens more deeply in implementation, bringing them into out-of-clinic events to help register girls and introduce interactive content through the Mjanja Connect app. Additional training was developed, along with a new cadre of 'Super Queens' to help support and manage the Queens.

However, mobilization numbers through peers are smaller than through other channels – in Ethiopia under 3% of girls are mobilized through Youth Champions, and as of 2018 only 5% of girls in Tanzania were mobilized by Queens. Volunteer attrition is also high, linked to the lack of financial benefit in Ethiopia, and to the long gap between events in Tanzania. Peer mobilizers also sometimes face resistance or abuse from community members who disapprove of contraception, raising some concerns about duty of care, and sometimes struggle with mobilization due to lack of transport and access to a mobile phone.

In later stages of A360 new models were developed to engage young people meaningfully in learning and adaptation, with some interesting results.

In Ethiopia, a small number of young designers continued to support learning and adaptation by accompanying staff on ad hoc learning visits to communities, to investigate key implementation questions. Some also continued as advocates and ambassadors of A360, presenting to government, donors and other development partners.

In Tanzania, a team of 'youth experts' (informally known as the 'SWAT team') were hired in 2019 to help introduce adaptations to improve the out-of-clinic event model. Following an initial two-week design workshop, the youth experts were stationed with outreach teams around the country to observe events, make suggestions for ways to improve girls' experiences, and help embed adaptations within teams – continually sharing observations and brainstorming ideas with one another through WhatsApp. Youth experts rotated between teams, spending at least two weeks with a team at a time. This allowed them to get to know the teams and learn from them, as well as transfer knowledge and best practice. The youth experts helped improve implementation quality through supporting teams to gain confidence in the implementation model, and helped roll out changes quickly across multiple outreach teams. They also helped strengthen youth engagement beyond their own roles, by identifying ways for youth mobilizers to play a more meaningful role in events, supporting the design of a new training curriculum on leadership and advocacy

skills, and helping to engage them in advance of the outreach teams coming to an area.

Engagement in A360 provided young people with new opportunities and skills.

Designers interviewed for the process evaluation were generally positive about their experiences, felt they were valued members of the A360 team, and said they had learned many new skills. These findings were echoed in a global A360 Young Designers conference in December 2020, attended by 30 young designers. Respondents to a self-assessment exercise conducted as part of the conference felt that youth had been actively engaged in decision making, provided with opportunities to engage with their communities and develop leadership and other skills, and acknowledged and rewarded. In order to strengthen meaningful youth engagement in the next phase of the program, participants suggested establishing mechanisms to ensure youth engagement is central to all phases of A360 (including a Youth-Adult advisory board), providing more consistent capacity building and training with certifications, and finding ways to forge stronger links and promote knowledge sharing between young people, designers and adult mentors.

Box 6. Meaningful Youth Engagement - Defined

PSI drew on the WHO Global Consensus Statement on MYE¹² to guide its engagement with young people:

Meaningful youth engagement (MYE) is an inclusive, intentional, mutually-respectful partnership between youth and adults whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms and organizations that affect their lives and their communities, countries and globally.

MYE recognizes and seeks to change the power structures that prevent young people from being considered experts in regard to their own needs and priorities, while also building their leadership capacities. Youth includes a full spectrum of the population aged 10-29 regardless of socioeconomic status, ethnic identity, sexual orientation and gender identity, disability, political affiliation, or physical location.

¹² <https://www.who.int/pmnch/mye-statement.pdf>

3.2. The A360 solutions

This section synthesizes insights from across the A360 countries to tell the story of how implementation unfolded. More detailed analysis on each solution is presented separately in the Country Annex.

3.2.1. Performance headlines

Summary findings: Program monitoring data demonstrates that A360 has substantially exceeded its performance targets – reaching over 600,000 girls since 2017, over 400,000 of whom adopted a modern contraceptive method. This achievement is notable in the context of COVID-19, which significantly affected performance across all contexts. Conversion rates have improved significantly over time, (84% of girls who attended A360 events or counseling adopted a method in 2020 compared to 63% in 2018). Long-acting contraception accounted for 40% of all methods adopted, comparing favorably to national benchmarks.

However, the program has been less successful at reaching younger girls – 32% of adopters across all settings were aged 15-17, and most of these were from Tanzania, which is being phased out of the follow-on program in 2021. For a variety of reasons it has been difficult for A360 to accurately monitor continuation. Continuing user figures remain low (11% of girls reached in 2020) and have not substantially increased over time.

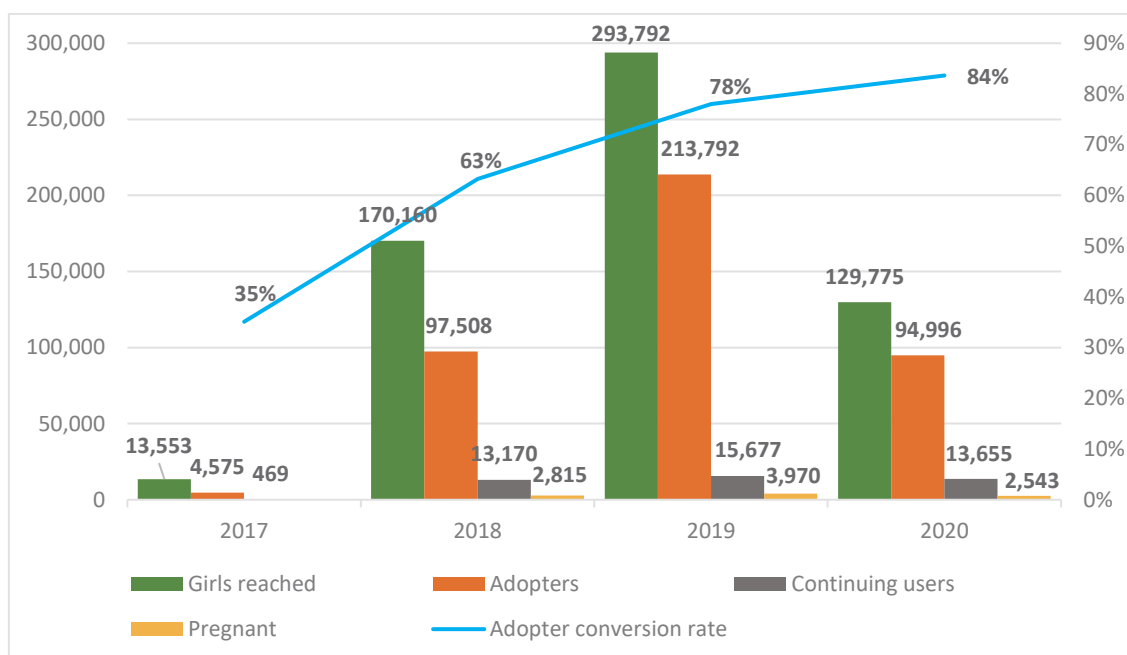
This section presents headline figures from A360 routine monitoring data. This data spans the final months of the Prototyping phase (from October 2017) to the end of the program (end of September 2020). Data was collected by A360 and has not been independently verified by the evaluation team. The outcome evaluation will complement this data by looking at population-level changes in modern contraceptive prevalence rates and a range of secondary outcomes. Detailed performance data for each of the four solutions is presented in the Country Annex.

By the end of September 2020, 607,280 adolescent girls had attended A360 events or counseling sessions, and 410,871 of these had adopted a modern contraceptive method. Overall, 74% of eligible girls (i.e. those not already using contraception or pregnant) adopted a method after attending an event or counselling session. Conversion rates¹³ have improved significantly over time (see Figure 3) and are considerably higher than an identified benchmark of 51%.¹⁴ The total number of adopters hugely exceeded the overall program goal of 285,674 adopters. While this target shifted downwards during the design stage, A360 also substantially exceeded the original adopter target of 300,000 girls.¹⁵ This achievement is notable in the context of COVID-19, which significantly affected performance across all contexts.

¹³ Adopter 'conversion rate': percentage of girls reached who adopt a method, minus continuing users and pregnant girls.

¹⁴ Benchmark figures derive from the Future Fab 2017 Impact Report.

¹⁵ See evaluation mid-term review (p.29) for further details on evolving targets. <https://www.itad.com/knowledge-product/midterm-review-of-the-adolescents-360-program/>

Figure 3: Global performance data¹⁶ (Oct 2017 - Sept 2020). *Note: values under 100 not shown*

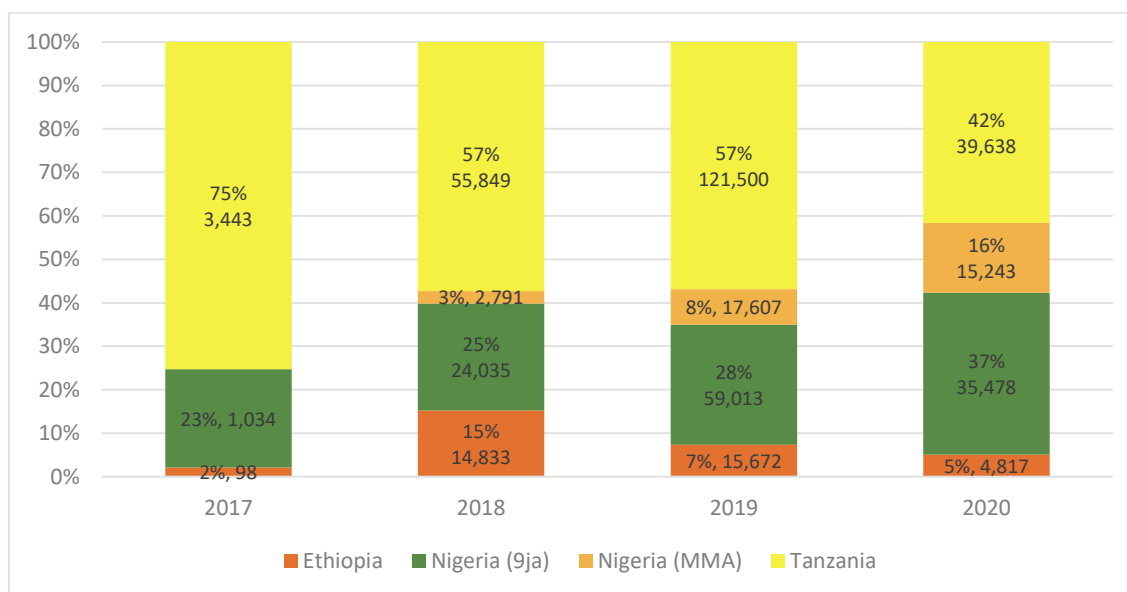
Adopter numbers vary significantly across the A360 countries and solutions, reflecting differences in target group and solution design. As shown in Figure 5, Tanzania accounted for more than half (54%) of adopters. This is explained by the outreach model, designed to reach large groups of girls through out-of-clinic events and mass mobilization. This model meant that Tanzania was most affected by COVID-19, resulting in a complete halt of services for three months in 2020 and a significantly scaled-back service offering once the program resumed in June. 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 due to the saturation of targeted regions and the transition of sites from A360 into the follow-on investment RISE. In Nigeria, adopter numbers for MMA were lower because the solution was developed later and was not scaled until 2019, at which point it was rolled out in only two states (compared to 9ja Girls’ in six states). In 2019, A360 Nigeria introduced the ‘Hub and Spoke’ model which incorporated over 100 new ‘Spoke’ facilities, allowing A360 to reach significantly more girls through both 9ja Girls and MMA.

The Country Annex contains further details on how the four solutions evolved over time.

Continuation has been difficult to accurately monitor and measure. In Nigeria and Tanzania, girls who receive follow up services outside of A360 facilities or events are not captured in program monitoring data. In Ethiopia, the program does not report services delivered after the initial six-week implementation period, meaning that most continuers noted in monitoring data did not initially adopt through A360. Overall, just under 43,000 continuers were served through A360, representing 7% of all girls reached.¹⁷ The proportion of continuing users has increased over time but only slightly, from 8% of girls reached in 2018, to 11% of girls reached in 2020. However, these figures do not necessarily provide an accurate picture of continuation, given the relatively high number of LARC adopters through the program (see below), most of whom would not have required resupply during the program period, and the wider availability of short-term methods outside of A360 channels meaning that not all continuers will have been captured in program monitoring data.

¹⁶ Girls reached: girls who attend A360 counselling or events. Adopters: girls who adopt a method, who were not previously using contraception the day before or at last sex (with the exception of Tanzania which counts girls who start contraception for the first time, in line with government indicators). Continuing users: girls who were already using a method, who continue or switch.

¹⁷ Overall A360 performance data, Oct 2017-Sept 2020. In Ethiopia, continuers account for 27% of girls reached overall (Oct 2017-Sept 2020).

Figure 4: Adopters by solution (Oct 2017 - Sept 2020)

Long-acting reversible contraceptives (LARCs) accounted for 40% of methods adopted program-wide.

Method mix has been an important consideration for A360, given PSI's commitment to ensuring adolescent girls have access to the widest available contraceptive options. There has been a particular focus on ensuring girls can access LARCs, which are among the most effective methods and result in fewer unintended pregnancies and lower discontinuation rates, but which are frequently denied to adolescents globally (FP2020, 2020b). Across all three countries, LARC uptake through A360 (defined as implants and intrauterine devices - IUDs) exceeded national Demographic and Health Survey (DHS) / Multiple Indicator Cluster Survey (MICS) figures. Method mix varied widely by country and intervention model, as detailed in Table 4:. The proportion of LARCs adopted decreased over the course of the program (see Figure 5:), from 46% in 2018 when the program first scaled to 38% in 2020. This is largely attributable to a decline in LARC adoption in Tanzania. Section 3.2.6 discusses the factors affecting method mix across contexts.

