A360

Pursuing Adaptive, Youth-Powered Adolescent Sexual and Reproductive Health Programming:

The Case of *Kuwa Mjanja* in Tanzania

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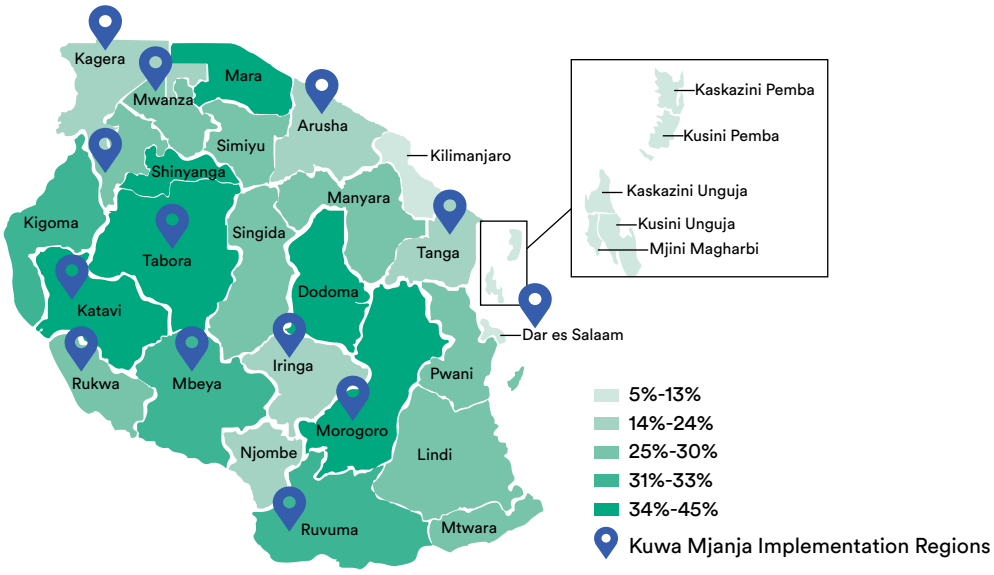
Introduction

Global health programs aiming to improve adolescent sexual and reproductive health (ASRH) have generated important learning over the past three decades.[1] Still, questions remain about how to best design, implement, and scale sustainable programming that demonstrably responds to the priorities, needs, and experiences of adolescents and youth. Adolescents' experiences, expectations, needs, and priorities are far from homogeneous. Individual factors such as age (young versus older adolescents), marital status, gender, and the external environment all need to be explicitly and carefully considered in adolescent-focused policy and programming. As the ASRH field continues to advance its understanding of how to implement impactful programs, it is important to partner with adolescents directly to shape programming that aims to improve their health and wellbeing.

In 2016, Population Services International (PSI), with funding from the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF), launched Adolescents 360 (A360). A360 was a four-and-a-half-year project that worked directly with young people to design and deliver interventions that increase demand for, and voluntary uptake of, modern contraception among girls aged 15-19 in Ethiopia, Nigeria, and Tanzania. This technical brief presents the case of Kuwa Mjanja, 'Be Smart' in Swahili. Designed through a multi-disciplinary human-centered design (HCD) process, Kuwa Mjanja was implemented by PSI across 13 regions in Tanzania throughout the course of the initial A360 investment. Kuwa Mjanja reaches primarily unmarried adolescent girls through a powerful and resonant brand, with a relatable story and imagery, and combines aspirational programming with varied options for sexual and reproductive health (SRH) service delivery. Kuwa Mjanja strives to transform the service delivery experience for girls into one that is highly social and focused on life planning, skills acquisition, and supportive relationships–between girls and their peers, as well as girls and health service providers. Kuwa Mjanja offers lessons for similar ASRH programs seeking meaningful partnership with adolescents to design and implement community-based programs that align contraceptive use with girls' aspirations, and ultimately contribute to the achievement of broader development objectives.

Figure 1: Tanzania teenage childbearing rates and Kuwa Mjanja implementation by region



Source: Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS), 2015-16

Background

Adolescence Globally

The WHO defines adolescence as the stage of life between the ages of 10-19. There are approximately 1.2 billion adolescents in the world today, making up 16% of the global population.[2] Adolescence is a period marked by rapid physical as well as emotional development. Critical to this period is the formation of a new identity that bridges the gap between childhood and adulthood. Adolescents shape and refine their identities through exploration, experimentation, increased responsibility, independence-seeking, and pursuit of new experiences.[3] Some of these new experiences and experimentation expose adolescents to risk. Social and emotional decision-making and health-related behaviors during this period have direct bearing on present, as well as future, health and developmental outcomes.[4]

Adolescents face a range of social, systemic, economic, and political barriers that prevent them from accessing critical information, services, and support, including access to accurate and age-appropriate SRH information and services.[5] These challenges can have considerable impact on their health and wellbeing.[6–9] Among girls 15 to 19 globally, pregnancy and childbirth complications are the leading cause of death.[10] Additionally, children born to adolescent mothers are at higher risk for low birth weight, neonatal complications, and other long-term adverse effects than children born to women aged 20 to 24.[11] Even when a girl safely gives birth, adolescent mothers and their children can experience long-term social and economic consequences. For instance, girls who become pregnant before the age of 18 are more likely to experience intimate partner violence, and unmarried pregnant adolescents may endure social isolation, stigma, and family rejection.[12,13] Adolescent pregnancy and childbearing often result in discontinuation of schooling, jeopardizing girls' educational attainment and diminishing their future employment prospects and earning potential.[11,13,14]

There are opportunities to reach adolescents with messages and services tailored to their needs across the developmental trajectory. In addition to other influential actors and institutions, a responsive health sector can be a powerful source of information for adolescents, provided they can discuss concerns with respectful and knowledgeable providers, through health facilities or in other settings, and that the information received is correct and actionable. The public health community is increasingly pursuing more holistic, multi-sectoral approaches to ASRH that are complementary and expand beyond health. This is in line with global evidence that points to the importance of strategies that extend beyond a single sector.[15,16] There is recognition that skills acquisition, positive beliefs, motivation, and confidence can normalize healthy behavior and help young people

apply their acquired knowledge and skills to protect themselves from adverse outcomes, including unintended pregnancy. A positive youth development (PYD) approach includes meaningful, structured activities with peers and adults, targeted efforts to encourage belief in the future, and creation of opportunities for individuals to build new skills and exercise self-efficacy.[17,18] These PYD components are all relevant to favorable health outcomes. Adolescents who have positive educational, economic, and interpersonal aspirations are more likely to use modern contraception and avoid the consequences of early and unintended pregnancy.[19,20]

Adolescence and SRH in Tanzania

Forty-seven percent of the population of Tanzania is under the age of 15, making it one of the youngest populations in Africa.[21] At 17, median age of sexual debut for Tanzanian women precedes median age of first marriage by roughly two years (Table 1). Reported first sex and first marriage among rural women occurs even earlier than their urban counterparts. The proportion of Tanzanian girls aged 15 to 19 who have given birth or are pregnant with their first child has increased from roughly 23% in 2010 to 27% by 2016.[21] There are stark differences in teenage childbearing based on residence (urban/rural), wealth quintile, and level of education.

Table 1: SRH landscape in Tanzania

Data in Tanzania reveals a two-year gap between median age at first sexual intercourse and first marriage. There is a high total fertility rate (TFR), particularly in rural areas, and high unmet need for contraception, especially among sexually active unmarried girls.

SRH and fertility, women aged 25-49	
Median age at first sexual intercourse: urban, rural	17.8, 16.9
Median age at first marriage: urban, rural	20.4, 18.7
Total fertility rate (number of births per woman): urban, rural	3.8, 6.0
Median birth interval (months), women 15-49: urban, rural	42.9, 33.2
Median birth interval (months): girls 15-19, women 30-39	24.1, 38.6
Adolescent health and development, girls aged 15-19	
% who have reported ever having sexual intercourse	52.2%
% who are pregnant or who have had a live birth: urban, rural	19%, 32%
Adolescent fertility rate (births per 1,000 girls 15-19)	132
Current use of any modern method of contraception: sexually active unmarried girls, all girls	33.1%, 8.6%
Unmet need for contraception: currently married girls, sexually active unmarried girls	23%, 42.4%
Health outcomes, girls and women aged 15-49[i]	
% who have experienced either physical or sexual violence	44%
Pregnancy-related mortality rate [per 100,000 live births]	556
Neonatal mortality rate, per 1,000 live births: women aged 20-29, girls <20	25, 36

All data extracted from Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS), 2015-16

[i]The World Health Organization (WHO) recommends an interval of 24 months between the date of a live birth and subsequent pregnancy (or roughly 33 months between consecutive live births) in order to reduce the risk of adverse maternal, perinatal and infant health outcomes (WHO, Report of a WHO Technical Consultation on Birth Spacing Geneva, Switzerland, 13–15 June 2005). In the decade preceding the 2015-16 DHS, the percentage of children born after an interval of less than 24 months in Tanzania increased from 16% to 19% (Tanzania Demographic and Health Survey and Malaria Indicator Survey [TDHS-MIS], 2015-16).

A high number of unmarried sexually active Tanzanian adolescent girls (42.4%) report an unmet need for contraception.[21] Stigma around unmarried sexual activity often leaves girls with few trusted sources of accurate SRH information and lack of access to SRH services.[21,22] As limited formal SRH education exists for adolescents in Tanzania, they tend to learn about sex, sexuality, and fertility from a variety of cultural sources. Some adolescents, girls as well as boys, participate in initiation rituals, signaling the transition from childhood to adulthood.[23,24] These traditions shape how adolescents learn about and experience important moments in their lifecycle,[25] including the onset of sexual maturity. Some rituals directly and positively address sex and sexuality, others prioritize abstinence, reinforcing expectations for girls to remain chaste and "good".[24,26]

An array of social and structural inequalities also influence girls' sexual decision-making.[27] Limited economic opportunities can lead Tanzanian girls to exchange sex for jobs, money, or basic necessities for themselves and for their families, in some cases sanctioned or acknowledged by their parents.[26,27] Violent or coercive sexual experiences are not uncommon, with 11% of adolescent girls 15 to 19 reporting they have experienced sexual violence.[21] Gender inequality pervades Tanzanian girls' social and sexual interactions and severely limits their power to negotiate whether, when, and with whom they have sex.[28–30]

Though legal and regulatory frameworks in Tanzania affirm adolescents' rights to reproductive health services, including contraception,[ii] national discourse around adolescent contraceptive use and pregnancy is highly stigmatized. Lack of clarity around national ASRH policies creates an unfavorable environment whereby many providers are unwilling or disempowered to serve adolescents.[22] Provider bias, parental consent requirements, age restrictions, and lack of capacity in youth-friendly service (YFS) provision all pose barriers to contraceptive access and uptake for young people.[31] Adolescent girls may also face other systemic barriers to contraceptive access such as long distances to facilities, financial constraints (e.g., cost of transit and of contraceptives), stock outs of contraceptive products, plus stigma and discomfort due to long wait times or lack of privacy at health facilities.[31,32]

Within this socio-cultural and political landscape, many adolescent girls in Tanzania face pressure to enter into sexual relationships despite societal expectations to avoid sex (and certainly pregnancy) before marriage. This social and financial pressure coexists with an inability to access critical protective SRH knowledge and services.

A360 Design

A360 used a multi-disciplinary approach, bringing together a consortium of experts from a variety of disciplines and working alongside youth to design solutions that challenge the status quo and are meaningfully rooted in girls' experiences and perspectives. Figure 2 outlines the A360 process and timeline. A360's design process (inquiry, insight synthesis, and prototyping) adhered to two key principles: meaningful youth engagement and transparency in communicating results of the process. In Tanzania, design took into consideration the high maternal (and neonatal) mortality rates – trends that are linked to early, frequent, and closely-spaced pregnancy, high unmet need for contraception (especially amongst sexually active unmarried girls), and lack of youth-friendly SRH information and services. The project recruited eight young people to work as co-researchers and program designers alongside disciplinary experts, ensuring that youth perspectives were an integral part of research, synthesis, and program design. The project sought to understand girls' goals for the future, and to identify the structural and enabling environment facilitators and barriers that support or prevent girls from achieving these goals. These factors helped A360 to understand how to position contraception as relevant to girls' aspirations, and achievement of their life goals. A360's interventions were informed by, and co-created with, youth and adolescent girls, with young people actively leading and providing insight at every stage, from situation analysis through implementation, evaluation, and scale up.

[ii]The Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC, or MoH) National Adolescent Health and Development Strategy 2018–2022 and the National Health Policy 2017 in Tanzania support adolescent access to SRH services. It is not clear these policies and other legislative frameworks are being consistently implemented in Tanzania (Bylund, 2020).

Figure 2: A360 Process and Timeline

Methods

Formative research in Tanzania began prior to A360's inception through a partnership with human-centered designer and philanthropist, Pam Scott. This initial investment was intended to improve PSI's existing youth programming to have greater resonance and effectiveness for adolescent girls. In 2015 and 2016, PSI Tanzania staff, alongside adolescents, conducted formative research to understand adolescent girls' experiences, and developed concepts to reach unmarried adolescent girls with contraceptive services. In the process, PSI Tanzania also built its team's capacity to lead HCD processes and apply design thinking. The team conducted 100 semi-structured interviews with unmarried youth and providers in PSI's pre-existing private Familia network facilities in Bagamoyo, Morogoro, Dar es Salaam and Mbeya (with consent from both youth and parents). Though the scope of this investment was to improve PSI's existing programming, the insights and concepts unearthed during this initial inquiry period provided a foundation for the design process for A360 in Tanzania, which began in late 2016.