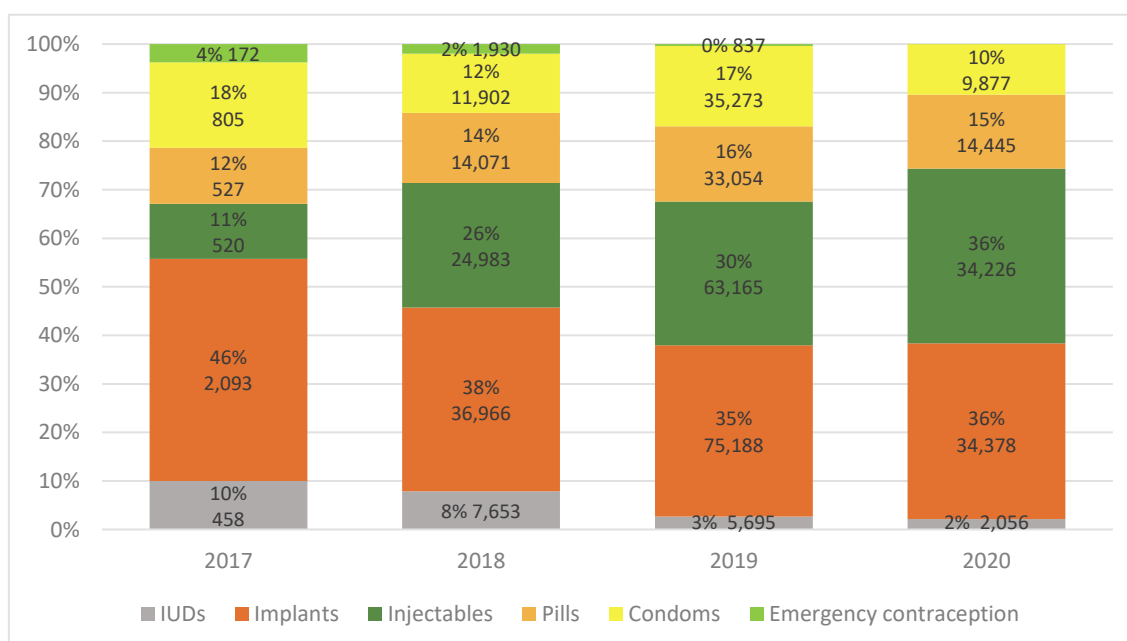
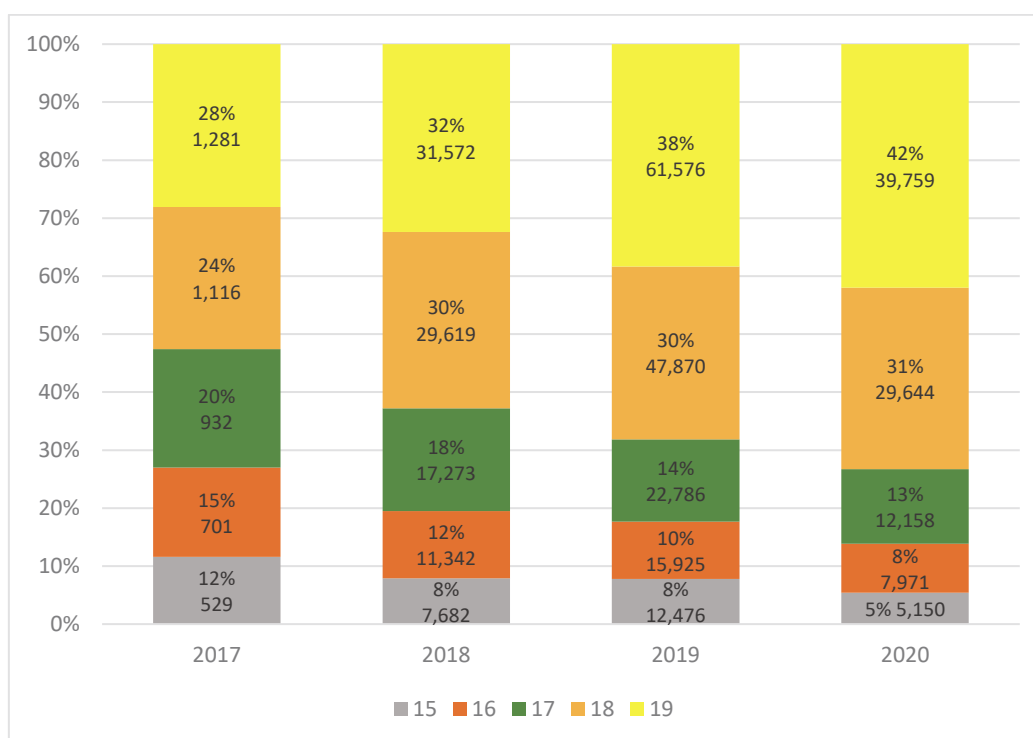
Figure 5: Overall A360 method mix by year (Oct 2017 – Sept 2020). *Note: values under 100 not shown*

Table 4: Method mix per country compared to benchmarks, Oct 2017 – Sept 2020

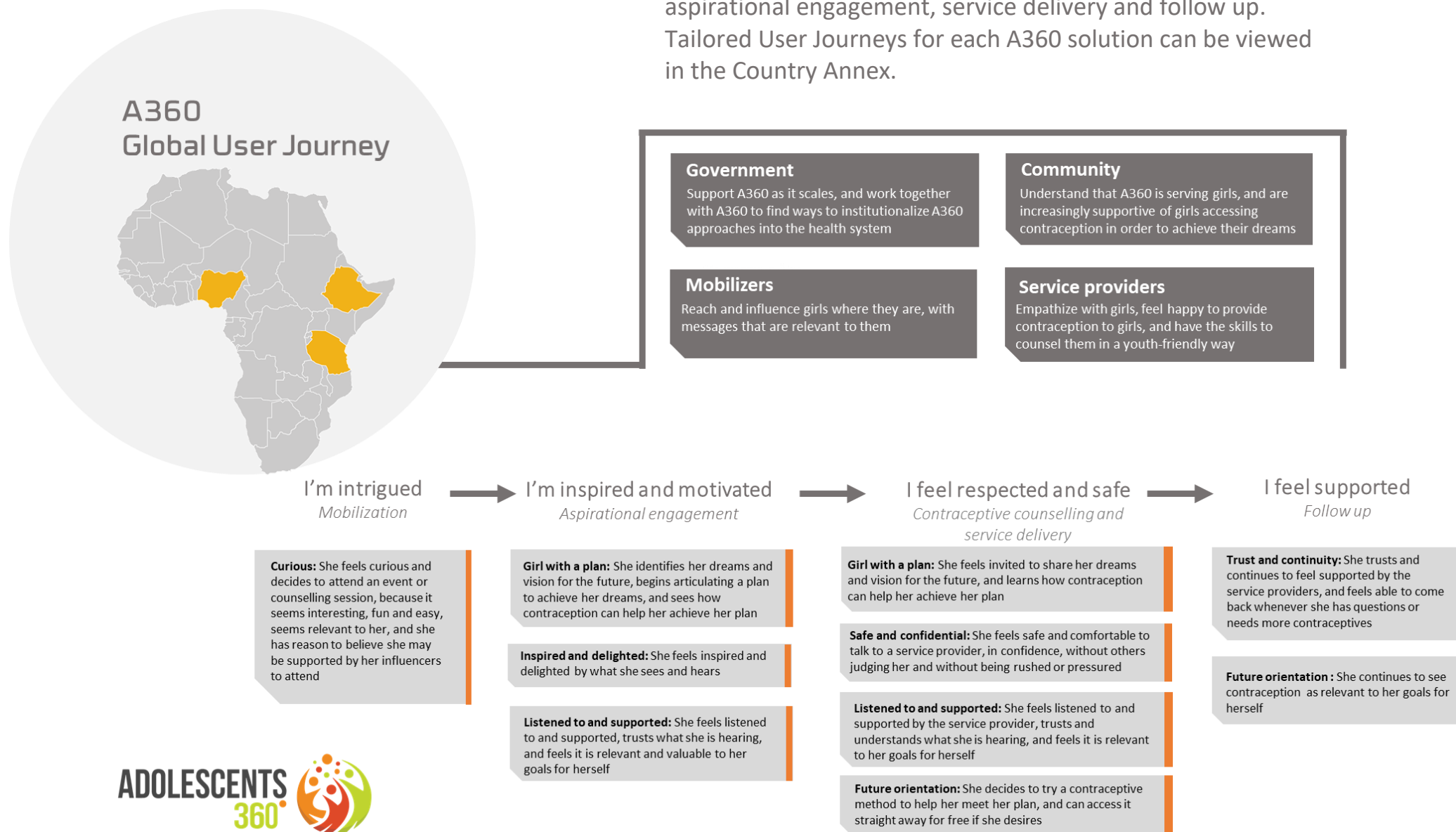
	Ethiopia (married girls)		Nigeria: 9ja Girls (unmarried girls)		Nigeria: MMA (married girls)		Tanzania (unmarried girls)	
	A360	DHS 2016	A360	MICS 2016-17	A360	MICS 2016-17	A360	DHS 2015
LARCs	21%	18%	31%	1%	39%	0%	49%	17%
IUD	0%	3%	3%	0%	2%	0%	5%	0%
Implant	20%	15%	28%	1%	37%	0%	44%	17%
Injection	71%	75%	49%	6%	47%	24%	10%	20%
Pill	8%	6%	14%	25%	10%	47%	18%	6%
Condom	0%	0%	7%	67%	4%	28%	22%	56%
EC/Other	0%	N/A	0%	1%	0%	7%	1%	1%

A360 has been more successful at reaching older girls, with the exception of Tanzania. A360 routinely monitored the age of adopters. This is important as younger adolescents (aged 15-17) often face stronger socio-cultural barriers to accessing contraceptive services, including stigma and requirements for parental consent. Just under a third (32%) of adopters through A360 across all settings were aged 15-17, while 68% were aged 18-19. The proportion of younger adopters has declined over time (see Figure 6:). This is largely attributable to 9ja Girls, which has reached proportionally fewer 15-17-year-old girls since it scaled, due to a strategic decision to focus mobilization on older girls to help meet adoption targets. The Kuwa Mjanja model in Tanzania proved particularly effective at reaching younger girls: 71% of all adopters aged 15-17 were from Tanzania. This is linked to the out-of-clinic event model used in Tanzania, which particularly appeals to younger girls, as well as mobilization of girls through schools (discussed in Sections 3.2.4 and 3.2.6).

Figure 6: Global age disaggregation of adopters by year (Oct 2017 – Sept 2020)¹⁸

¹⁸ Note the age data received by the evaluation team has 53,510 missing values from Tanzania.

Figure 7: A360 Global User Journey



The following sections synthesize insights from across the A360 countries to tell the story of how far implementation has unfolded in line with the User Journey and to highlight key successes and challenges. See Section 1 and the Country Annex for further details on each of the four solutions.

3.2.2. Health systems and service providers

Summary findings: A360 has effectively worked through public health facilities and with public providers, enabling the program to reach scale and serve harder-to-reach girls. The final process evaluation confirms the evaluation mid-term review finding that A360's work with public providers has helped shift health worker attitudes towards serving girls, and build their capacity, with particular progress made in Nigeria. On-the-job support of A360 staff has been crucial to the success of this strategy and has helped mitigate the challenges of high public sector workloads and staff shortages.

However, A360 training is generally light touch. The final years of the process evaluation confirmed the evaluation mid-term review finding that this is often insufficient to address persistent service provider bias and misconceptions. Reliance on A360 staff to support overburdened health workers and government officials also poses challenges to sustainability, including the risk that quality and fidelity will drop dramatically when interventions are fully integrated into government health systems.

Integration into health systems has enabled A360 to scale up nationally and serve harder to reach girls, although it has required substantial effort to navigate health system constraints.

All A360 solutions work through public health facilities and with public providers. This has facilitated scale-up and allowed the program to serve harder to reach girls in rural areas. In all settings, government health systems supply contraceptives and medical supplies to support free service delivery to girls, although A360 has occasionally plugged gaps with small amounts of program funding.

Health system integration is strongest in Ethiopia, where Smart Start has been delivered by public Health Extension Workers (HEWs) through the national Health Extension Program from the outset. In Nigeria, 9ja Girls and MMA are implemented through public health facilities, with A360 Young Providers working full time alongside government providers to deliver counseling and services. The move to a 'Hub and Spoke' model in 2019 has enabled A360 to provide capacity building, equipment and technical support to providers in more remote government 'Spoke' facilities while maintaining a permanent presence in 'Hub' sites, increasing reach into rural areas. Health system integration is weakest in Tanzania, where Kuwa Mjanja is implemented through A360 outreach teams, with the support of district and local level government providers who are brought in to deliver services at in-clinic and out-of-clinic events.

Integration of A360 into public health systems has required working closely with multiple layers of government to coordinate and implement the program, which has helped build government buy-in for the program (discussed further in Spotlight 2 below). However, this has required substantial efforts to navigate persistent health system constraints, including poor-quality facilities and limited government capacity to support and supervise health workers. Regional and national contraceptive shortages are common across all contexts, which has often placed limits on girls' choice of methods and in some cases inhibited uptake of long-acting methods (see Box 10). A360 regional staff have invested significant time and effort to proactively identify and report gaps, and in some cases liaise and negotiate with government officials and other non-governmental organizations to address stock-outs and supply challenges.

Training and on-the-job support to government service providers has helped shift attitudes towards serving youth, and build capacity to deliver A360.

Each solution provides training and ongoing support to government providers (see Table 5), to build capacity to implement A360. The AYSRH literature emphasizes that training health providers on

adolescent-friendly services can improve knowledge, attitudes and counseling skills (Bankole and Malarcher, 2010; Mwaikambo et al., 2011; Gay, Croce-Galis and Hardee, 2012).

Table 5: Comparison of training and support provided across A360 countries

Ethiopia Smart Start	<ul style="list-style-type: none"> HEWs undertake a two-day training course prior to the launch of Smart Start in their kebeles.¹⁹ Training covers how to implement Smart Start, including youth-friendly and financial planning counseling skills. A360 Smart Start Navigators work alongside HEWs in all regions but Amhara during an initial six-week implementation period, providing full-time on-the-job support.²⁰ A360 Adolescent Health Officers at the woreda level provide further support in the months after the Navigator moves on to a new community.
Nigeria 9ja Girls and MMA	<ul style="list-style-type: none"> Government service providers and A360 Young Providers stationed at Hub sites are inducted through a 6-day training on contraceptive service provision and a further 7-day training on youth-friendly provision and A360. A shorter three-day on-the-job training is delivered to providers in Spoke facilities. State level Quality Focal Persons provide ongoing supportive supervision, mentoring and on-the-job training to government and A360 providers as part of routine supervision visits, to help build youth-friendly service provision skills and address capacity challenges.
Tanzania Kuwa Mjanja	<ul style="list-style-type: none"> 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 1-2 service providers from a nearby facility, who receive a short video orientation to introduce the program and share advice on youth-friendly provision. A360 has also supported government training on youth-friendly service provision and conducted additional training on LARCs in the three regions it is targeting with 'sustainability pilots' (see Section 3.3.2) to address capacity gaps.

Across all three countries, service providers have consistently reported that A360 has influenced their attitudes towards serving adolescent girls. Providers said the program had helped them understand the urgency of girls' contraceptive needs, in part through connecting contraception to the idea of girls achieving their goals.

"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)

However, A360 training and support has not always been sufficient to ensure girls have long-term access to quality youth-friendly counseling.

The AYSRH literature suggests that training should prepare providers to offer a range of methods to adolescents as well as accurate information on side-effects (McCleary-Sills *et al.*, 2012). In most cases A360 training aims to build on existing government training – assuming providers already have the capacity to provide counseling on a wide range of methods. In practice, this is not always the case. In particular, not all service providers are qualified in LARC insertion and removal, creating blockages to service provision. In some cases the program has provided additional training to help plug this gap, but concerns remain – particularly in Tanzania where large numbers of girls have been given implants (almost 95,000²¹) in a context where there are few providers with skills to remove them.

The process evaluation has found that service provider bias and misconceptions about contraceptive methods often persist despite A360 training and mentoring, particularly in Ethiopia and Tanzania (see Section 3.2.6). Interviews suggest this may be less of an issue in Nigeria, where training is more in-depth

¹⁹ Kebeles are the lowest administrative structure in Tanzania.

²⁰ The Health Extension Program is considered particularly strong in Amhara, and regional government opted not to incorporate the Navigator role.

and where A360 has invested substantially in improved mentoring and supervision following observations of counseling weaknesses in 2018. Nigeria also introduced 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. A360 attempted to introduce this tool in Tanzania, but was unable to influence government training curricula.

Concerns about service provider training and support are most acute in Tanzania, where providers are allocated by district government to work with A360. While the criteria for selection includes prior training or experience in youth-friendly service provision, in practice many providers do not have this. A360 piloted a 'girl-screening' approach in which girls were trained to rate the youth-friendliness of providers before enlisting them to work on the program. However, the outreach model (in which new districts and wards are reached each month), has made large-scale screening or training unfeasible given program resources. A short introductory video was developed to help ensure providers have some understanding of Kuwa Mjanja before they participate in events, but is not a replacement for formal training. Interviews suggest providers are sometimes unclear about how Kuwa Mjanja counseling should differ from their usual approach.

In Ethiopia and Nigeria A360 staff provide crucial on-the-job support to help build provider capacity and mitigate the challenges of high workloads and staff shortages – however, this poses challenges to sustainability.

The high workloads of public health workers have been a consistent challenge across all contexts. In Ethiopia, HEWs have shouldered ever more responsibility over the years, delivering more and more services and frequently facing fatigue and burnout. COVID-19 has further exacerbated this challenge. In both countries there are also capacity constraints within district or state-level government health departments to support and supervise health workers.

“During the training we were resistant to accept and implement Smart Start. We mentioned that we are very busy and we have so much work, but later we believed that it is our responsibility to serve the community.” (Health Extension Worker, Ethiopia, 2018)

This issue has in-part been mitigated through on-the-job support, which the literature suggests is important for long-term impact on service provider capacity (World Health Organization, 2015; Chandra-Mouli *et al.*, 2017). In Nigeria and Ethiopia, A360 staff have been stationed in communities and facilities, to work alongside government providers to implement the program. The process evaluation found that this support reinforced formal training, built confidence and capacity, and provided a crucial 'extra pair of hands' to ease the burden on providers through supporting mobilization, service delivery and reporting. At the regional or state level, A360 supervisors work alongside government officials to support health workers – proving critical to ensuring quality and consistency as the program scales.

However, reliance on A360 staff for delivery and supervision raises concerns about sustainability, with the risk that quality and fidelity will drop dramatically once A360 staff are no longer supporting government providers. In 2019 the Nigeria team tested the program without the support of an A360 Young Provider, but this led to a significant drop in service quality, with providers forced to limit adolescent services to one day a week given their high workloads. In Ethiopia, the Smart Start Navigator plays a vital role in mobilization and often leads on financial planning counseling as HEWs are less confident with this component – which creates risks to fidelity after the Navigators transition out.

“Government providers have so many responsibilities; most are overstressed, they're understaffed, so it's always a challenge for them to have time to be around to listen to how we attend to girls.” (A360 regional staff member, Southern Nigeria, 2020)

3.2.3. Engaging communities and key influencers

Summary findings: Girls face powerful sociocultural barriers to contraceptive access across all three A360 countries, and addressing these has been one of the most challenging areas for the program. As noted in the evaluation mid-term review, A360 was not designed with a substantial social norms component, and pressures to prioritize adoption targets during scale up initially inhibited community engagement activities. It has often been a challenge for A360 to reach key influencers in numbers, or engage them deeply.

However, the final process evaluation finds good progress since the evaluation mid-term review. In most cases A360 has succeeded in operating with the active or tacit acceptance of communities, despite some community resistance and backlash. This has been achieved through employing light-touch approaches to addressing social norms with a focus on key influencers, enlisting the support of community leaders and government officials, and harnessing program messaging to build on existing norms around family planning, and link contraception with community concerns and economic empowerment. Where A360 has managed to engage husbands and mothers, the process evaluation finds this has demonstrably increased support for girls to access contraception. There is considerable scope for the next phase of the program to build on these efforts.

Girls face powerful sociocultural barriers to contraceptive access across all three A360 countries, which have led to resistance and backlash in some cases.

Barriers vary across the A360 contexts and between married and unmarried girls. Early marriage is common in Ethiopia and Northern Nigeria (see Section 1.2), and married girls face significant pressure to become pregnant soon after marriage to prove their fertility and cement their status in the marriage. Among unmarried girls in Tanzania and Southern Nigeria pre-marital sex is often highly stigmatized, and girls who use contraception are viewed as promiscuous. Across all contexts, widespread fears and misconceptions persist that contraception (particularly long-acting methods) can cause infertility or other harmful side effects, especially for girls who have not yet had a child. Religious objections to family planning are still widespread, and there are also growing political sensitivities around contraceptive use in some countries. A series of high-profile criticisms of family planning by senior government officials in Tanzania led A360 to temporarily pause outreach events in 2018, while in some parts of Ethiopia, political opposition leaders claim that family planning is a government strategy to reduce population size among particular ethnic groups.

These contextual factors have led to some backlash and resistance to A360 across all three countries. In the early years of the program, there were at least two cases of Nigerian and Tanzanian providers or partners being arrested due to complaints from local government officials. Across all contexts, mobilizers have sometimes faced verbal abuse from community members when raising the topic of contraception. Girls and community members frequently spoke about the potential risks that girls face – in the form of anger, stigma, forced removal of methods and sometimes violence – if they go against the wishes of parents, husbands or wider family to adopt contraception. In Nigeria, an attempt to introduce the 9ja Girls model for unmarried girls in the North was abandoned due to high levels of community resistance.

Although light-touch, in most cases community engagement activities have enabled A360 to operate without widespread resistance.

The literature is clear that sociocultural factors pose important barriers to adolescent contraceptive use, and that AYSRH interventions should engage communities and seek to address social norms (WHO, 2011; Prata and Weidert, 2020). However, A360 was not designed with a substantial social norms component. A social norms lens was incorporated into the program Theory of Change in 2017, but this was not accompanied by new resources and at times was inhibited by pressures to prioritize reaching new adopters (as discussed in Section 3.1 above).

As a result, each country has incorporated light-touch approaches to addressing social norms, with a focus on key influencers – husbands of married girls (see Box 7) and parents, particularly mothers, of unmarried girls (see sections on Mechanisms of Impact in the Nigeria and Tanzania Country Annexes for more details). Alongside these, A360 has employed various techniques to circumnavigate the sociocultural barriers discussed above. In most cases, this has allowed it to operate with a level of (active or tacit) community acceptance despite the challenges outlined above:

- **Working through community leaders, local government officials and trusted community structures.** Across all three countries, the support of community leaders has been actively enlisted before starting work in a new area. Local officials also help introduce the program to communities, and add credibility to A360 through their presence at meetings and events. Supportive local health officials have also helped manage some cases of backlash when other, more conservative government stakeholders raised concerns about the program. Working through existing and trusted community structures – for example the HEWs and Womens’ Development Army volunteer cohort in Ethiopia, and community-based health workers and mobilizers in the other countries – has also helped build trust and acceptance within communities.

“When we go to the kick-off meeting, we are not going alone. We have the woreda officials [with us]. We use them as an entry point, which makes it easier to engage with the community.” (A360 regional staff member, Ethiopia, 2019)

- **Tapping into community concerns.** These vary across contexts, but A360 staff have succeeded in highlighting contraception as a tool to address early pregnancy, school drop-out and unsafe abortion (among unmarried girls in Tanzania and Nigeria), and worries about economic security and maternal health (among married girls in Nigeria and Ethiopia). Among parents of unmarried girls, the program has sometimes been able to tap into a sense of pragmatism – parents may not like the fact that girls are using contraception but accept it as a means of avoiding worse consequences and ensuring girls can continue their education.

“The productivity of our land is declining while population numbers are growing, which reduces pastureland. As a result, our community does not have sufficient milk, meat or butter to properly feed families...That is why we started advising and supporting young couples to practice family planning.” (Mother-in-law, Ethiopia, 2020)

- **Building on existing norms around family planning,** which is becoming increasingly accepted for older married women across all three countries. The concept of child spacing is widely understood in Northern Nigeria, and A360 has found that emphasizing spacing over ‘family planning’ helps the program resonate more strongly with both husbands and girls. In Ethiopia, years of work by HEWs in communities has helped raise general awareness and acceptance of family planning, and the program has been able to extend this to adolescent girls through linking contraception to financial security.
- **Providing the prospect of economic empowerment and helping girls achieve their dreams:** The aspirational components of the program are a big draw for community members, offering the potential to teach girls valuable skills that will help them in the future. Entrepreneurial skills sessions are particularly popular among parents and government stakeholders, who hope these will help girls become economically independent in a context of poverty and high youth unemployment. This helps secure the approval of stakeholders who may not have supported a program purely focused on contraceptive service provision given concerns about promiscuity. However, the popularity of vocational skills sessions also comes with high expectations which A360 is unable to fully meet – discussed in Section 3.2.5.

While there are signs that the program is helping to build a more supportive environment for girls to access contraception in some cases, there is considerable scope for improvement.

The evaluation mid-term review noted that A360's light-touch community engagement work reached only small numbers of people. This has continued to be a problem in later years of the program, with girls continuing to face stigma and judgement from the broader community. In Tanzania, there is some concern that the deliberate ambiguity of program messaging – framing events as wellbeing, rather than contraceptive events – does little to help make the enabling environment more conducive for girls, and potentially makes discontinuation more likely if girls are hiding contraceptive use from parents. One common request from communities has been to engage adolescent boys and fathers given their influence over the decisions of unmarried girls. While A360 staff acknowledge the potential value of this, it has not proved possible within program resources.

“Boys have been alienated... they are the one who make the decisions when they are in a relationship. Involving boys will help us in making girls start using contraceptives early.” (Community member, Tanzania, 2017)

Despite these limitations, staff and other stakeholders interviewed across all three countries in 2020 suggested that many communities have become increasingly supportive of the program over time. This suggests that although A360 was not designed to shift social norms, its work to engage key influencers, combined with the tactics to build community support discussed above, may have been enough in some cases to influence wider community attitudes. However, as the process evaluation was not designed to measure community norm change, no strong conclusions can be reached on this point.

Box 7. Engaging husbands in Ethiopia and Northern Nigeria

In both contexts, girls are often unable to make decisions about whether to adopt a method without their husband's consent. A process evaluation case study in 2019 also found that husbands in Ethiopia play a key role in girls' decisions to discontinue – either because they wanted to have a child, or because they were concerned about the side effects their wives were experiencing. Conversely, where husbands were supportive of contraception it was easier for girls to resist pressure from in-laws to get pregnant (Punton, Gebremedhin and Lagaay, 2019).

A360 has built husband engagement into its interventions for married girls, in recognition of their central role. In Ethiopia, Smart Start was designed around couples' counseling, with the aim of engaging husbands in conversations about how financial planning and contraception could help them achieve their goals. In Northern Nigeria, the MMA model was designed with a husband referral pathway – with male mobilizers trained to start conversations with groups of men to encourage them to refer their wives to counseling. This has proved successful, with 47% of MMA participants referred by their husbands.²²

In both contexts, engaging husbands has provided an opportunity to increase their support for contraception. Girls in Ethiopia were 1.6 times more likely to adopt a method when accompanied by their husbands,²³ and girls referred by husbands in Nigeria were 1.4 times more likely to adopt a method than those referred by a mobilizer.²⁴ Where girls are counseled alone in Ethiopia or without a husband referral in Nigeria they often do not accept contraception on the spot – instead going home to discuss the decision with husbands, imposing an additional obstacle to service provision.

²² LSHTM analysis of A360 monitoring data (June 2017-April 2020)

²³ 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)

²⁴ 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)

“We didn’t possess our own properties or wealth. We were living with his parents. [Smart Start] taught him that to save money it is better to delay childbirth because raising children expends resources. Then he agreed! He is saving money now.”
(Adolescent girl, Ethiopia, 2020)

However, only 28% of counseling sessions involve husbands in Ethiopia,²⁵ as they are often away during house-to-house mobilization visits. In Nigeria, engagement with husbands is limited to a short conversation with a mobilizer. A360 trialed more in-depth sessions to build stronger awareness and understanding, but these did not prove successful. In Ethiopia, A360 is currently using HCD to design improved ways to engage husbands with funding from Maverick Next, including ‘gatekeeper meetings’ to demonstrate support of community leaders, and group sessions held at times and places that work better for men.

As noted in the evaluation mid-term review, in both countries there are also some concerns that husband engagement risks undermining girls’ agency. Although girls in Ethiopia generally prefer to be counseled with their husbands, observations of counseling sessions suggested this can limit girls’ time and space to speak and ask questions, with husbands dominating discussions and receiving more attention from the provider. In Northern Nigeria a number of stakeholders reported that husbands sometimes make unilateral decisions about whether their wives should adopt a method and even which one, with some girls sent to counseling by their husbands without understanding why. Compounding this issue is the fact that girls referred by their husbands do not access the aspirational and empowerment aspects of A360, as they are referred to walk-in counseling rather than joining skills classes. In 2019 A360 engaged a gender expert in Nigeria to review the MMA curriculum, but this had not yet resulted in specific changes by the end of the first phase of the program.

3.2.4. Mobilization

Summary findings: A360’s success at reaching high numbers of girls is linked to its use of a diverse array of mobilization approaches. These have succeeded in reaching girls in ways that resonate with them – through multiple, reinforcing channels and through key influencers or peers. In Ethiopia, the engagement of the Women’s Development Army to support mobilization has been a major success story, highlighting the value of harnessing existing, trusted local structures to reach adolescents. The aspirational components of the program have often proved a crucial ‘hook’ encouraging girls to participate, alongside the offer of a low-stigma, free channel to access SRH education and contraception.

However, A360 has heavily relied on face-to-face mobilization, which is time and resource intensive and vulnerable to seasonal constraints and high staff turnover. There are also questions for the next phase of the program about how paid mobilization roles can be folded into over-stretched government systems, and the reliance in Ethiopia on overworked female volunteers.

A360 uses a diverse array of mobilization approaches, largely face-to-face, using various entry points to reach girls where they are, and in ways that resonate with them.

In most cases A360 is introduced to girls through face-to-face contact by key influencers, peers or paid mobilizers – see Table 6: below. The main exception to this is Tanzania, where public announcements and school-based mobilization has been used successfully to reach larger numbers of girls (see Figure 5 above).

A360 initially planned to use digital channels to support mobilization, and Facebook referrals were designed and prototyped in Nigeria and Tanzania. However, these did not prove successful in either country due to low levels of engagement. In Tanzania, plans to develop an app to refer girls to services

²⁵ LSHTM analysis of A360 monitoring data (June 2017-Oct 2019)

were sidelined – in part due to the success of the other approaches in reaching large numbers of girls. There were also plans to develop a virtual hub, where girls could access information about Kuwa Mjanja and be referred to services. However, the prospective partnership to implement this idea did not come to fruition (discussed further in Section 3.2.2).

Table 6: Comparison of A360 mobilization approaches

Ethiopia Smart Start	<ul style="list-style-type: none"> HEWs, A360 staff, Women’s Development Army volunteers and Youth Champions (sometimes supported by kebele leaders) travel door-to-door, aiming to reach girls and husbands in their homes – using the knowledge of HEWs and volunteers to target households with newly married girls.
Nigeria 9ja Girls	<ul style="list-style-type: none"> Paid mobilizers work in pairs, five days a week for four hours a day, with a target of referring 200 girls per month. They work in communities near A360 facilities (including around Spoke sites near designated A360 days), reaching girls one-to-one or in groups to invite them to life skills classes or walk-in sessions. Mothers who attend Moms’ Sessions are encouraged to refer their daughters, and girls informally invite their friends.
Nigeria MMA	<ul style="list-style-type: none"> Paid male mobilizers work in communities near A360 facilities, reaching men (usually in groups) to inform them about the program and encourage them to refer their wives to a walk-in counseling session. They have a target of contacting 400 men per month, generating 100 referrals. Paid female mentors work in communities near A360 facilities, traveling door-to-door to reach married girls in their homes and invite them to attend life skills classes at a nearby venue. They aim to mobilize groups of 12 girls at a time to attend four weekly classes as a cohort.
Tanzania Kuwa Mjanja	<ul style="list-style-type: none"> Outreach teams deliver public announcements in communities where outreach events are due to be held, inviting girls to events. Kuwa Mjanja Queens (peer mobilizers) travel door-to-door to inform girls and parents about events and invite girls to attend. Outreach teams visit schools and work with teachers to bring groups of girls to nearby out-of-clinic events. Girls informally invite their friends, and parents who attend parents’ sessions refer their daughters.