In November and December 2016, A360 sought to build on the insights and concepts developed in 2015, focusing on knowledge, attitudes, and access to contraception amongst married girls. The team interviewed 42 married adolescent girls, husbands, and in-laws in one district of Dar es Salaam (Illala) and two districts of Mbeya Region, Kyela (a rural area) and Mbeya Urban, over 26 sessions. The team relied on prototypes and other materials originally developed for unmarried girls to generate insights about the lives of married girls and the barriers they face to using contraception.

Findings: Insight Synthesis

Through the interviews carried out during the inquiry phase, A360 generated themes that reflected the complex layering of girls' experiences, aspirations, risk perception, and decision-making. A360 conducted data analysis through collaborative theming workshops in which youth-adult teams worked to build consensus on the meaning and significance of findings. A360 facilitators encouraged balanced contributions to synthesize insights in a way that reflected both the disciplinary expertise of the project's consortium as well as the perspectives of young designers. Insights from Tanzania represent essential learning that informed all work going forward and ultimately coalesced around the overarching themes outlined below. Since Institutional Review Board (IRB) approval was not sought for the inquiry phase, material used from that phase is summarized though remains illustrative of the prevailing themes. Direct quotes from processes that took place outside of the inquiry phase are included.

Anxiety & Uncertainty About How to Secure a Stable Future

Families of unmarried girls expected them to contribute financially at a young age, despite a lack of skills, education, and resources. Married women also felt it was important to establish an income source independent of their husbands as a safety net in case of divorce, illness, or failure by their husband to provide for the family. These expectations around income generation often spurred entrepreneurialism, with girls and young women pursuing their own small businesses. Girls perceived having their own money as a way to assert some control, allowing them to make their own decisions. Yet, they faced the reality of limited opportunity, resources, and unsafe working environments, which restricted their entrepreneurial options. According to girls and their influencers, this uncertainty and limited financial opportunity led to increased pressure to engage in transactional and/or coercive sex as a way to achieve economic security and address their material needs.

> The contradictions and barriers girls are facing are huge; start to become financially independent, don't have sex, overcome the very limited alternatives for generating income, and just deal with being a teen by staying on the 'right' track. It's a very complicated landscape to navigate.
> **–Insight from unmarried girl, Tanzania**

> Wives cannot control and do not trust how their husbands spend money, so they look for ways to earn their own income to meet personal needs and ensure the family's financial security. Starting a business is the most acceptable and realistic option, but limited skills and competing household and childcare responsibilities makes this a challenging prospect.
> **–Insight from unmarried girl, Tanzania**

Misalignment Between Sexual Behavior, Contraceptive Use and Identity

Respondents across all groups voiced negative perceptions of girls engaging in sex before marriage, while also acknowledging the reality and prevalence of adolescent sexual activity, including transactional sex among unmarried adolescents in their communities. The expectation that "good" girls refrain from sex until marriage was reflected in parents' denial of their daughters' sexual activity, and in the refusal of some providers to discuss contraceptive options outside of abstinence with unmarried girls. However, girls and providers differed in their interpretations of what sexual activity was, with providers associating sexual activity with behavior, and girls considering "sexually active" as an identity. Girls avoided self-identifying as sexually active at almost any cost due to associated stigma, and a desire to align with social expectations of being a "good" girl. Since being sexually active was a pre-condition for contraception, and they were not "sexually active," many girls considered contraception to be irrelevant for them.

> Birth control is accepted if you are married. If you use it and you are unmarried, you are looked at as selling yourself, or that you have many boyfriends.
> **–Insight from unmarried girl, Tanzania**

> "Many [girls] think that the provider will consider them in a negative way as they go to seek for services. They may think that she is involved in promiscuous behaviours and that's why she is afraid of getting a pregnancy currently. So, most of them are afraid of that…I still have some worries because I have never [visited a provider]."
> **–Girl interviewed for A360 Tanzania process evaluation, Itad 2020**

Motherhood as the Achievable Dream

Similar to other A360 implementation countries, motherhood in Tanzania was a vital part of girls' visions for the future, though they differed on when and under what circumstances they wanted to become mothers. Though girls had other ambitions, such as completing school, motherhood was venerated and universally upheld as the central ambition. Motherhood carried great meaning and the promise of joy, social status, and security. Girls acknowledged that some of their other goals may, in fact, never be realized. Motherhood, by contrast, was attainable, treasured, and reliable.

Though a too-early or mis-timed pregnancy was also a source of shame, this was ultimately a more acceptable, and temporary hardship as it was still a path to motherhood.
–Insight from unmarried girl, Tanzania

"I don't like to advise them on injections. I do discourage them to use it. Mostly, I advise them to use an implant…the injection method is very powerful compared to an implant…it might make it that she won't conceive easily, and when she gets married, she will not get pregnant early."
–Service Provider interviewed for A360 Tanzania process evaluation, Itad 2020

"You find that the girl tells her parent about the method. Then, the parent says, 'that method is not good. You can end up getting problems like being unable to have a child.' So, the majority of them are discouraged."
–Girl interviewed for A360 Tanzania process evaluation, Itad 2020

Contraception as Threat to Girls' Dreams of Motherhood – as well as to Reputation

Respondents across groups shared stories that exposed the social consequences of unplanned pregnancy among adolescents, whether resulting in community ostracization, expulsion from school or their family, or increased financial hardship. Girls and their influencers shared concerns that contraceptive use could encourage promiscuity, and young unmarried women encountered significant stigma in accessing contraception or carrying condoms. Worse was the fear that contraceptive use, particularly hormonal contraception, could result in infertility. The prevalence of myths and misconceptions related to infertility were in part linked to poor quality contraceptive counseling that did not provide sufficient information on side effects. Girls and their influencers therefore viewed contraceptive use as only safe for women after having children. Given the perceived link, some even saw illicit abortion as a safer alternative to contraceptive use. Despite the tremendous negative consequences of unintended or mistimed pregnancy to girls' social and financial stability, they still viewed these risks as more acceptable than any path that they believed would limit their ability to become a mother in the future.

Isolation and Mistrust, Including a Complex Relationship with Mothers

Girls could name few people with whom they could discuss sexuality or contraception openly and honestly. Many girls reported feeling alone in coping with the host of social and physical changes that accompany adolescence, and were left navigating social norms, financial pressure, relationships (including sexual relationships), and family expectations largely on their own. These girls faced a challenging set of obstacles to arrive at a secure future, with limited opportunities and resources to draw on for support. Some girls wanted their mothers to be a trusted source of information. At the same time, they were reluctant to be fully transparent with their mothers regarding their decision-making around sex. Many girls, particularly younger girls, desired their mothers' approval and advice, and their explicit (or implicit) permission to engage with SRH information and services. Yet, a burgeoning independence from their families and parental reluctance to discuss sex often led to avoidance and secrecy regarding new social and sexual relationships and behaviors.

When I have a problem, the only support I get is from my mother.
–Insight from unmarried girl, Tanzania

"In the community, the adult people, especially our mothers, can call such a girl some names when they find out that she is using these methods. You can hear someone saying that, 'Do you see that girl? She is very promiscuous. She is using the methods while she is young."
–Girl interviewed for A360 Tanzania process evaluation, Itad 2020

Technical Strategy

This body of insights generated by A360 was used alongside expertise from the project's consortium of multidisciplinary experts and the global evidence base to craft a technical strategy that would be responsive to the life experiences of Tanzanian adolescents. This strategy informed the design of early-stage prototypes that were tested and refined through collaborative analysis and decision-making with youth-adult design teams. Throughout this process, A360 evaluated prototypes on desirability, feasibility, and scalability, building out components of the final intervention design with higher fidelity. See Table 2 for discussion of how A360's insights informed the Kuwa Mjanja technical strategy in response.

Table 2: Summary of Kuwa Mjanja insight synthesis and technical strategy

Insight synthesis	Technical strategy in response
Anxiety & uncertainty about how to secure a stable future	
• From a young age (often at menarche), Tanzanian girls are expected to contribute to their family's income. • Entrepreneurialism is one pathway to income generation and stability but can be challenging to realize given absence of skills and resources. • Research shows that linking clinical services with non-clinical activities, like skill building and goal setting, can have synergistic effects.[20]	• Kuwa Mjanja begins by inquiring about girls' aspirations, thereby demonstrating respect and reinforcing adolescent girls' power to set their own life goals and make a plan for achieving them. • Kuwa Mjanja responds to girls' self-expressed needs by supporting them with entrepreneurship and vocational skills that can build the foundation for financial independence.
Misalignment between sexual behavior, contraceptive use and identity	
• Initiatives that help young people develop a healthy self-identity can lower the likelihood that they will engage in health-compromising behaviors.[33] • Adolescent girls in Tanzania considered "sexually active" as an identity rather than associated with behavior. • Influenced by their desire to conform to societal expectations of abstinence before marriage, and strong stigma around unmarried sex, girls vehemently rejected this identity. • When contraception was positioned as being for girls who are sexually active, or as family planning, girls who did not identify this way, or who were not planning a family, saw contraception as irrelevant for them.	• Kuwa Mjanja's outreach and counselling messages lead with girls' self-defined aspirations. • Once girls are inspired to articulate their aspirations and goals, Kuwa Mjanja positions contraception as one tool (among many) that all girls can use to achieve their dreams. • In this way, girls engage with messages and programmatic content that connects with their positive self-image and life plan, rather than their sexual activity status.
Motherhood as the achievable dream	
• Evidence from adolescent developmental science demonstrates adolescents' acute need to know that their perspectives and contributions are respected.[34] • Though education, jobs, and entrepreneurship were all cited as desirable life goals, girls rarely saw these goals as achievable. • Motherhood, by contrast, was highly valued and attainable.	• Kuwa Mjanja begins by affirming that girls' dreams are valid, and that a wider array of aspirations is possible—without compromising their dream of motherhood. • The program inspires girls to dream of achieving their other goals for the future so that they can have equal (or greater) rewards in life, and still pursue motherhood when the time is right for them.

Insight Synthesis	Technical strategy in response
Contraception as a threat	
Contraception as a threat to motherhood	
• With few sources of accurate information, girls rely heavily on the experiences and opinions of their parents, partner, and/or peers (who are often themselves misinformed). • Girls and community members (including providers) hold deeply entrenched views of contraception, including beliefs that contraceptive use can cause infertility. • Becoming a mother represents a central and significant aspiration for girls. As a threat to the dream of motherhood, modern contraceptive use was thus unacceptable to many.	• Kuwa Mjanja ensures that providers share comprehensive and accurate information, so girls learn that modern contraceptive methods are safe, reversible, and pose no threat to fertility. • The program supplements this quality counseling with other sources of information on contraceptive method use, including personal, relatable testimonials from peers through a digital app, Mjanja Connect.
Contraception as a reputational threat	
• Girls view contraceptive use as a danger to their social standing or reputation, as it is a sign of sexual activity. • Even when girls desire to use contraception, seeking out SRH services requires facing entrenched stigma and other social and structural barriers.	• Kuwa Mjanja's branding and messaging introduce SRH as an integral part of girls' health, wellbeing, and ability to pursue a stable future. • The inclusion of entrepreneurship and vocational skills development and other health information in its programming is often well-received by parents and influential stakeholders in girls' lives. • This model also allows girls to access embedded SRH services with support from their influencers. • Private contraceptive counseling opt-out[iii] moments during events reduce the decision-making burden of meeting with a provider. This normalizes contraceptive counseling and increases the cover and privacy of that interaction.
Isolation & mistrust	
• In Tanzania, many girls report that they do not have trusted individuals in their lives to discuss SRH topics, and as a result feel alone as they navigate the challenges and changes they experience during adolescence. • Social learning can reinforce positive behavior. • Research suggests that bonding with peers and positive role models is crucial for healthy adolescent development.[35]	• Kuwa Mjanja promotes pro-social experiences where girls learn about SRH, but also develop vocational skills through social interactions, and can ask questions from peers and experts without judgment. • The experience can also create a foundation for a longer-term health-seeking relationship with a trusted provider, so the girls have a consistent source of accurate information.
Complex relationship with mothers	
• Mothers are considered key sources of information and support, but at the same time, can be figures from whom to hide information. • Many girls interviewed—particularly younger girls—desire approval or affirmation from their mothers, while simultaneously turning to avoidance and secrecy in these relationships out of fear of judgement or as they become more independent.	• To support the desire of some girls for parental approval, parent sessions were designed to promote parent-child dialogue and permission-giving. • In-clinic meetings similarly encouraged sharing information about Kuwa Mjanja with girls' parents. • As other girls prioritize confidentiality and independence from their mothers and caretakers, community-based events and interpersonal communication directly with girls ensures channels that honor the expressed need of these girls, too.

[iii]'Opt out' is an evidence-informed approach where every girl has an opportunity to meet with a provider, unless she opts out. This serves as a means of standardizing the encounter with the provider, and increases confidentiality as everyone meets with the provider, whether or not one decides to adopt a method.

Resonant branding is one key component of the Kuwa Mjanja strategy. Drawing from social marketing, A360 leverages the power of youthful branding to capture adolescents' attention, and to normalize and de-stigmatize the health service-seeking process. Kuwa Mjanja leverages storytelling and symbolism as ways to connect with Tanzanian girls. The brand uses a pineapple motif (in Kiswahili, a nanasi), a familiar fruit transformed into an inspirational symbol representative of girls who 'Stand Tall, Wear a Crown and are Beautiful on the Inside.'[iv] Initiation of contraceptive messaging takes place via discussion of girls' dreams, and inspirational archetypal stories of nanasi girls who have pride in themselves, wear their crown (showing that they know their worth), are strong, and aware of their power, their potential, and their inner strength.