A360’s array of mobilization approaches has helped to:

- **Reach girls through multiple, reinforcing channels.** In Tanzania, public announcements generate widespread awareness which helps ‘prepare the ground’ for Kuwa Mjanja Queens to visit girls one-to-one in their homes. In Ethiopia, many girls said they had heard about the program from friends and kebele leaders as well as from HEWs or Navigators who visited their homes.
- **Reach girls at times and places that work for them.** In Ethiopia, house to house visits allow the program to reach the relatively small numbers of girls in the target group, dispersed across often large rural communities. In Nigeria, mobilizers honed the times and places they worked to reach girls more efficiently – for example focusing on the end of the school day, while targeting older girls during their work lunch breaks.
- **Reach key influencers.** The male mobilizer channel in Nigeria has proved successful at reaching girls through their husbands (although raises some ethical questions, discussed in Box 7 above). In Ethiopia mobilizers are sometimes able to engage with husbands or mothers-in-law during house-to-house visits, which helps enlist support for girls to participate (although husbands are often away from home, as discussed in Box 7).
- **Reach girls and influencers through known and trusted members of the community.** In Ethiopia, working through the widely known and accepted HEWs and Women’s Development Army volunteers

has helped gain community acceptability as well as helping identify which households to reach (see Box 8 below). In Nigeria, recruiting young mobilizers and mentors from near target communities helps them build rapport with and secure the trust of girls and husbands.

The support of local government has also been important. In Tanzania, A360 began working with government youth development officers, who have their own targets around youth engagement and therefore have incentives to support A360 events. They have drawn on existing networks of community announcers and community leaders, and knowledge of where and when to reach adolescents in their communities. In Ethiopia, kebele leaders have often supported mobilization by helping HEWs reach girls and providing a sense of legitimacy to the program, particularly important for enlisting the support of husbands.

“People [from the community] feel more comfortable with somebody they know; with somebody they see around...The girls think ‘we know this person, we can relate with her, if we have any issue, we can talk to her’” – (A360 staff member, Northern Nigeria, 2019)

The aspirational components of A360 have proved a crucial ‘hook’ encouraging girls to participate, although many girls are directly attracted by the opportunity to learn about sexual and reproductive health or access contraception.

The promise of vocational or entrepreneurship skills development in Nigeria and Tanzania has been a key ‘hook’ for many girls. Girls are also keen to learn more about how to ‘be smart’ and achieve their goals (in Tanzania), and in the opportunity to talk about relationships and boyfriends without judgement (in Southern Nigeria). In Ethiopia, the program has found that introducing the financial planning components during mobilization helps spark girls’ curiosity, and acts as a useful first touchpoint that helps prepare the ground for the counseling session.

However, the process evaluation found that many girls are equally interested in learning about sexual and reproductive health or pregnancy prevention, or already know they want to adopt contraception and are interested in a low-stigma, free avenues through which to do so. This is particularly true of older girls, and girls who already have children. For some girls, the combination of skills sessions *and* access to contraception was what attracted them to the program, suggesting that this pairing helps widen A360’s appeal to a range of girls with different needs and motivations.

“The number one thing that got me interested was that I don’t want to have an abortion and I still want to further my schooling.” (Adolescent girl, Nigeria, 2019)

In-person mobilization is time and resource intensive, and vulnerable to seasonal constraints and high turnover of staff.

A360 mobilization is often very time intensive, involving significant efforts by HEWs, Women’s Development Army volunteers and Navigators (in Ethiopia) and by paid mobilizers and mentors (in Nigeria). In-person approaches are also vulnerable to seasonal challenges, and program attendance often suffers during rainy months when mobilizers are unable to reach girls due to poor infrastructure. A360 has faced challenges with mobilizer attrition and commitment, as a result of mobilizers working in often difficult conditions for low or no pay. In Nigeria, mobilizers found it increasingly challenging to reach new girls as they saturated communities near Hub facilities. Moving to more remote communities meant it became increasingly difficult for girls to reach facilities for classes and counseling. The introduction of the Hub and Spoke model has helped mitigate this issue to some extent.

Another concern is sustainability, particularly in Nigeria given the reliance on a paid mobilization model. As mobilizers have increasingly taken on more and more responsibilities – for example helping support in-person follow up, discussed in Section 3.2.7 – further questions arise about how this role could be folded into over-stretched government systems.

Box 8. The expanding role of the Women's Development Army in Ethiopia

The engagement of the Women's Development Army in Ethiopia is a major A360 success story, highlighting the value of harnessing existing, trusted local structures to reach adolescent girls.

The national Women's Development Army was established by the government in 2011. It consists of volunteers (mainly older married women) who support various development initiatives in their communities (Yitbarek, Abraham and Morankar, 2019). A360 initially discounted working with this group, fearing that older women would not be able to build a rapport with adolescent girls. However, it became clear that HEWs were drawing on volunteers to support mobilization regardless, and so A360 decided at the end of the Prototyping phase to formally integrate them into the program. Low-literacy mobilization materials were developed to support volunteers to talk to girls about Smart Start and introduce basic financial planning concepts.

The Women's Development Army works through a decentralized structure in which each volunteer is responsible for ten households in her neighborhood. This means that volunteers know which girls are eligible for the program in their area – helping A360 identify and reach girls even in more remote parts of a kebele. The process evaluation found that volunteers are generally well known and respected, are able to connect with girls through sharing their personal stories, and are frequently motivated by a desire to help girls avoid the challenges they faced when they were young. Bringing the Women's Development Army into the Smart Start model has proved very successful, with monitoring data showing that volunteers mobilized 37% of girls as of October 2019.²⁶ They also support HEWs with follow up, visiting girls in their neighborhoods and reminding them about upcoming appointments.

"You can consider the Women's Development Army volunteers 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?" (HEW, Ethiopia, 2020)

A360 plans to rely more heavily on the Women's Development Army in the follow-on program, to help mitigate the planned phase-out of the A360 Smart Start Navigator role. However, A360 faces various challenges as it seeks to expand the role of volunteers. The structure is more active in some areas than others, and commitment to Smart Start varies significantly between kebeles. A360 does not pay volunteers for their time – but women are occasionally paid by other organizations to support projects. In some cases this has given rise to resentment and diminishing commitment, with volunteers complaining about insufficient recognition for the work they do. 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 (Maes *et al.*, 2018).

3.2.5. Aspirational engagement

Summary findings: A360's aspirational engagement components have proved a major success, helping contraception feel more relevant and valuable to girls, and enabling girls to access services in a context of stigma through providing socially acceptable reasons to attend A360 events. This confirms and further nuances the evaluation mid-term review finding that aspirational engagement was a critical success factor for the program. A360's distinctive branding has been an important factor in its appeal, helping messages 'stick' and improving recognizability in communities. There is some evidence that the aspirational components have had an impact on knowledge, self-esteem, confidence and girls' ability to plan for the future.

²⁶ LSHTM analysis of A360 monitoring data, June 2017-Oct 2019

The main challenge relates to A360's entrepreneurial skills sessions. These have proved extremely popular, but often raise high expectations that the program will contribute to economic empowerment, which the sessions were not designed to do. This raises some ethical questions and risks community dissatisfaction. A360 is attempting to address these concerns through building a more substantial empowerment lens into the next phase of the program.

In all three countries, the aspirational elements of the solutions have helped contraception feel more relevant and valuable to girls.

The A360 solutions all incorporate 'aspirational engagement' components. These include goal setting exercises, life and vocational skills sessions, and aspirational messaging about girls achieving their dreams, the values of autonomy and self-worth, financial planning and caring for a family (see Table 7:). These are delivered alongside sexual and reproductive health education through participatory and youth-friendly sessions. The AYSRH literature suggests that participatory teaching approaches and a focus on empowerment can improve girls' knowledge, attitudes and behaviors (Kirby, Laris and Roller, 2007; UNESCO, 2009; Haberland and Rogow, 2015), and there is some evidence that life skills and vocational training can increase contraceptive use (Bandiera *et al.*, 2014; Heinrich and Brill, 2015).

Table 7: Comparison of aspirational engagement approaches in A360

Ethiopia Smart Start	<ul style="list-style-type: none"> Smart Start Navigators and HEWs provide financial planning counseling to girls and (where available) their husbands, using a visual discussion guide and Goal Card tool to encourage couples to consider how contraception can help them achieve their financial goals.
Nigeria 9ja Girls	<ul style="list-style-type: none"> Drop-in Life, Love and Health classes are held at public health clinics every Saturday. The classes teach life skills alongside vocational skills demonstration and practice sessions, encourage girls to think about their future plans using a Life Map tool, and discuss how contraception might help girls achieve their goals. In-person classes have been replaced with virtual classes since the COVID-19 pandemic began. Girls can also choose to visit a clinic directly for a walk-in appointment rather than attending a class. During these sessions, service providers draw on the 9ja Girls messaging to link contraception to girls' goals.
Nigeria MMA	<ul style="list-style-type: none"> Girls who are recruited by mentors attend four Life, Family and Health sessions over a four-week period, which teach girls life, vocational and financial planning skills, and provide information about health and nutrition. Group classes have been replaced with one-to-one sessions since COVID-19. Girls who do not attend classes but go directly for a walk-in appointment (including girls referred by their husbands) do not experience the aspirational components.
Tanzania Kuwa Mjanja	<ul style="list-style-type: none"> Out-of-clinic events provide education about body changes and/or how girls can achieve their dreams, using games and the Mjanja Connect app to introduce girls to contraception with fun, engaging content, and a practical entrepreneurial skills demonstration and practice session. These events have been on hold since COVID-19, as they tend to attract large numbers of girls. In-clinic events also provide education about body changes and achieving dreams, but do not involve the skills component.

The mid-term review identified A360's use of aspirational messaging as a 'critical success factor' that helped position contraception as relevant and valuable to girls. This finding was confirmed in the final years of the process evaluation, which found that aspirational messages helped girls understand the value of contraception across all contexts. In Ethiopia, most girls and husbands interviewed reported that Smart Start has helped them see contraception as a tool that can be used to achieve their goals, enabling them to delay or space pregnancies in order to build assets and achieve financial security. Process evaluation data suggests that this very focused, targeted message – tailored to tap into widespread community

concerns about financial security – has had the most marked success in connecting contraception to aspirations across the three countries.

“In the past it was common to have ten children, but at that time they had sufficient land, they had a lot of cattle...But when we compare our life now with the past...we don’t have any plans to have more than two children in the future.” (Adolescent girl, Ethiopia, 2019)

In both Southern Nigeria and Tanzania, the idea that A360 helped girls to achieve their dreams or goals by providing contraception was also mentioned frequently in interviews. This was often tied up with the desire to complete education – resonating with concerns about teenage pregnancy and resulting school dropout. However, in Tanzania it is not clear that service providers are always linking contraception to the aspirational content during the one-to-one counseling moment, potentially a consequence of the relatively short orientation providers receive on the program before helping to deliver events (see Section 3.2.1).

A360’s distinctive branding and messaging are an important part of the program’s appeal, although in some cases have been simplified over time.

Described in the design phase as ‘the DNA’ of A360, the Kuwa Mjanja, 9ja Girls and Smart Start brands encompass girl-oriented names and colorful logos, simple and attractive visual tools, and catchy slogans and messaging. These elements have been integral to the aspirational content of A360, helping it seem attractive and relevant to girls, helping messages ‘stick’, and improving the program’s recognizability in communities. Branded elements of the solutions were frequently mentioned in interviews with girls – for example the Goal Cards in Ethiopia, and the Life Map in Nigeria – as tools that helped girls consider how to achieve their dreams. In Nigeria an empowering mantra developed by young designers has resonated with girls, as has the Kuwa Mjanja message of ‘Be Smart’. The visual discussion aide in Ethiopia, which includes a ‘baby calculator’ (images that show how much it costs to raise a child in terms of sacks of grain), has helped make the connection between financial planning and contraception very clearly, and is popular with both girls and service providers. Overall, the process evaluation suggests that the A360 brands were important factors in the program’s appeal to girls across all three countries.

However, some elements of the highly designed brands did not survive as the program moved to scale. Most notably, in Nigeria the carefully designed girl-only spaces within clinics were dropped in 2018, as they were expensive and trials showed they had no impact on program performance. Feedback from girls suggested that the youth-friendliness of providers was more important than a branded girl-only space. This resonates with insights from the literature around the ineffectiveness of standalone youth centers as a way to improve access to contraceptive services (Zuurmond, Geary and Ross, 2012; Chandra-Mouli, Lane and Wong, 2015; Denno, Hoopes and Chandra-Mouli, 2015), and recommendations that interventions should make existing facilities youth-friendly rather than creating new adolescent-only spaces (Gay, Croce-Galis and Hardee, 2012). This experience underlines the importance of balancing attractive brands with practicality and feasibility as a program scales (discussed further in Section 3.1).

The aspirational components have enabled girls to access services in a context of stigma, although downplaying contraceptive provision comes with some risks.

The life skills and vocational/entrepreneurial sessions have helped unmarried girls participate in the program while to some extent avoiding the widespread stigma attached to contraceptive service provision – providing a socially acceptable reason to attend A360 events. In Tanzania, several community members and parents indicated that their support of the program was directly linked to the vocational skills components. In Nigeria, the classes helped secure acceptance from key community stakeholders through positioning the program as a ‘community-based wellness’ program rather than a contraceptive program.

“Communities are much more supportive and accepting of the life, dream, goal building events...community acceptance is high because we’re not going in saying we’re holding contraceptive events for adolescents.” (A360 staff member, Tanzania, 2018)

However, downplaying the fact that contraception is provided potentially comes with some risks. In Tanzania, interviews in the early years of the program suggested that many parents, community members and teachers were unaware that events offered contraception to girls, and mobilizers sometimes deliberately obscured this fact to ensure parents allowed their daughters to attend. This strategy undoubtedly helped girls access services ‘under cover’, in a context of widespread disapproval of adolescent contraceptive use. However, the evaluation mid-term review raised concerns that it places a burden of secrecy on girls, potentially putting them at risk. In Tanzania and Nigeria, interviews with unmarried girls and community members highlighted many examples of girls hiding their contraceptive use from their parents and expressing fear of the consequences if their parents found out. Ultimately, process evaluation research in the final years of the program found few tangible examples of girls facing harm after adopting a method from A360 – with the exception of a small number of girls who were forced by parents to discontinue – but the potential risks to girls of keeping their contraceptive use secret are difficult to monitor and measure.

There is some evidence that the aspirational components of A360 have had an impact on knowledge, self-esteem, confidence and girls’ ability to plan for the future.

In Ethiopia, many girls and husbands interviewed for the process evaluation described their Smart Start financial plans in detail and talked about the progress they had made towards their goals – for example starting new businesses or beginning to save. Several girls said they felt more hopeful about their futures and understood how financial planning could help them lead better lives.