Intervention Description: The User Journey

The Kuwa Mjanja intervention centers on altering the service delivery experience. It aims to help local health system actors to transform adolescent contraceptive service delivery from a clinical provider-client exchange only to a social experience focused on life planning, skills acquisition, and supportive relationships—between peers, as well as between girls and health service providers. The final intervention in Tanzania, Kuwa Mjanja, coalesced around two distinct models, an in-clinic model, and an outreach-based out-of-clinic model in the community (Figure 3). Together, these two service delivery channels work to ensure that girls have a variety of options to engage with the intervention at locations, venues, and times most convenient for them.

Figure 3: Description of Kuwa Mjanja out-of-clinic and in-clinic events

During in-clinic events, Kuwa Mjanja outreach teams convene on the grounds of designated public health facilities and work in partnership with providers and local government to engage in interactive dialogue sessions, offer girls Kuwa Mjanja's aspirational program messaging, and youth-friendly service delivery. In-clinic events support girls to build confidence and bodily autonomy, making linkages to contraception as a tool to help them achieve their future goals.

During community-based out-of-clinic events, Kuwa Mjanja outreach teams work with government youth development officers and with local health officials to implement Kuwa Mjanja's dynamic package of services through mobile outreach, in a tent or a community facility, apart from the health center. After an initial aspirational group talk, trainers orient girls to a vocational skill (such as making soap or reusable menstrual pads). During this session, trainers reinforce girls' pride in developing and pursuing life goals. Kuwa Mjanja Queens, girls from within the community with an active social network who are identified by A360 in collaboration with local government actors, play a key role in mobilization in their respective wards, and serve as co-implementers during the out-of-clinic events. Though events were originally planned only on weekdays during regular service delivery hours, the A360 team recognized the importance of weekend events when client volume in public sector facilities is typically lower and providers have more time to offer tailored service delivery in line with the Kuwa Mjanja brand. Weekends likewise present fewer scheduling conflicts for girls related to school or family responsibilities. Therefore, the A360 team decided to hold out-of-clinic events on Saturdays, in addition to regularly scheduled weekday events.

[iv] In 2019, A360 did a comprehensive review of its messaging to incorporate more gender-transformative approaches. In the process, A360 staff and adolescent girls flagged the initial phrasing, "Be Beautiful" as objectifying and potentially reinforcing harmful gender norms. As a result, A360 shifted the phrasing from "Be Beautiful" to "Be a Role Model."

Regardless of channel, both models adhere to the same overarching user journey. Kuwa Mjanja is designed to offer an experience that cultivates a girl's curiosity, taps into her life goals and aspirations, creates a safe and fun environment to ask questions, helps girls feel respected and safe when accessing services, and positions contraception as a relevant tool to help her achieve her goals (Figure 4).

Figure 4: Kuwa Mjanja User Journey

Step 1
Mobilization
"I'm Intrigued"

A girl learns about Kuwa Mjanja through public announcement (PA) within the community, A360 mobilizers with digital counseling tools, or through a peer, such as a Kuwa Mjanja Queen. She hears messaging covering puberty, menarche, and discussion of life goals. She may hear about Kuwa Mjanja from her teacher, who informs the class about events and offers her the opportunity to participate if she is interested. She is often curious about the vocational skills offered at Kuwa Mjanja events in particular and decides to attend an out-of-clinic or in-clinic event.

Step 2
Aspirational Engagement
"I'm inspired and motivated"

The Kuwa Mjanja event starts with an introduction to the 'nanasi' story, demonstrating how girls can 'stand tall, wear their crown, and be a role model.' These sessions lead with girls' goals, allow space to discuss body changes in adolescence, and reaffirm the relevance of contraception as a tool in pursuit of life goals. If she attends an out-of-clinic event, she then receives an orientation to a skill from a local entrepreneur (such as making soap or reusable menstrual pads) and is provided an opportunity to practice that skill.

Step 3
Contraceptive counseling & service delivery
"I feel respected and safe"

She is approached individually at some point during the course of the Kuwa Mjanja event and can receive a private counseling session with a provider. This 'opt-out' moment normalizes girls' care seeking behavior and reduces stigma by eliminating the distinction between girls who seek contraceptive services and those who do not. If desired, she receives her contraceptive method of choice, for free, on the spot.

Step 4
Follow up
"I feel supported"

She receives a card containing phone numbers of the closest service provider or other clinical staff who can answer her questions or refer her for further services. She is able to talk to a Kuwa Mjanja Queen if she has any questions, who can connect her with a provider if she has further needs. She can access a convenient and free unstructured supplementary service data (USSD) portal as an immediate source of information to respond to specific needs or concerns. She feels supported in her ability to make choices for herself and continues to see the relevance of contraceptive use to achieving her life goals.

Looking beyond girls

To improve the enabling environment for girls' SRH and decision-making, A360 engages a number of key actors to build support for participation in Kuwa Mjanja events.

Mobilization through schools

Mobilization through schools was not part of the original project design. Yet, between design and implementation, the national landscape shifted, and in 2017, secondary school became free and compulsory, thus becoming a further mobilization point for girls to attend nearby out-of-clinic events. A360 first gains permission to engage with in-school adolescents through a letter to the school, with the support of the regional education officer. Staff visit the school to orient teachers and administrators and request support in recruitment. While not all teachers and school leaders are supportive, and there can be sensitivities around the SRH content, teachers play an active role in building SRH knowledge and access to services, before and after engagement with Kuwa Mjanja.

Involving the community, parents and other key influencers

Working with local leaders, including the village chairperson and church leaders, has been helpful to ensure community buy in. Staff engage these stakeholders by visiting communities in advance to prepare events. Parent sessions target the caretakers of adolescent girls (notably mothers) prior to events starting in the community. These sessions provide an opportunity for staff and providers to talk to parents about the challenges their daughters face, educate them on SRH topics and orient them to Kuwa Mjanja in the hope of building support for their daughters to attend. The promise of skills training is an important driver of community acceptability, and of securing parental support.

Collaboration with national, regional and local government

Strong government partnership at various levels assists Kuwa Mjanja to identify priority regions and districts for implementation and supports mobilization and event logistics. A360 continuously works alongside key government partners, such as Youth Development Officers (YDOs), District Medical Officers (DMOs), and District Reproductive Child Health Coordinators (DRCHCos) in program implementation.

Strengthening public health facilities

Strengthening public sector service provision is critical for program scale and sustainability. In early implementation, PSI Tanzania conducted a comprehensive provider training on YFS plus a separate provider training on long-acting reversible contraception (LARC). Afterwards, the project worked alongside the MOH to support on-the-job training (OJT) of public sector providers in provision of LARC to ensure contraceptive choice and provided LARC insertion equipment to facilities with certified providers. PSI staff conducted further provider OJT on LARC and YFS during events, and supports DRCHCos to conduct ongoing joint supportive supervision. Data collection systems were strengthened through quarterly data quality checks and reporting.

The User Journey

Mobilization: "I'm intrigued"

While the design team initially planned to tailor outreach to Tanzanian adolescents based on their marital status, A360's multi-disciplinary design process provided a more nuanced understanding of girls' experiences and needs. From this, A360 recognized an opportunity to refine its segmentation. Rather than distinguishing girls primarily by marital status or based on sexual activity, A360's behavioral segmentation analysis yielded two priority archetypes of Tanzanian adolescent girls based upon where they were within their respective life trajectories.[v] A360 initially prioritized developing messaging and programming according to the social and developmental trajectories of its priority archetypes, Farida and Bahati, helping them to feel connected to trusted and relevant information and services (Table 3).

Table 3: Initial segmented messaging strategy for two priority archetypes

	Farida	Bahati
Segment description	Typically younger (15-17 year old) 'Farida' wants to better understand her changing body, her role in her family and community and her reproductive health. Her immediate concerns revolve around navigating the social, emotional and physical changes that she is experiencing in adolescence. Farida is likely to be sexually active, but remains socially dependent on her family, particularly her mother, for knowledge and support, including around her engagement with SRH information.	Somewhat older, more independent, physically and sexually mature 'Bahati' tends to be influenced by mothers, teachers, and a boyfriend or husband. She has a greater sense of her life goals and priorities and is interested in accessing support to achieve these goals – finding ways to make money, manage growing responsibility, and navigate the transition into adulthood.
Tailored mobilization messaging	For Farida, the Kuwa Mjanja mobilizers open dialogue with girls through "Know Your Body" messaging, with discussion of menarche and puberty as an entry point to discuss contraception. From there, mobilizers share the Kuwa Mjanja story, based on the symbol of the nanasi. Mobilizers then invite girls to pose any questions they may have, and transition to providing information about upcoming events.	For Bahati, mobilizers introduce the intervention through "Know Your Path" messaging. In these discussions, mobilizers share the same nanasi story, but focus primarily on initiating conversations based on girls' life goals. They invite girls to share their own desires for the future before providing information about upcoming events.

Mobilizers are themselves often girls and young women. Kuwa Mjanja Queens receive an initial orientation as well as ongoing support from A360 outreach teams to play a key role in mobilizing girls in their ward, while receiving their own skills development in the process. Notably, Kuwa Mjanja Queens are not peer educators, leaving the counseling and information to the health provider on site at out-of-clinic events. An additional cadre of 'Super Queens,' girls with extensive experience with the program and interest in entering into a leadership role, was added in Katavi, Rukwa, and Ruvuma regions in 2020. Super Queens receive a week of training to function as trainers of Kuwa Mjanja Queens. In the absence of a Super Queen, a Reproductive Health Services Outreach Supervisor or team leader is charged with orienting Kuwa Mjanja Queens.

In early implementation (2018-2019) around half of girls heard about out-of-clinic events through public announcement (PA), where A360 teams travelled via a branded car with loudspeakers sharing information with the community about upcoming Kuwa Mjanja events using fun, welcoming messages. The remaining girls were mobilized through Kuwa Mjanja Queens and local government. For in-clinic events, nearly two-thirds of girls were mobilized through PA and the rest through local government as Kuwa Mjanja Queens only support out-of-clinic events. The mobilization approach shifted in 2020 in response to the COVID-19 pandemic. The use of PA was halted to minimize the size of Kuwa Mjanja events, and A360 relied mainly on individual mobilization, supported through existing government cadres such as Community Health Workers (CHWs), often paired with a Kuwa Mjanja Queen.

[v]Originally, there were four archetypal figures: Farida; Furaha; Pendo; and Bahati. A360 selected Farida and Bahati as its priority segments, and then ensured that the project effectively targeted these segments. Furaha and Pendo are similar archetypes to Farida and Bahati respectively, but have not yet experienced their sexual debut.

The entrepreneurship and vocational skills content of Kuwa Mjanja often sparks girls' curiosity to attend Kuwa Mjanja and is helpful in building support from their key influencers. The 'Kuwa Mjanja' slogan itself also sometimes acts as a 'hook,' with some girls noting that they came to the events because they wanted to receive information that would make them "smarter" or would help them achieve their goals. Other girls were simply interested in the opportunity to receive training or information more generally from knowledgeable people.

"The word that motivated me the most is the word that says 'Kuwa Mjanja.' That's what made me go and listen to the seminar because, I am supposed to become clever in some things."
–Girl interviewed for A360 Tanzania process evaluation, Itad 2020

Aspirational Engagement: "I feel inspired and motivated"

Kuwa Mjanja branding, symbolized by the pineapple, is intended to signify fun and youthfulness. Girls redefined "Kuwa Mjanja," which traditionally was used as a euphemism for being 'clean' (in reference to menstrual hygiene), staying away from boys, and avoiding pregnancy to 'Be Smart.' Messages delivered via Kuwa Mjanja encourage girls to take pride in knowing their goals and making a plan to achieve them. The program's atmosphere, branding, and messages aim to create a culture that is judgment free, encourages girls to ask questions freely, and promotes dialogue. Facilitators kick off events with a call-and-response refrain, based on the nanasi story. These animated talks focus on key elements of Kuwa Mjanja's girl-centered brand messaging, sharing differing inspirational stories of girls who are standing tall, wearing their crown (exuding pride and inner beauty), and acting as role models. These sessions lead with girls' goals, allow space to discuss body changes related to adolescence, and reaffirm the relevance of contraception as a tool to achieve their life goals.

"I took some good advice from the event, that the girl should stand by her own opinion so that she may be able to reach her dreams. There should be nobody to discourage her who would say that 'you are unable to do this.' No, she is to stand by her opinion and she will make it."
–Girl interviewed for A360 Tanzania process evaluation, Itad 2020

Clinical Counseling & Service Delivery: "I feel safe and respected"

A360 orients all providers on Kuwa Mjanja's approach and YFS provision prior to each event, including leading with discussions of girls' aspirations. Using these strategies, a provider can guide a girl to identify the contraceptive option that might be most suitable for her based on her circumstances, and the method characteristics that she identifies as important while respecting full, free, and informed choice. For instance, the service provider may discuss desired timing for next pregnancy, the need to keep contraceptive use secret, and tolerance for changes in menstrual bleeding. Mjanja Connect, a pre-counseling tool, incorporates many of the same principles (Figure 5).