“If I simply have 10 children without any plan...my family will face many challenges, they won’t get a balanced diet, they can’t get education and all basics needed for life. If I use family planning, I can manage my family size as per my resources.” (Husband, Ethiopia, 2019)

In Nigeria and Tanzania, various stakeholders reported that A360 events are viewed as a place where girls can access information, get advice about relationships and sex without judgement, and socialize with other girls. Girls felt they had developed confidence and learned life skills including how to stay focused on their goals, and how to navigate relationships and refuse unwanted advances from men. In Northern Nigeria, girls’ ongoing relationship with a mentor, who meets girls over the course of four weeks and delivers the skills curriculum, is an important factor in building girls’ confidence and trust. However, 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.²⁷ WhatsApp groups set up to continue engaging girls throughout the COVID-19 pandemic have proved a useful addition to the Nigeria model, particularly to reach older girls who generally were not attending in-person classes. This resonates with the wider literature, which finds that digital forums provide convenience and anonymity, allowing girls to share feelings and ask questions about stigmatized topics (Guse *et al.*, 2012; McCleary-Sills *et al.*, 2012).

“You’ll see girls coming to us telling us about their crushes, telling us about heart breaks, you know. It’s somewhere they can lay everything bare without being judged. My phone is always ringing, I’m like an adopted mother.” (Service provider, Southern Nigeria, 2017)

While entrepreneurial skills sessions are extremely popular, this often comes with high expectations that the program is unable to meet.

²⁷ LSHTM analysis of A360 monitoring data, June 2017-April 2020

In Nigeria and Tanzania, the entrepreneurial skills elements of A360 were consistently described by girls as their favorite parts of the program. Unsurprisingly given the narrative promoted by A360 – that these sessions will contribute to empowerment – many girls, parents and government officials had the expectation that A360 would support girls to ‘achieve their dreams’ through becoming entrepreneurs. This is an unlikely outcome from a short, one-off skills demonstration and practice session without follow up support, with activities designed more as a ‘hook’ than as an empowerment intervention.

Unsurprisingly given the context of widespread poverty and an absence of other skills training opportunities, girls (and also husbands and parents) in Nigeria and Tanzania often wanted more from A360 than is offered. Requests included more time for in-depth learning and practice, financial support to purchase tools and materials, and lessons on a greater variety of skills. Similarly, in Ethiopia stakeholders often felt that Smart Start should link girls to economic empowerment schemes to help them generate income to meet their financial plans. A360’s absence of follow-up support can cause dissatisfaction in communities. As noted in the mid-term review, raising expectations about entrepreneurship when in fact economic empowerment was never a program objective also raises some ethical questions. A360 is aware of these limitations and is building a more substantial empowerment lens into the next phase of the program.

“We are not going nearly as deep as we need to be into financial empowerment. I think it’s going to hurt us in the end. It’s only going to be so interesting to learn how to make candles and purses until your community is filled with a thousand purse-makers and candle makers and no markets to sell it to...there needs to be much more integration with the needs of the labour market.” (A360 Global staff member, 2020)

In Northern Nigeria, there is some concern that the skills sessions may unintentionally reinforce inequitable gender norms.

The skills curriculum for the MMA solution was adapted from 9ja Girls to address specific needs and life experiences of married girls in the North, incorporating content on family nutrition, hygiene and child spacing as well as life and financial planning skills. The content is considerably less grounded in aspirational messages about goals and dreams than other A360 solutions, and emphasizes girls’ domestic duties and role as caregivers. Girls and other stakeholders reported that the program teaches them to be ‘obedient’ and how to take better care of their families. There is a risk that MMA is employing messaging that is acceptable to communities and husbands, but which potentially reinforces girls’ subservient roles. A360 is currently working with a gender expert to review the content of the curriculum.

“If women practice all that they have learnt from MMA – cook good food, clean the house –the husband can readily attribute the changes to the program. This then spreads the positive news about the program in the community.” – Adolescent girl, Northern Nigeria, 2019

3.2.6. Contraceptive counseling and service provision

Summary findings: In line with the evaluation mid-term review, the final process evaluation finds that A360 has greatly increased the availability of services through flexible delivery models that reach girls with free contraceptives at times and places that work for them. ‘Opt-out moments’, in which all girls who attend A360 events receive contraceptive counseling unless they ‘opt out’, have helped girls feel more comfortable speaking to a provider in the presence of their peers – although A360 has sometimes struggled to ensure sufficient time and privacy to make this strategy effective.

A360’s youth-friendly contraceptive counseling is helping to dispel common fears and misconceptions around side effects – for example concern that methods will lead to infertility or health problems.

However, these fears are often deep seated and cannot be fully addressed through a single counseling session. Persisting fears can limit girls' choice of method, and also contribute to discontinuation. Weaknesses in counseling quality and provider bias were noted in the evaluation mid-term review and continue to cause challenges for the program, particularly in Tanzania and Ethiopia. Service providers do not always counsel girls adequately about side effects and often convey that certain methods are more or less suitable for adolescents. This undermines freedom of choice and can reinforce girls' fears and misconceptions.

Flexible service delivery models offer choices that appeal to girls with different needs and preferences, and improve access for girls in more rural areas.

Across all contexts, A360 has greatly increased the availability of services to adolescents through flexible delivery models that aim to reach girls with free services at times and places that work for them. For example in Ethiopia counseling is delivered either at girls' homes or the health post; in groups or one-to-one with girls and (where possible) their husbands. The process evaluation has found that this flexibility helps reach girls in ways that match their preferences and take into account their circumstances (e.g. challenges in reaching the health post). In Tanzania and Nigeria, providing options to access counseling and services outside of a formal clinic setting (through out-of-clinic events or classes) frequently appeals to girls who do not wish to risk being seen by someone they know in a clinic setting.

"Some of us young girls will not come to take up services at the regular clinic, because there will be many people and they will be looking at us." (Adolescent girl, Southern Nigeria, 2019)

This flexibility has helped to overcome common provision-side barriers affecting adolescent access to contraception, including cost, access and awareness (WHO, 2011; McCleary-Sills, Stoebenau and Hollingworth, 2014; Chandra-Mouli *et al.*, 2017). The attempt to reach girls 'on the spot' with the method of their choice has also been broadly successful, although there are many factors that inhibit this – for example contraceptive stock-outs (see Section 3.2.2) and the need for married girls to consult with their husbands before adopting a method (See Box 7 above).

'Opt-out moments' have helped girls access one-to-one counseling in group settings but have been difficult to implement in practice.

'Opt-out moments' were introduced in Nigeria and Tanzania at the design stage. All girls who attend an A360 class or event receive one-to-one counseling with a provider unless they 'opt out', to help normalize counseling and mitigate fear of stigma among girls who may not wish their peers to know they are considering using contraception. The literature on opt-out testing for sexually transmitted infections suggests that this approach can be effective, although there is limited evidence in relation to contraceptive service provision (Harder *et al.*, 2011; Malek *et al.*, 2011; Ritchie *et al.*, 2014).

Interviews conducted for the process evaluation suggest that, where implemented effectively, opt-out moments do help girls feel more comfortable to speak to a provider in the presence of their peers. However, there have been several implementation challenges, including ensuring enough time for one-to-one counseling during events – a challenge raised in the evaluation mid-term review. The final process evaluation confirms that this has remained a challenge in the final years of the program, although there has been progress in addressing it. In Nigeria, the opt-out moments are built into classes, meaning that time is often limited to ten minutes per girl. In Tanzania, staff observed that girls sometimes left events before seeing a provider because they were bored of waiting. New games and improvements to the event flow were introduced in 2019, reportedly helping reduce the number of girls leaving early. In both countries, the program has experimented with a more staggered approach to counseling throughout a session, rather than requiring girls to queue at the end.

Preserving privacy in group settings is also challenging. Some girls in Nigeria have been unwilling to adopt a method during the opt-out moment, concerned that their peers would know due to the time spent with the provider. Monitoring data shows that girls who are counseled through classes (as opposed to walk-in counseling) are statistically less likely to adopt a method even when adjusting for age.²⁸ While this can be partly explained by the fact that not all girls who attend skills classes are interested in adopting contraception, service providers report that girls often come back for a walk-in counseling session later due to privacy and confidentiality concerns. This introduces an additional hurdle for girls to access services. In Tanzania, school-based mobilization often leads to large groups of girls attending events with their fellow students and teachers. As in Nigeria, 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.

“Maybe they don't want their friends to know, so they come during the week to pick up the method. If they know somebody is outside, they will want to hurry up so they won't suspect. Probably that is why most of them come back on weekdays.” (Service provider, Northern Nigeria, 2018)

A360's youth-friendly counseling is helping dispel fears and misconceptions about contraception, although these are often deep-seated and hard to address in a single session.

Across all contexts, interviews with girls and service providers suggest that A360's youth-friendly contraceptive counseling is helping to dispel common fears and misconceptions around side effects – for example concern that methods will lead to infertility or health problems. Many girls said their fears had been addressed and their questions adequately answered by providers. Visual aids and the practice of showing physical methods to girls have proved helpful to increase girls' knowledge and comfort with different contraceptive options. Most girls interviewed across all contexts had positive interactions with providers, felt safe and listened to, and trusted the provider and the information they had been given.

“Some said that family planning services at a young age can give you cancer or the implant can disappear in the body. I came to realise that it is not true. The service providers have said that these are just myths.” (Adolescent girl, Tanzania, 2017)

However, girls' fears are often deep-seated and rooted in widespread community beliefs about the negative effects of contraception (see Section 3.2.3), and so can be difficult to dispel in a single counseling session. Interviews across all three countries suggest that many girls still have some concerns about contraception, or about particular methods, even after counseling. In some cases, this affects girls' choice of method (see Box 9 below). The process evaluation found that persisting fears combined with counseling weaknesses can also contribute to discontinuation. Some girls discontinue due to concerns about minor side effects such as changes to menstruation, because they are worried these will cause long term damage to their fertility or health. Others stop using contraception because there are no alternative methods that seem acceptable to them, after experiencing side effects from the first method they try (Punton, Gebremedhin and Lagaay, 2019). This suggests that adopters may need additional reassurance to understand and manage minor side effects.

The program has also faced consistent challenges with counseling quality and provider bias, particularly in Tanzania and Ethiopia.

The process evaluation has found that service providers do not always counsel girls adequately about side effects. Some inform girls that methods have no side effects – often motivated by a desire not to ‘scare girls off’ contraception. This risks eroding trust and potentially reinforcing common myths and misconceptions, which are often linked to legitimate concerns about side effects (such as delays in return to fertility after receiving the injection).

²⁸ LSHTM analysis of A360 monitoring data (June 2017–April 2020). Results of a logistic regression mixed model adjusted for age. Odds ratio for class vs walk in = 0.46 for MMA (95% confidence interval: 0.40–0.54); and 0.44 for 9ja Girls (95% confidence interval: 0.42–0.46).

“Girls don’t like being lied to....The provider was telling her if you take this method you won’t get side effects...she chose an implant and the provider said you will find it where we have put it [but then] the implant disappeared... she was then afraid of anything else from Kuwa Mjanja.” (Adolescent girl, Tanzania, 2018)

Across all contexts, service providers often believe that certain methods are more or less suitable for adolescents – reflecting deep-seated community beliefs that have persisted in spite of training. Interviews in Northern Nigeria and Tanzania suggest that providers sometimes discourage girls from adopting longer-term methods, fearing they will cause harm, and many providers are concerned that the injection will lead to infertility among girls who have not yet given birth. In Ethiopia, the implant is sometimes explicitly recommended over other methods by HEWs, which may be influenced by a previous quota system established by the government to boost LARC adoption. In all contexts this undermines freedom of choice and can reinforce girls’ fears and misconceptions.

“She told us about the injectable contraceptive. But she also added that its chemical will not be easily removed from our body. She advised most of us to use the implant.” (Adolescent girl, Ethiopia, 2019)

In Nigeria, substantial investment in new counseling tools and supportive supervision have helped improve counseling quality over time (as discussed in Section 3.2.1). In the final two years of the program, the process evaluation found fewer examples of service provider bias and misinformation about side effects than in the other two countries.

Box 9. Factors affecting girls’ choice of methods

A360 monitoring data shows distinct differences in method mix across the A360 solutions (See Table 4 above). Monitoring data and qualitative insights from the process evaluation link these differences to the following factors:

- **Age and number of previous children:** Across all four solutions, the odds of girls adopting any method and the odds of adopting a long-acting contraceptive method (LARC) both increased significantly with age.²⁹ Girls with at least one child were also significantly more likely to adopt any method and to adopt a LARC than girls with no children.³⁰
- **Service provider capacity:** Lack of training on LARC insertion has sometimes limited girls’ choice. In Nigeria, A360 staff attribute the improvement in LARC uptake over time to increased on-the-job training and supervision to build provider capacities in method insertion and removal.
- **Availability of methods:** regional or national stockouts have often limited girls’ choice. In Ethiopia, short-acting methods are often the only options available at the health post, meaning that girls need to travel to a health center to adopt a LARC. In 2020, the proportion of implants adopted increased from 8% to 21% between April and June, which staff attributed to the consistent restocking of LARCs in A360 sites, before declining again due to stockouts and medical supply shortages in some regions.³¹ In Nigeria, LARC stockouts have at times led to increased uptake of condoms, with girls opting to use condoms until a LARC became available.
- **Familiarity with particular methods:** in Ethiopia, the injection is felt to be popular largely because so many girls are familiar with it already and know friends or family members who have used it. In Nigeria, girls have sometimes reported that they are familiar and comfortable with condoms because they are easy to get hold of and they know others who use them.

²⁹ LSHTM independent analysis of A360 monitoring data: Ethiopia June 2017-Oct 2019; Nigeria June 2017- April 2020; Tanzania Nov 2017-Nov 2018. Results of logistic regression mixed models.

³⁰ LSHTM independent analysis of A360 monitoring data: Ethiopia June 2017-Oct 2019; Nigeria June 2017- April 2020. Results of logistic regression mixed models adjusted for age and for data dependency between observations.

³¹ Overall A360 performance data, 2020.

- **Desire for secrecy:** Across all contexts, stakeholders have reported that the injection is popular among girls who do not wish their parents or partners to know they have adopted a method. Pills are considered harder to hide, as is the implant due to the surgical plaster required on insertion.

“I chose the injection because I don’t want anybody to notice contraception on me. I can’t take the pill because my parents can see it in my bag, my friends can see it and they will take me as a bad girl.” (Adolescent girl, Southern Nigeria, 2019)

- **Fears and misconceptions:** concerns about side effects and possible infertility often lead girls to choose short term methods rather than LARCs, and sometimes lead service providers to encourage or discourage particular methods (as discussed above). Girls often wish to think about a LARC before adopting and may leave with condoms in the meantime.
- **Attitudes and preferences of husbands:** In Northern Nigeria, girls referred to A360 by their husbands sometimes have instructions to adopt a particular method (see Box 7 above). In Ethiopia, girls whose husbands migrate for work often do not wish to adopt a LARC, partly due to the prevalent belief that if a girl uses contraception while her husband is away, she is more likely to be unfaithful.
- **Policy constraints:** In some states in Nigeria, under-18s require written consent from a parent or guardian before adopting a LARC. Staff have observed that this can steer younger girls towards short acting methods, or in some cases lead to girls leaving without a method and not returning.

3.2.7. Follow up and continuation

Summary findings: Supporting girls to continue contraception after adopting a method has been one of A360’s biggest challenges, although there has been progress in the final years of the program. Ethiopia has seen the most success, where working through HEWs has helped build sustained relationships between girls and local providers, ensuring girls have support to continue using contraception. Conversely, in Tanzania the outreach model and lower reliance on local providers potentially leaves girls without access to services once outreach teams move on from communities.