Kuwa Mjanja facilitators use the registration list to discreetly approach girls individually throughout the course of the event and provide them an opt-out moment to receive counseling from a YFS provider. This normalizes girls' care seeking behavior, rendering the reason(s) for the visit more private and less stigmatized. Contraceptive implants, the intrauterine device (IUD), injectables, pills, and condoms are all offered for free, and on-site, regardless of whether it is an in-clinic or out-of-clinic event. The out-of-clinic model in particular is effective at increasing reach by bringing services directly to communities and gathering (particularly younger) girls together into a safe space where they can meet their peers, share their challenges, and avoid the stigma of going directly to a health facility. This model also serves to raise overall community awareness.

"To be honest the provider was very careful with me and she was listening attentively to me, and she answered me very well, such that I received a larger understanding of things."
–Girl interviewed for A360 Tanzania process evaluation, Itad 2020

Figure 5: Mjanja Connect

Recognizing an opportunity in 2017 to create additional engaging, adolescent-friendly tools through which to mobilize girls and convey Kuwa Mjanja messages, A360 partnered with Vodafone Foundation to develop a mobile-enabled tool called "Mjanja Connect." Mjanja Connect introduces girls to Kuwa Mjanja through a series of self-selected videos, games and fun quizzes, including one called "What kind of nanasi are you?" The tool uses girls' responses to one such quiz to determine which priority archetype a user matches (Farida or Bahati) and then presents messaging and other information depending on how the girl self-identifies. A method-focused quiz supplies information about contraception, with methods presented according to a girl's stated priorities, needs, and experiences, followed by a description of all other methods. For instance, if a girl indicates that she has trouble maintaining a daily routine, the tool first presents those methods that are less user dependent, such as the injectable, implant, or IUD. The app then introduces all methods in conjunction with male condoms for protection against HIV/STI infection. The tool concludes with a video about the importance of emergency contraception (EC).

Ongoing Follow Up: "I feel supported"

In 2019, A360 shifted its outreach model to ensure that the program re-visits each district every three months, to support contraceptive continuation. Each Kuwa Mjanja event is linked with a nearby health facility to provide continuity of services for girls in between times when A360 is present. Girls are provided with a "next visit" card to remind them when it is time for a resupply of their chosen method, as well as phone number of the closest service provider or other clinical staff who can answer questions or refer them for further services. The intent of the next visit card is to nurture a habit of seeking care, in addition to providing girls with a point of contact. Although not initially part of their role, Kuwa Mjanja Queens have supported follow up with girls in their districts after events. As trusted peers, Queens maintain ongoing relationships with girls in their catchment areas. A360 supports the Kuwa Mjanja Queens to understand how to identify needs and link girls with services after or between events.

> **"When she takes a method and it causes some challenge or discomfort to her, she will just come and see you and ask you about it. When she asks me, my responsibility is to call any provider and I will connect the provider with the girl and the provider will speak to her and tell her the kind of medicines to go and buy, so the girl will continue with her method as usual."**
>
> **–Kuwa Mjanja Queen interviewed for A360 Tanzania process evaluation, Itad 2020**

A360 also connects with girls after service delivery through a call center and the USSD portal. The project's call center reaches out to a sample of girls who have consented to be contacted three and six months after adopting a contraceptive method through Kuwa Mjanja. Girls are asked a series of questions regarding their experiences, can discuss any challenges with their contraceptive method, and have their queries answered by a PSI Quality Assurance Coordinator. Call center staff foster an open dialogue, answering questions and supporting girls to access further in-person care. If needed, users can be connected to an external call center staffed by trained medical professionals through a partner NGO to speak directly to a provider about their concerns. Through a free USSD portal, accessible on any mobile phone, adolescents can access customized SRH information via text that responds to their specific needs. This includes responses to commonly asked questions about contraceptive use, contraceptive side effects, and menstruation. A360's call center and USSD portal both supply real-time user experience data and insight for project staff into girls' experiences with contraceptive use to support the program's continuous quality improvement efforts.

Implementation Experience

Kuwa Mjanja formally launched in Tanzania in January 2018. Throughout the course of implementation, A360 operated in 13 regions across Tanzania, though regional prioritization varied throughout the life of the project. A360 transitioned from ten priority regions at the start of implementation to fewer regions (including some new ones) in early 2019 when the MOH recommended that the project refocus its implementation strategy on fewer target geographies that had teenage pregnancy rates above the national average and no or few existing ASRH programs in the region. As highlighted in Figure 3, the final intervention in Tanzania coalesced around two distinct models: an in-clinic model, and an outreach-based out-of-clinic model. Kuwa Mjanja service delivery is conducted in partnership with regional and local MOH representatives, who assign health providers to staff Kuwa Mjanja events, determine monthly rotation schedules, identify event locations, and secure local government permissions (Figure 6).

Figure 6: Kuwa Mjanja service delivery and event implementation team

A360 Outreach Team	A360 Youth Officer	Kuwa Mjanja Queen (support out-of-clinic model only)	Government Youth Development Officer (YDO)	Government Health Provider(s)	District Reproductive Child Health Coordinator (DRCHCo)
• Consists of one Reproductive Health Services Outreach Supervisor and one field assistant/ driver. • Responsible for facilitating Kuwa Mjanja events, working closely with local government officials.	• Based in each implementing region. • Spearhead A360's adaptive implementation approaches. • Support gathering of client experience feedback to inform continuous program improvement.	• Play a key role in mobilization at the ward/village level. • Super Queens oversee a council and support local recruitment and orientation of Kuwa Mjanja Queens.	• Coordinate youth development programs and implementation. • Engaged as facilitators of Kuwa Mjanja events in collaboration with DRCHCos. • Succession strategy to replace the role of PSI as event organizers and facilitators.	• Two government health providers tasked by local government to staff each Kuwa Mjanja event. • Supply contraceptive counseling and services.	• Develop outreach routes and select facilities in partnership with PSI. • Supervise all FP/RCH interventions. • Enforce quality checks and supportive supervision for public health facilities.

Whenever possible, providers at Kuwa Mjanja events are girl-selected, but in all cases are oriented by A360 to YFS provision. A vocational trainer identified by the local government teaches skills like soap making or tie-dye at events. Teams work on a rotating schedule, implementing in one district per month and conducting a total of 16 community-based out-of-clinic events and in-clinic events per district. Following completion of the 16 events, teams move to a new district the following month.[vi] Aligning with global best practice, A360 continued to refine and evolve its approach throughout program implementation, maintaining a balance between fidelity to its evidence-based user journey and responsiveness to an ever-shifting service delivery context. The following reflection details some of the primary outcomes of this process of continuous program quality improvement.

From 'Speed and Scale' to Holistic Programming

In the initial stages of implementation, A360 prioritized speed, scale, and cost-effectiveness. The project intensified focus on program components that directly contributed to higher contraceptive adoption–increasing program efficiencies and driving down cost. For example, when Kuwa Mjanja's out-of-clinic and in-clinic model revealed clear differences in cost-effectiveness, with the out-of-clinic model reaching higher numbers at a lower cost per adopter, A360 shifted its approach to prioritize the out-of-clinic model. Frequency of parent sessions was also reduced; despite creating buy-in from girls' key influencers, these sessions did not directly correlate with contraceptive uptake.