Since the evaluation mid-term review A360 has stepped up one-to-one follow-up, in the form of phone calls and in-person visits, to check in with girls and remind them about upcoming appointments. While these have had some success, phone ownership among adolescent girls is patchy and girls’ concerns about confidentiality have limited the reach of these strategies. Mass engagement channels to support sustained engagement (for example apps and Facebook groups) have been explored but not widely adopted, although there has been some success with WhatsApp groups in Nigeria during the COVID-19 pandemic.

A360 aims to build sustained relationships between girls and local providers to support continuation – this has been most effective in Ethiopia but remains a gap in Tanzania.

Through working with local government service providers, A360 aims to build sustained relationships that help girls feel safe and comfortable to access follow up services and continue using contraception. In all contexts, difficulties in monitoring and measuring continuation (discussed in Section 3.2.1) have made it challenging for the program to track the success of these strategies.

Process evaluation research suggests differing levels of success across contexts. In Ethiopia, the process evaluation visited several kebeles where Smart Start transitioned out over six months previously. In general, it found that the continued presence of well-known and trusted HEWs was helping girls feel supported to continue using contraception. In Nigeria and Tanzania, some girls reported feeling more comfortable seeking follow-up services after a positive experience with A360. However, there is some concern that youth-friendly providers may not always be available when girls visit facilities for follow-up services.

This challenge is particularly evident in Tanzania, where girls may not have been served by a local provider and may not have access to a youth-friendly provider in her ward (see Section 3.2.2). The process evaluation found that many unmarried girls who attend out-of-clinic events remain unwilling to visit clinics for follow-up due to persisting community stigma. The intention was for outreach teams to visit the same areas every three months to ensure continued access to services for girls. However, in practice this has proved challenging, in part because of government requests for the program to visit new areas that have not yet been served. A360 initially piloted Kuwa Mjanja Clubs in communities reached by the program, as a mechanism to support sustained engagement and ongoing dialogue between girls and service providers. However, 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.

“It becomes a challenge because you might find [some girls] who took a method from [a Kuwa Mjanja event] and she does not want anyone else to find out about it, so 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, Tanzania, 2020)

The program has had most success with intensive one-to-one follow-up strategies, but relying on phone access limits reach.

Across all three countries, A360 has increasingly used phone calls and in-person visits to check in with girls and remind them about follow-up appointments. In Ethiopia, HEWs are sometimes able to check up personally with girls who have missed appointments, which is very much appreciated by girls – although in practice this is often limited by HEWs’ workloads. Providers often give girls their phone numbers along with ‘next appointment cards’ so girls can contact them with questions, and also frequently take girls’ numbers so they can call them to remind them of follow-up appointments or check in on how they are doing. In Nigeria this has become increasingly formalized, with protocols and call logs used to keep track of follow-up contacts. Girls generally appreciated this contact, and felt confident to seek additional services or raise concerns with service providers.

However, in Nigeria and Tanzania follow-up approaches rely to a large extent on girls having access to a phone. Phone ownership among adolescent girls is patchy, especially among poorer, rural and younger girls. While many girls can use a partner’s or family member’s phone, this can make it difficult to reach girls confidentially, and some girls leave false numbers as they are worried about a call exposing their use of contraception. Tanzania established a call center to answer girls’ questions and circulated details of an Unstructured Supplementary Service Data (USSD) number that girls can text with their questions.³² However, relatively few girls are using either channel.³³

In light of these challenges, A360 has expanded the role of mobilizers to support sustained engagement through face-to-face contact. In Ethiopia and Nigeria, Women’s Development Army volunteers and mobilizers work with providers to visit girls who are due a follow-up appointment, while in Tanzania Kuwa Mjanja Queens are a consistent presence in communities who can help direct girls to a nearby youth-friendly provider. In Nigeria, a network of ‘Big Sistas’ (satisfied contraception users) has recently been rolled out in the South to support girls who adopt short-term methods, particularly self-injection, and act as a link to facilities for girls facing access challenges. In the North, mentors are acting as an ongoing point of contact for girls, playing a key role in supporting continuation. This highlights the importance of maintaining trusted community-based points of contact to support girls in the longer-term, but once again raises issues with sustainability if government health systems are not able to absorb community mobilizers.

³² USSD is a common technology used across East Africa to help girls find answers to their sexual and reproductive health 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).

³³ A360 reported that around 3,000 girls aged 15–19 used the USSD 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).

The program has had less success with mass-engagement virtual channels – with the exception of Nigeria during COVID-19.

In Tanzania, the program developed a ‘Mjanja Connect’ app, which was initially intended to allow girls to ‘rate’ their experience with a provider, seek further information, and receive reminders about follow-up. However, the app is currently only used by providers and Kuwa Mjanja Queens at events and has not yet been made available for girls to use directly. Both Kuwa Mjanja and 9ja Girls hoped to use Facebook groups to support follow-up, but these were dropped as the solutions scaled due to low levels of engagement.

However, the Nigeria team have had more success with virtual engagement during the COVID-19 pandemic. In 2020, WhatsApp groups were useful to support sustained engagement – some girls are now using them to contact service providers when they need to renew their method. Weekly SMS messages have also been sent to girls, with information on COVID-19, life skills messaging, and contact details so girls can get in touch with a provider. However, virtual engagement is only available to girls with Android phones who can afford to pay for data, which generally excludes younger girls and most girls in the North.

3.3. Adoption and Replication

This section describes how A360 has promoted the adoption and replication of the approach and solutions, and its progress to date.

Headline findings

Promoting the adoption and replication of A360 was a core program objective, with the aim of catalyzing donor investment to support global learning and innovation. However, adoption and replication outcomes were never clearly defined or systematically measured, contributing to a lack of clarity in relation to goals and target audiences. There were concerns that A360 attempted to promote the approach too soon, before solutions were fully defined and evidence existed on their effectiveness. Country teams found engagement with AYSRH audiences substantially easier once the solutions were ‘landed’, and A360 had promising performance data to share.

At the global level, A360 has invested extensive efforts to generate global public goods and share learning through publications, conferences, meetings and online content. These have been appreciated by AYSRH stakeholders, who felt there is real interest in learning from A360 – in particular around how to apply HCD, engage youth meaningfully, and tap into girls’ aspirations. A360 has tangibly influenced thinking and practice within PSI, SFH and the Foundations, with insights from the approach and solutions incorporated into other projects and organizational design principles. However, although online engagement has been good, there is some scepticism among external actors about the cost and complexity of the A360 approach, and as yet there are few concrete examples of adoption or replication at the global level beyond donors and implementing organizations.

Since the mid-term review, A360 has had considerable success in promoting national-level adoption and replication. A360 country teams have led or engaged actively in national and state level platforms to share learning and influence policy, and have provided learning tours and other support to organizations interested in adapting elements of the program. This has led to a growing number of examples of replication among national AYSRH actors. A360 has also succeeded in leveraging external funding and partnering with other BMGF and CIFF-funded initiatives to expand the reach and scope of the program – although formal partnerships with other non-government organisations have proved more challenging.

In the final year of the program, A360 focussed efforts on health system integration for sustainability. Progress has varied substantially across countries, influenced by the degree of existing integration into health systems, as well as the broader political context and level of national and regional commitment to AYSRH. The biggest success story is the decision of the Ethiopian Federal Ministry of Health to roll out Smart Start nationwide, aiming to reach one million married girls by 2025. However, across all contexts, a key challenge for A360 Amplify will be ensuring fidelity and quality of core intervention components, while reducing program complexity to facilitate government ownership.

3.3.1. What was A360's approach to adoption and replication?

Promoting the adoption and replication of A360 was a core program objective, driven by donors' desire to catalyze investment to support learning, scale and sustainability. However, outcomes have not been clearly defined or systematically measured.

Significant resources have been invested in developing public goods, engaging with potential partners, and sharing learning nationally and globally – the evaluation Costing Study estimated that US\$1 million – US\$1.5 million was spent on adoption and replication activities during the design phase.³⁴

"We want our investment to be shown to be able to be adopted and replicated and taken to scale, so that there will be broader investment in these types of approaches if they are successful." (Donor, 2019)

Adoption refers to A360 inspiring other interventions to adopt a similar approach to design and implementation. For example: including youth as designers, employing HCD or a multidisciplinary approach, or using an adaptive implementation process.

Replication refers to A360 inspiring other actors to replicate the A360 solutions (or elements of them) within and beyond intervention areas, with other funding sources.

However, a clear theory of change was never established for adoption and replication, and several respondents felt there has been a lack of clarity on 'what good looks like.' Staff felt this was partly due to A360 not having a consistent view on the essential elements of the A360 approach or solutions (its 'secret sauce' – see Box 10). Although outcome-level indicators were initially developed to help measure adoption and replication, they were later abandoned due to difficulties in measuring this type of change, and donor prioritisation of country-level performance over other objectives. In the final years of the program A360 focused on monitoring outputs rather than outcomes, including communication, stakeholder engagement and conference activities, and resources produced.

In addition, the target community that A360 is seeking to influence has remained broad and has never been officially defined. A360 has not used formal landscape mapping, audience segmentation, or other systematic ways of identifying target audiences. While this allowed the program to be opportunistic in identifying potential partnerships, it has also contributed to the overall lack of clarity with regards to adoption and replication.

A360 has invested extensive efforts to package the approach and solutions for external audiences, which has tapped into global interest with good levels of online engagement.

A360 has published a large number of thought pieces and technical publications (see Table 8), and launched the 'Open Source' in 2019. Staff described this as an exercise in 'radical transparency', making available a large array of resources and stories from A360 for the benefit of other stakeholders at national

³⁴ See evaluation mid-term review (Newport *et al.*, 2019): <https://www.itad.com/knowledge-product/midterm-review-of-the-adolescents-360-program/>

and global levels, including information on both successes and failures. A360 has also been actively *‘tapping into networks and being opportunistic’* in sharing learning, both within PSI and with other organizations – through learning exchange calls with like-minded partners, a technical webinar series, and on-demand assistance for A360-inspired PSI programs.

Table 8: Headline A360 online engagement figures

A360 Learning Hub and Open Source	21,000 visitors have engaged with the Hub and Open Source since the website’s launch in January 2018.
Publications	142 thought pieces and 100 resources for download are available on the A360 website. The Case of Kuwa Mjanja in Tanzania has received 1,348 pageviews; The Case of Smart Start in Ethiopia 1,246 pageviews.
Social media engagement	A360 had 1,556 Twitter followers as of December 2020; 442 Facebook followers, and 230 followers on LinkedIn

Global AYSRH stakeholders interviewed for the process evaluation felt that there is real interest within the sector in learning from A360, particularly about how to move away from ‘one size fits all’ programming, engage youth in meaningful ways, and tap into girls’ aspirations. Interest in A360 was linked to the growing profile of HCD in global health.

“There is a lack of grounded evidence and good documentation on how HCD can be integrated into public health... I think there is a big demand for really understanding how it worked and why, did it result in better interventions or better processes?”
(Global AYSRH stakeholder, 2019)

This sense of widespread interest in A360 learning is reflected in program reporting data, which suggests good levels of online engagement (see Table 8: above). However, external stakeholders also expressed some scepticism about the cost and complexity of A360, and concerns around how replicable the approach is in practice. Several felt that a more focused approach to packaging and sharing learning would be helpful, as tools and documents are not always clearly catalogued or easy to find on the A360 website. Some stakeholders also questioned whether A360 had delivered truly innovative solutions for AYSRH programming, as central A360 components (in particular, integrating empowerment and livelihoods programming) are not new. This is discussed further in Box 10.

Box 10. What is A360’s ‘secret sauce’?

A360 staff have grappled with this question from the outset, as the approach and solutions have continued to evolve. In 2018 A360 published its ‘Blueprint for Change,’³⁵ which aimed to draw out the core elements of the program to help others replicate it. This, combined with interviews with the A360 global team in 2019 and 2020, suggest that the A360 ‘secret sauce’ includes the following components:

- 1. Drawing on multiple disciplines**, including but not limited to HCD, in the program design. This has included designing interventions to account for developmental differences among different categories of girls, developing engaging girl-oriented brands, and tapping into community norms affecting girls’ choices and trajectories.
- 2. Meaningful youth engagement:** involving youth as core partners in the design and implementation of the program, to ensure young people’s ideas and insights are integrated throughout (see Spotlight 1).

³⁵ See <https://a360learninghub.org/open-source/adaptive-implementation/blueprint/>

3. **Adaptive implementation:** viewed as complementary to HCD, and a means of moving from design to implementation while still maintaining curiosity and the ability to iterate and contextualise as A360 has scaled.
4. **Aspirational programming:** positioning contraception as a tool that can help girls achieve their self-defined goals, and delivering life and entrepreneurial skills sessions that both engage and empower girls, and enlist support from government and communities.
5. **‘A whole greater than the sum of the parts.’** Staff recognize that many of the concepts within the A360 solutions are not new in and of themselves (for example combining contraceptive service provision with skills training, or outreach-based service provision to reduce barriers to access), but feel that the input of multiple disciplines has enabled A360 to tweak and combine these components in new and innovative ways.

“I don’t think A360 has been ground-breaking in the sense of creating something wholly new...but in taking concepts that have become so tried and tested that we stopped trying to really question whether we sufficiently understood. And opening up ways to see that indeed we haven’t been curious enough.” (A360 global staff member, 2019)

3.3.2. What is the evidence for adoption and replication?

A360 has influenced thinking and practice within PSI, SFH, BMGF and CIFF.

The evaluation mid-term review reported early progress towards adoption and replication, particularly within PSI and SFH. Since then A360 has continued to influence thinking and practice within the implementing organizations. A360 staff have provided direct technical assistance to PSI projects in Mozambique and Mali that are attempting to replicate elements of the A360 approach and solutions. The Mozambique program has adapted the Smart Start content and tools, and there are plans to further adapt the tools for programs in India and Kenya. Smart Start is viewed by staff as potentially highly replicable, tapping into a ‘universal truth’ around the need to consider the resources required to bring up healthy children.

PSI and SFH country teams have also incorporated HCD into several other projects and proposals, and in Nigeria SFH is planning to roll out training on core principles of HCD to the entire organization. Within PSI Global, the ‘Keystone’ design framework developed in 2019 was reportedly influenced by the A360 approach, encouraging program developers to use tools and techniques from HCD to understand girls’ desires, hope and dreams. However, staff reflected that it is challenging to expect country teams to manage and lead an HCD process themselves without the support of external design experts, especially for teams who have not been through the process before. HCD requires adopting a different mindset to program design, being open to new ways of working and rapid iteration, which may be difficult to embed without ongoing support.

A360 has also influenced thinking within BMGF and CIFF. Donors felt that A360 had demonstrated the importance of incorporating aspirations into AYSRH, as well as meaningful youth engagement. The CIFF India team has written a proposal adapting Smart Start for India, and conversations have been held with other teams around building A360 tools and messaging into other programs.

“The biggest lesson that we have taken away from A360 is reconsidering how we talk about contraceptive uptake...having it be centered around some kind of hook that speaks specifically to [adolescents], is something that we think is a huge benefit to the program.” (Donor, 2019)

There are few global examples of adoption or replication as yet, but since the mid-term review there has been considerable success at the national level.

As yet there is limited evidence of A360 influencing global programming or practice outside of donors and implementing organizations. Disentangling the influence of A360 on broader AYSRH practice is challenging – in part because neither the consortium nor the evaluation is resourced to investigate this in depth, and in part because the core components of A360 are not necessarily new, and to some extent reflect a broader shift in the AYSRH community around how to program for adolescents. Staff feel that the hyper-competitive nature of the sector means that even where A360 materials and presentations later appeared to be integrated into intervention models, this was difficult to prove. Nonetheless, consortium members and external stakeholders feel that A360 has made a contribution to wider take-up of models that link vocational skills, gender empowerment and contraception, by donors and by partner NGOs.

There is significantly more evidence of policy influence, adoption and replication at the national level. Across all three countries, A360 has established or revitalized national or state level platforms (such as Champions Meetings or Technical Working Groups). These have allowed A360 to share learning and showcase program innovation and results, as well as support coordination and engage with a broad range of stakeholders. National AYSRH stakeholders interviewed for the process evaluation often expressed appreciation of the work A360 had done to bring stakeholders together and share learning. Engagement proved substantially easier once the design process was over and the solutions were ‘landed’ – at times in the early years, A360 struggled to keep potential partners engaged while the intervention was not yet clearly formed. This validates the evaluation mid-term review finding that adoption and replication goals were likely pursued too soon, before clear evidence existed on the effectiveness of the solutions.

“I think my biggest personal learning is to not expect a program to do too much up front...where we expect not only a proof of concept but to go to scale... asking to have scale, plus adoption and replication, is a bit too much.” (Donor, 2019).

Through these forums and active engagement in other national AYSRH activities, A360 has raised its profile and in some cases influenced policy – for example providing technical input into the 2019 National Accelerated Investment Agenda for Adolescent Health and Wellbeing in Tanzania. In Ethiopia, some government stakeholders felt that recognition of A360’s successes has reinforced government support for AYSRH programming in general.

“During the Technical Working Group meetings on the development of the adolescent health strategic framework in Ogun, A360 was a very key partner...we really leveraged the A360 project data to inform what we put in the policy.” (Regional government stakeholder, Southern Nigeria, 2020)

In the final year of A360, country teams focused efforts on sustainability and integration of A360 solutions into government health systems (see Table 9:). Progress has varied substantially across countries, with most success in Ethiopia and least progress as yet in Tanzania. Spotlight 2 below provides further insights into the factors affecting progress.

Table 9: Progress towards government integration across A360 countries

Ethiopia Smart Start	<ul style="list-style-type: none"> ▪ In 2019 the Federal Ministry of Health committed to rolling out Smart Start nationwide, with the support of a \$10.5 million investment from CIFF. The Roadmap for Integrating Smart Start in Ethiopia (RISE - which will form part of A360 Amplify) aims to reach one million married adolescent girls across 11,000 kebeles by 2025 through full integration of Smart Start into the national Health Extension Program, training 38,000 HEWs and 240,000 Women’s Development Army volunteers, and strengthening public sector capacity and incentives to improve performance. RISE is being led and implemented by the Ministry of Health, with A360 playing a technical advisory role.
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	<i>"[We are] integrating the Smart Start program over the entire health structure all the way down to community level. That means making sure the program is included in the key policies and strategies of the Ministry of Health and the HEWs' training manual." (Federal Ministry of Health official, Ethiopia, 2020).</i>
Nigeria 9ja Girls and MMA	<ul style="list-style-type: none"> A360 conducted ongoing government outreach and engagement to identify opportunities to incorporate elements of the solutions into state activities, budgets and operational plans. By mid-2020 six of the eight A360 focal states had expressed an interest in replicating components of the solutions and expanding to new areas and facilities. Progress and commitment varies by state, but some states (including Kaduna, Nasarawa and Ogun) have already allocated funding and/or begun training. However, the details have yet to be confirmed and the government is unlikely to adopt all elements of the solutions.
Tanzania Kuwa Mjanja	<ul style="list-style-type: none"> 'Sustainability pilots' were held in three regions with substantial unmet need and existing buy-in from regional government. In these areas, A360 is supporting regional government staff to run their own Kuwa Mjanja events. The program has also supported planning and budgeting processes with the aim of integrating Kuwa Mjanja into council health budgets. While regional governments have expressed willingness to incorporate Kuwa Mjanja into budgets and planning processes, as of September 2020 there were no concrete commitments. A series of events implemented and funded by government health teams were supported by A360 in 2020 but were halted by COVID-19.

A360 has also leveraged external funding to expand the reach and scope of A360, and there are a growing number of examples of replication among national AYSRH actors.

A360 has successfully leveraged external funding across all three countries and has developed links with several other BMGF and CIFF-funded initiatives (see Table 10:). As A360 has scaled and produced evidence of its effectiveness, there has also been growing interest among national AYSRH actors to learn from and replicate elements of the program. A360 country teams have conducted learning tours for other organizations and supported them with budgeting, as well as using national and state level platforms to showcase program learning and results. There are now several examples of uptake across all three countries, though most are relatively small scale, and some reported examples have not been possible for either A360 or the evaluation to verify.

Table 10: Non-governmental partnerships and leveraged funding

Ethiopia Smart Start	<ul style="list-style-type: none"> The Maverick NEXT investment in Ethiopia (co-funded by six women philanthropists that take part in the Maverick Next program of the Maverick collective) will design and prototype new models to improve husband engagement and link couples to livelihood opportunities. In 2020, A360 began a formal partnership with Marie Stopes International with funding from Global Affairs Canada, to expand Smart Start to reach an additional 150,000 adolescent girls. Pathfinder are planning to use young designers in the development of a new national curriculum aimed at older adolescents, and the Talented Youth Association also adopted elements of the youth engagement component after learning about it through the national Champions Meeting platform.
Nigeria 9ja Girls and MMA	<ul style="list-style-type: none"> MTV Shuga (an international drama series funded by BMGF to promote AYSRH) mentioned and promoted 9ja Girls in episodes and outreach activities, and A360 helped review scripts. Sayana Press (funded by CIFF to promote self-injectable contraceptives) supported training for A360 providers on self-injections. A360 subsequently introduced community-based distributors to support self-injection. Integrate-E (funded by BMGF): A360 conducted joint outreach events to increase service delivery among community pharmacists and with Proprietary Medicine Vendors in Lagos and Kaduna, and to develop a referral model to track clients.

	<ul style="list-style-type: none"> ▪ In Kaduna state, UNFPA has been supporting the government to replicate the full MMA model across three local government areas and is in talks with government about replicating 9ja Girls in additional facilities in Lagos. ▪ The Challenge Initiative has adopted the 'life map' concept and other components inspired by A360, after a learning tour and engagement with SFH.
Tanzania Kuwa Mjanja	<ul style="list-style-type: none"> ▪ Vodafone Foundation provided US\$1 million grant funding to develop the Mjanja Connect app through an HCD process. ▪ In 2018, A360 leveraged 15 additional DFID and KfW funded outreach teams to roll out Kuwa Mjanja to new areas – a major factor in helping the program reach scale quickly. ▪ A360 has signed a Memorandum of Understanding with the Aga Khan Foundation, which has begun implementing an outreach model drawing on Kuwa Mjanja in Mwanza region, incorporating entrepreneurship sessions and community level service provision. ▪ Well Told Story are planning to run A360-inspired events, following engagement with PSI to demonstrate the A360 model.

A360 has found it challenging to establish formal partnerships with other non-governmental organizations.

During the design phase A360 sought to establish partnerships with other organizations to support scale-up and delivery, and help position the program for sustainability. However, the program did not have a clear partnership strategy from the outset, and forming lasting partnerships proved challenging for several reasons:

- Replication by non-government partners has been constrained by the **competitive nature of the sector** – this can discourage formal partnerships that make attribution to a specific program more challenging, and which involve sharing innovation that may benefit competitors. In Tanzania, A360 was close to reaching agreement on a major partnership that would have seen Kuwa Mjanja branding and content adopted in a national online information hub for girls, but this did not come to fruition due to challenges around the ownership of branding.

“Tanzania has several sexual and reproductive health implementing partners on the ground who have prior commitments with donors. Organizations tend to be very protective of the work they are doing, that’s their competitive advantage. We have struggled getting that buy-in from others.” (A360 staff member, Tanzania, 2020)

- Establishing and managing partnerships proved a **time-consuming process**, and staff struggled to invest in this alongside the many other demands of the program.
- The need to retain the **quality and integrity of the design** was another barrier, especially as the solutions became more complex through various iterations. In Tanzania, A360 initially aimed to partner with one community organization per region to support management and coordination of Kuwa Mjanja events. However, this was abandoned as the program scaled, due to challenges with implementation quality in events run by community partners.
- A360 arguably started to **pursue partnerships too late**, after the interventions had already been designed. While this allowed A360 to approach potential partners with a clearer ‘ask and offer’, it also led to challenges in matching A360 objectives with partner objectives. In Tanzania in 2018, A360 attempted to forge a partnership with a national youth organization to help run the Kuwa Mjanja Clubs, but it proved too challenging to find a model that made sense for both programs.

A360 eventually moved away from its initial plans to establish an array of formal non-governmental partnerships to support scale-up, focusing instead on strengthening relationships and engagement with government. As A360 begins its next phase, the focus on external partnerships has been renewed, with a particular focus on partners who can help expand the entrepreneurial skills and empowerment components of the program.



Spotlight 2: How sustainable is A360?

A360 was not designed from the outset to be fully embedded into public health and social systems by its close. Despite this, some substantial progress has been made, especially in Ethiopia where A360 is now being integrated into the national Health Extension Program through the RISE investment (see Table 10: above). However, staff acknowledge that A360 is some way off being fully sustainable and reaching this status will be a primary aim of the follow-on program. The process evaluation has identified four key factors affecting sustainability across A360 contexts:

1. **Degree of integration into health systems and existing community structures.** As discussed in Section 3.2.1, this is strongest in Ethiopia where the Health Extension Program is fully responsible for implementing Smart Start, and where the volunteer Women's Development Army have been increasingly incorporated into the model. Integration is weakest in Tanzania, which relies on an outreach model with less sustained engagement from

government health staff. These distinctions help explain differential progress towards government integration across the three countries. However, A360-funded staff play key roles across all countries, providing on-the-ground support to implementers as well as mentoring and supervision, and this remains one of the biggest challenges for the next phase of the program.

2. **Political context and level of commitment to AYSRH.** Across all three A360 countries, there was pre-existing interest and buy-in at the federal level to improve modern contraceptive access for adolescents. A360 aligns with and helps support national policies, targets and plans relating to AYSRH, helping build government buy-in for the program. Growing global focus on AYSRH, for example through FP2020,³⁶ has also helped foster national level support.

However, commitment to AYSRH varies between countries and regions, and gaps and shortfalls in public funding for health in general

and family planning in particular pose a significant risk for long-term sustainability. In Tanzania, government and AYSRH stakeholders highlighted the challenges of limited funding and competing priorities, both within and beyond youth and health programming. In Nigeria there was a 90% budget cut in the national family planning commodity counterpart budget in 2019, and further reductions in health funding in 2020. In both contexts there is reliance on donor-funded programs to plug service delivery gaps. It is yet to be seen how the global economic impact of COVID-19 will affect budgeting for AYSRH over the course of A360 Amplify.

"One challenge we have at the Ministry is that we don't fund our programs...we have budgeted for them, but money is not released." (National government stakeholder, Nigeria, 2020)

³⁶ FP2020 is a global partnership to empower women and girls by investing in rights-based family planning. See <https://www.familyplanning2020.org/>.

The fact that AYSRH does not sit within a single government department in Nigeria has also presented a challenge to coordination, integration and ownership. Across all contexts, conflict and elections pose ongoing challenges to integration and sustainability, including the evolving civil war in Ethiopia, and forthcoming state-level elections in Nigeria.

3. Engagement of government stakeholders at all levels from the outset of the program. Across all countries A360 has proactively engaged with government stakeholders, to ensure health officials were involved as core partners in key activities. Playing an active or leading role in national and regional AYSRH forums has helped raise A360's profile and build government relationships. Sharing data and results has been crucial to building buy-in, showcasing how A360 is helping government to achieve their own family planning goals, and providing proof of concept for the A360 solutions – this in large part drove the decision of the Ethiopian Federal Ministry of Health to scale Smart Start. The aspirational and youth-engagement elements of the program have consistently helped secure the interest of government stakeholders, who appreciate that A360 aims to empower girls as well as meet their contraceptive needs. Across all contexts, government officials interviewed for the process evaluation consistently expressed their appreciation for the close working

relationship fostered by the A360 team and viewed A360 as trusted partners.

“One of the first things we did in Nasarawa was ensure that all our processes were embedded in the state structure. We allow the state to take the lead and then we guide from the back.” – A360 regional staff member, Northern Nigeria, 2020

Effective government engagement has required substantial investments of time from A360 staff, initially at federal level, and subsequently at regional, district and community levels – all of which have different structures and key individuals, with different priorities and capacity constraints. The time and resources required to engage stakeholders consistently and effectively at multiple levels, and develop new relationships when officials move to a new position, should not be underestimated.

4. Solution complexity considered alongside health system constraints and capacity gaps at the level of service delivery and supervision. One of A360's biggest strengths has been its ability to adapt and iterate in response to learning (see Section 3.1). In some cases this has led to increasing complexity as solutions have evolved – improving performance, but raising questions about sustainability. Finding a balance between ensuring 'core components' of the solution remain intact

and delivered to a high standard, while at the same time reducing complexity to facilitate government ownership, will be a central focus of the follow-on program. For example in Tanzania there are some concerns over the quality of government-run pilot events due to limitations with government facilities and capacity to coordinate the full range of Kuwa Mjanja activities. One core question is the extent to which meaningful youth engagement can be continued within a government-led model. A360 is exploring ways in which the government might work with Kuwa Mjanja Queens without paying them a formal stipend.

As A360 Amplify begins, another key challenge for A360 staff will be the shift in focus from implementation to technical assistance, which requires different approaches and skill sets



Conclusions & Recommendations

4. Conclusions

A360 reached over 400,000 adolescent girls with modern contraception since 2017, significantly exceeding its performance targets.

Program monitoring data shows that conversion rates have improved significantly over time with 84% of girls who attended A360 events or counseling adopting a method in 2020 compared to 63% in 2018. Long-acting contraception accounted for 40% of all methods adopted, comparing favorably to national benchmarks. While the outcome evaluation will be necessary to make a judgement on the overall impact of the program, A360 has clearly achieved considerable success and has hugely exceeded performance expectations since the evaluation mid-term review. This is particularly notable given the impact of COVID-19 on service delivery in 2020.

However, the program has been less successful at reaching younger girls – 32% of adopters across all settings were aged 15-17, and most of these were from Tanzania. For a variety of reasons it has also been difficult for A360 to accurately monitor continuation, and figures on continuing users remain low (11% of girls reached in 2020) and have not substantially increased over time.

A360's use of HCD, in combination with insights and tools from various other disciplines, has been an important factor in its success. However, there is a question over whether the same results could have been achieved without the complex, multidisciplinary design.

The HCD approach brought rigor and innovation to A360. It provided a defined framework for designing the solutions and ensured that the consortium kept the needs of adolescents at the center as the solutions evolved. HCD was credited with shifting the mindsets of those engaged with it towards more empathy for adolescent girls, humility and curiosity, as well as permission to try, fail and adapt. The process evaluation suggests that this adaptive mindset was an important factor in A360's success. The involvement of young people in the design process was particularly transformative – it fostered new ways of thinking, understanding and advocating for meaningful youth engagement, which has the potential to extend beyond A360 into other programs.

That said, delivering a program with a complex, multidisciplinary design with a new approach -HCD - at its core also brought challenges and tensions, including a lack of clarity in roles and responsibilities within the consortium, a concern that existing evidence was not sufficiently considered from the outset, and tension between the 'desirability' of solutions to girls and their feasibility and scalability in constrained public health systems. A360 struggled to engage young people fully in the design process and involve them systematically after the design stage, although there are some promising examples (particularly the youth 'SWAT team' in Tanzania, and youth advocates in Ethiopia). This is due to the lack of clear strategy and insufficient resources to ensure youth could be meaningfully engaged from the outset.

As noted in Section 3.1, the disciplines other than HCD and youth engagement made important contributions to the design of the solutions, but their inputs were generally focused and specific rather than fully integrated into core ways of working.

The introduction of adaptive implementation complemented the HCD-driven design phase and helped A360 continue improving performance.

One of A360's biggest strengths has been its ability to adapt and iterate in response to learning. The adaptive implementation approach introduced in 2018 complemented the HCD process, building on and reinforcing the new, more flexible ways of thinking and working that the country teams had been practicing during the design stage.

Adaptive implementation provided useful tools and processes to support regular review of data to generate learning and inform continuous adaptations of the solutions. There are several examples across

the A360 countries where adaptations led to tangible improvements – for example the shorter discussion guide and incorporation of the Women’s Development Army in Ethiopia, and the introduction of the Hub and Spoke model in Nigeria. Experience with adaptive implementation also helped country teams to pivot more quickly to respond to the COVID-19 restrictions on service delivery.

However, adaptive implementation was brought in mid-course and proved time consuming and difficult to implement for country teams, requiring significant support to integrate it into their ways of working. Rolling out adaptations to multiple regions and implementation teams, and embedding adaptive ways of working into staff practices on the ground, proved particularly challenging.

In a complex adaptive program like A360, there is a need to balance adaptation and iteration with clear parameters and expectations.

Several core components of A360 developed as the program progressed, rather than being planned from the outset – reflected in the lack of a youth engagement strategy, unclear roles and responsibilities among consortium members, the absence of an established M&E system before scale-up, and lack of clarity in A360’s strategy for partnerships, adoption and replication. Had the parameters around these areas been planned and communicated more clearly from the outset, it is likely there would be been less frustration, especially for country teams, and more efficient working.

Across Ethiopia, Nigeria and Tanzania, A360’s strong performance is underpinned by several common success factors:

1. **Close engagement of government as partners from the outset.** A360 has successfully forged strong relationships with health departments through up-front engagement and regular review meetings, and ensuring health officials are core partners in key activities from site selection to mobilization. Sharing data and results has been crucial to building buy-in, showcasing how A360 is helping government to achieve national family planning goals, and providing proof of concept for the A360 solutions.

The level of effort and commitment required to engage multiple layers of government at national, sub-national and community level should not be underestimated, particularly through election upheaval and frequent staff turnover in government departments. However, it has paid dividends for A360: building the national profile of the program, securing community access and buy-in, supporting core program activities and ongoing supervision of health staff, and laying the groundwork for government integration in the next phase.

2. **Integration into health systems.** All A360 solutions work through public health facilities and with public providers. This has enabled national scale-up, improved program reach, and helped build service provider capacity and motivation to serve adolescent girls. It is notable that A360 has made most progress towards government ownership where solutions are more deeply integrated into health systems (in Ethiopia and to a lesser extent Nigeria), while sustainability in Tanzania is somewhat hampered by the reliance on A360 outreach teams. This points to an important trade-off, given that Tanzania has reached many more girls than the other solutions, and more younger girls aged 15-17 than the other two countries combined.

A360 has succeeded in supporting youth-friendly counseling by government providers – with most girls reporting feeling safe, listened to and supported. However, service provider and health system capacity – flagged as challenges in the evaluation mid-term review – have remained a difficult area for A360. The process evaluation has consistently highlighted issues with service provider bias and weaknesses in contraceptive counseling quality. In Nigeria, the program invested in increased on-the-job mentoring and support along with new counseling tools, which (combined with an intensive two-week training) have helped improve performance since 2018. In Ethiopia and Tanzania, the short training provided by A360 may not be sufficient to address observed capacity challenges. In all contexts, A360 staff provide crucial on-the-job support and mentoring, which helps to reinforce training messages and manage the persistent challenge of high workloads and staff shortages across public health sectors. This raises concerns that quality and fidelity could drop dramatically once A360

staff are no longer supporting government providers with delivery – an important issue to monitor in follow-on programs.

3. **Life skills, vocational sessions and aspirational messaging.** The final process evaluation confirms a key insight from the evaluation mid-term review: in all three countries the aspirational elements of the solutions have helped girls feel that contraception was relevant and valuable to them and attracted them to A360 activities. Aspirational components have also helped secure the support of government, service providers and community stakeholders, who appreciate that A360 aims to empower girls as well as meet their contraceptive needs. This helped unmarried girls access services in a context of widespread stigma, by framing the program as about more than contraception. There is also some evidence that skills sessions and aspirational messaging have had an impact on girls' knowledge, confidence and ability to plan for the future (although these outcomes have not been systematically measured).

However, A360's financial planning and vocational skills training often come with high expectations that the program is unable to meet, as they are relatively superficial and designed more as a 'hook' than empowerment interventions. Short, one-off skills sessions without follow-up support are unlikely to lead to lasting empowerment outcomes, which puts A360 in the somewhat uncomfortable situation of promoting a story about empowerment that it was not designed to deliver. Deepening the empowerment offer of the program, with the support of broader partners, will be a key focus of follow-on programming. In addition, downplaying contraceptive provision comes with some risks. In Tanzania and Nigeria, unmarried girls often hide their contraceptive use from their parents and communities – while framing A360 as a wellbeing program rather than a contraception program undoubtedly helps these girls access services, it puts them in a position of secrecy that may make continuation less likely.

4. **Flexible service delivery models supported by a diverse array of mobilization approaches.** Across all contexts, A360 has greatly increased the availability of services to adolescents through flexible delivery models that reach girls with free services at times and places that work for them – including life skills classes and out-of-clinic events; facility-level youth-friendly counseling opportunities; home and community-based counseling; and outreach services. These are supported by a variety of (mainly in-person) mobilization approaches, which reach girls as they go about their daily lives through peers, influencers, trusted community members and trained youth-friendly mobilizers. This has helped A360 overcome several common barriers to adolescent access to contraception – including cost, access and awareness. However, in-person mobilization is time and resource intensive, vulnerable to seasonal constraints and high staff turnover, and often reliant on mobilizers working in difficult conditions for low or no pay. There are also ongoing questions about how far government health systems will be able to absorb and manage A360's intensive mobilization approaches and outreach delivery models.

A360 has made progress on deepening its community engagement and support to follow-up, but has more work to do.

A360 was not designed or resourced to substantially address social norms. Instead, it has used various light-touch approaches to engage communities and enlist their support – or tacit acceptance – for girls to access contraception in the face of powerful sociocultural barriers. A360 has attempted to enlist the support of communities and key influencers through parents' sessions and couples' counseling; working with community leaders, local government officials and trusted community structures; and messaging that taps into existing concerns around pregnancy, school dropouts, abortion, maternal health and economic security. Community engagement efforts have evolved since the evaluation mid-term review, and (with some exceptions) have enabled A360 to operate without widespread community resistance. Efforts to engage key influencers have helped build support for girls to access contraception – although it has been challenging to engage influencers consistently or in large numbers. There is some risk that A360 is improving access to contraception without adequately addressing the underlying norms and beliefs that persistently hinder girls' access to contraception and undermine continuation.

Overall, there is considerable scope for the next phase of the program to build on and deepen community engagement. The AYSRH literature suggests that community-level interventions should be intensive and sustained rather than piecemeal, in order to have long term impacts on knowledge, attitudes, practices and behaviors (Robin *et al.*, 2004; Durlak and DuPre, 2008; Villarruel *et al.*, 2010; Gottschalk and Ortayli, 2014; Chandra-Mouli, Lane and Wong, 2015).

Since the evaluation mid-term review, A360 has intensified its efforts to ensure girls have access to follow-up support. New processes have been introduced – including a call center and USSD service in Tanzania, a formal follow-up procedure in Nigeria, and enlisting the support of mobilizers in all contexts to engage with girls after they adopt a method. However, many of these processes rely on girls having access to a phone which excludes many younger, rural and low-income adopters. While there is some evidence that some girls feel more comfortable seeking services after a positive experience through A360, and that the aspirational elements of the program can help build longer-term relationships, there are still important shortcomings. These are most acute in Tanzania, where A360 is not always able to visit the same communities on a regular basis, leaving girls who are unable or unwilling to visit a clinic without access to services.

5. A360 has influenced thinking and practice within implementer and donor organizations, and there are several examples of replication across Ethiopia, Nigeria and Tanzania.

Promoting the adoption and replication of the A360 approach and solutions was a core program objective, but outcomes were never clearly defined or systematically measured, and balancing them against demands of implementation has been a consistent challenge. A360 has shared knowledge widely, and influenced thinking and practice within implementer and donor organizations. Across the A360 countries, the program has also successfully engaged with stakeholders and thought leaders through national and state forums and working groups, leveraged external funding to help deepen or scale up solutions, and developed partnerships with other BMGF and ClIFF-funded initiatives. Since the evaluation mid-term review several external organizations have incorporated aspects of A360 into their own programming, including HCD processes, youth engagement, and activities that tap into aspirations. However, most examples are relatively small-scale, and some have not been possible for either A360 or the evaluation to verify, in part due to the competitive nature of the sector. Although there is significant curiosity about and interest in A360 within the global AYSRH community, there are few examples of adoption or replication beyond the three A360 countries.

One of A360's biggest success stories is in Ethiopia, where A360 is being integrated into the national Health Extension Program and rolled out to reach a million girls over the next five years through the RISE investment. Across the board, sustainability has been influenced by the degree of A360 integration into health systems and existing community structures; the extent of government commitment to AYSRH, and continual engagement of government stakeholders including through sharing performance data and success stories. A key challenge for A360 as it moves into its next phase is reconciling its nuanced, highly iterated solutions with health system constraints and capacity gaps. Finding a balance between ensuring 'core components' of the solution remain intact and delivered to a high standard, while at the same time reducing complexity to facilitate government ownership, will be a central focus of the follow-on program.

Finally – was A360 worth it?

The findings of the outcome evaluation and cost effectiveness analysis are needed in order to make an overall judgement on program effectiveness. However, the process evaluation highlights that A360 helped showcase the value that HCD, meaningful youth engagement, incorporating insights from different disciplines and working adaptively can bring to AYSRH interventions. While the components within each of the solutions are by and large not new, A360 has succeeded in conceptualizing and combining them in effective and sometimes innovative ways, delivering interventions that substantially improve contraceptive access for adolescent girls.

5. Recommendations

The following recommendations are based upon the findings in this report. They are organized into two sections:

- Recommendations for A360 to take into account in the next phase of implementation.
- Recommendations related to specific components of A360 – the HCD approach and empowerment activities - for funders and implementers to take into account when designing and delivering programs that include these components.

In its follow-on phase, A360 should:

- **Manage, monitor and regularly feedback learning from the integration of A360 into public health systems. This will help to manage tensions and trade-offs between quality implementation, reach and government ownership.** Doing this requires adequate resources to build strong government relations and ownership. It also requires a shift in focus from implementation to technical assistance, with new skills required of the A360 team. A360 will need to have realistic expectations of potential loss of fidelity to some components of the solutions when they are integrated into the public health system. In line with the adaptive implementation approach of A360, the components where it is acceptable or inevitable that fidelity will not be maintained should be identified up-front, preferably in coordination with government counterparts, so there is alignment on what the interventions will look like. Components which are considered essential to ensure quality – i.e. comprehensive counseling on method mix, regular follow-up to support continuation, community engagement to build and sustain acceptance - will need to be prioritized by A360 for focused support, capacity building and phased handover. To monitor performance and learn from government integration, the process will need to be closely documented, and data on service provision, as well as what is working/not working and why will need to be regularly collected, analyzed and discussed in joint forums between A360 and with government counterparts.

As part of the integration into public health systems, it will also be important for A360 to **acknowledge the implications of increasing reliance on overworked and underpaid health worker cadres and volunteers.** This requires working closely with the supervisors of health workers and volunteers, as well as the health workers and volunteers themselves, to ensure expectations around roles and responsibilities are manageable and acceptable. It also requires ensuring that the A360 model which is handed over to the public health system can adapt to the potential limitation of availability and capacity of health workers. Given that the majority of these health workers are women, it will be important to build in a gender lens from the outset of the follow-on program.

- **Develop clear goals and indicators around adoption and replication to guide communication and engagement activities.** Lack of clarity around the extent to which core components could be adapted while still maintaining fidelity to the A360 model (e.g. youth engagement, roles and responsibilities, adoption and replication, adaptive implementation), and shifting expectations over time (e.g. around social norms and government integration) created frustrations and inefficiencies. While space to adapt and evolve is crucial, this needs to be accompanied by clear parameters and expectations to ensure time and resources aren't wasted and to avoid too much pressure on staff. For example, the aims of adoption and replication, the target audiences and what success looks like all need to be clearly defined.
- **Systematically plan, monitor and learn from processes to engage young people in design and implementation phases.** Both young people and the adults who worked with young people during A360 reported that this added value both to the program and personally. For young people, it was an opportunity to learn and develop new skills. For adults, it positively shifted their mindsets around the

value of young people being engaged in a program for young people. MYE is seen to be an important component of A360. In order to get the most out of this, we recommend clearly defining the expected outcomes of MYE, putting in place a plan upfront for how those outcomes will be achieved and developing indicators to track progress against this plan. The plan needs to include internal processes for recruitment, induction, and professional development and support which are appropriate for working with young people. It also needs to consider where young people can most add value to A360 given the skills they have and the requirements of the program. For example, the skills and experience that a young person brings to the design phase may not be appropriate during implementation.

Future programs should:

- **Structure HCD programs to harness the benefits of multiple disciplines without the cost and complexity of large consortia.** A360's use of HCD, in combination with other disciplines, has been an important factor in its success, but introducing a new and complex approach brought challenges and tensions. The Process Evaluation team recommends a core consortium composed of the partners expected to have the greatest influence and engagement on design and implementation. For example, a consortium led by the implementing organization (PSI) in close partnership with the design partner (IDEO.org) during the design phase with the other disciplines could be represented on an advisory and accountability group which would both provide advice and hold PSI accountable to excellence in elements of the program which relate to the group's areas of expertise. This group would be guided by a clear terms of reference, agreed at the outset, which sets out when and how they are expected to contribute at different stages of design and implementation. After the design phase, when implementation takes center stage, IDEO.org could shift to the advisory group.
- **Harness the value of empowerment components, while being alert to the risks of light touch approaches that attract more than empower.** The process evaluation has demonstrated multiple advantages of life skills, vocational sessions and aspirational messaging to AYSRH programs. However, this component needs to be a core focus of future programming rather than an add-on, and have sufficient resources attached to it, to have an impact on girls' empowerment. This requires either in bringing expertise of economic empowerment initiatives with adolescent girls into the consortium, partnering with organizations who specialize in this or a combination of both. It will also be important to define success upfront and periodically track progress and review learning.
- **When applying HCD or design processes, build in sustainability considerations from the outset,** by adequately resourcing time to build strong relationships with government at multiple levels and building them into joint activities and data collection; considering trade-offs between reaching high numbers of adopters and integrating into health systems; engaging actively in national and sub-national forums to influence thinking, policy and practice on AYSRH.

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