While scale and cost-effectiveness remain important goals, and these elements produced high performance at low cost, the approach also led to elimination of some intervention components that are critical contributors to long-term impact, such as investing in fostering a more supportive enabling environment or building the capacity of the health system to support adolescent contraceptive continuation. A360's mid-term evaluation revealed, for one, the potentially perverse incentives of focusing so heavily on cost-efficiency. Recognizing the trade-off the

[vi] For large districts, two teams will occasionally operate simultaneously in the one district, effectively implementing 32 events in that district during the month.

program had made, A360 began to broaden its approach again in 2019 by considering contraceptive uptake alongside investment in fostering a more supportive enabling environment for adolescents to access, adopt, and continue to use contraception. A360 explored what changes were needed, and what program components could be re-introduced or newly adapted to move beyond speed and scale to deliver quality programming. For example, an adapted version of the parent sessions was reinstated in 2019 where parents were invited to an information session about the project and what their daughters would be learning. Parents (notably mothers) are still considered the backbone when it comes to consent and community support for adolescent SRH. As such, this approach to parental engagement is continuing to be refined moving forward.

Adapting to Better Support Continuation

Kuwa Mjanja took a two-pronged approach to bolster continuation, improving counseling to emphasize key messages at point-of-contact during Kuwa Mjanja events, as well as focusing on post-event follow up. A video was also developed to help introduce Kuwa Mjanja and reinforce youth-friendly principles as part of provider orientation prior to events. Kuwa Mjanja aimed to improve continuation by focusing on knowledge retention at point-of-contact and leveraging research that associates the quality of family planning counseling with contraceptive method continuation over time.[36] Mjanja Connect consolidates knowledge and information to better prepare girls for their visit with the provider, using testimonial videos that discuss contraceptive method attributes, side effects, and what to expect during method use. Building on findings from evaluation of the Method Information Index (MII)[vii] in social franchises (or networks of private health care providers), and studies that show that girls' and women's comprehension of side effects correlates to improved contraceptive continuation,[36,37] A360 focused its adaptations on improving knowledge and retention of information related to side effects. The project incorporated games led by Kuwa Mjanja Queens into events to build girls' identification and management of contraceptive side effects.

To support follow up after events, A360 adapted its implementation strategy to promote continued opportunities for engagement with Kuwa Mjanja, to ensure consistency of support networks for girls in between events, and to provide ongoing resources to support continuation. Implementation schedules were adapted so the team would return to districts every three months. The local service provider who participated in the event would remain available for consultation at the local facility between events. The role of Kuwa Mjanja Queens expanded to support girls after event attendance and A360 began leveraging the call center and USSD portal to gather girls' feedback and experiences with contraception, specifically around side effects, to inform program improvement.

Adapting to COVID-19

During the COVID-19 pandemic, Kuwa Mjanja responded to changes in the operating environment in a number of ways. Out-of-clinic events were no longer feasible given restrictions on large group gatherings. Focus shifted to refine the in-clinic model to ensure a safe environment for girls in which social distancing was possible. Door-to-door visits became the primary mobilization route as opposed to PA, with no more than five to ten girls recruited at a time. During mobilization and events, girls were informed of the precautions they should take to prevent the spread of COVID-19. The program had used CHWs in some settings early on to support mobilization through house-to-house visits, though at the time this was reported as less effective, as CHWs tend to be older and less relatable to the girls. However, in the COVID-19 environment, pairing of Kuwa Mjanja Queens and CHWs (using personal protective equipment) to supply the relatability of a peer with the trusted experience of a CHW seemed to be a promising approach to mobilize girls to attend the COVID-adapted in-clinic model.

The team reduced the length of its in-clinic session in order to limit the risk of exposure and maximize the number of girls that it was possible to accommodate. This truncated session contained an inspirational talk, which integrated the 'Know Your Body' and 'Know your Path' messaging in a less segmented way, encompassing both Farida and Bahati narratives, and encouraging girls to think about their life goals. Given the difficulty and resource intensiveness of using detailed segmentation consistently, A360 ultimately permanently shifted its approach away from such targeted messaging in order to scale more effectively. The entrepreneurship and vocational skills practice session was removed in the COVID-adapted Kuwa Mjanja model given the time constraints and need to maintain social distancing. The opt-out moment, however, was retained, allowing providers the time to talk to girls about their body and other topics, as well as provide contraceptive counselling. Staff found that girls continued coming for services, even without the entrepreneurship training, but acknowledged that this new model seemed to appeal more

[vii]The Method Information Index (MII) is a widely available measure of contraceptive counseling quality. The index measures whether a client was told about other contraceptive methods, potential side effects with her chosen method, and what to do if she experiences side effects.

to girls who already knew that they wanted contraception as opposed to younger girls, who came to events primarily because of their desire to learn a skill or new information. The follow up protocol remained the same, with girls provided with a next-visit card and USSD number.

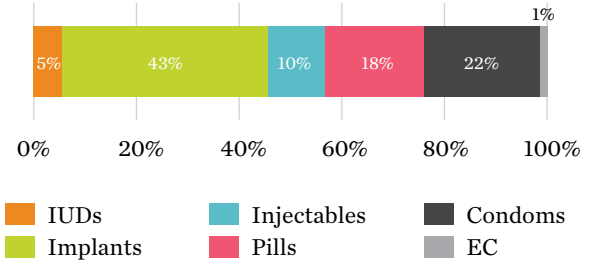
During the height of the pandemic, outreach teams spent up to a week at each facility, providing more capacity building opportunities for government providers. Staff reported this not only allowed providers to learn from the teams, but also gave girls more time to come to the facility for services. While this adapted model was implemented throughout most of 2020, the program began reintroducing out-of-clinic events in early 2021, with necessary safety precautions.

Performance

By the end of September 2020, Kuwa Mjanja had reached more than 310,000 girls, over 220,000 of whom voluntarily adopted a modern contraceptive method (Figure 7). Over the life of the project, nearly three-quarters of girls who attended Kuwa Mjanja events have taken up a contraceptive method. Compared to A360's other implementation geographies, Kuwa Mjanja has experienced the most cyclical performance, directly connected to environmental factors such as school attendance and seasonal weather patterns. Performance is always highest during the months when school is out (Q2, Q3), and girls have the ability to freely attend out-of-clinic events on weekdays. In contrast, during the quarters when girls are busiest with school and family-related tasks, their opportunities are more limited to attend events. Kuwa Mjanja also saw relatively minimal performance during the initial months of the COVID-19 pandemic (Q2 2020) when nearly all service delivery halted at the request of the Tanzanian government.

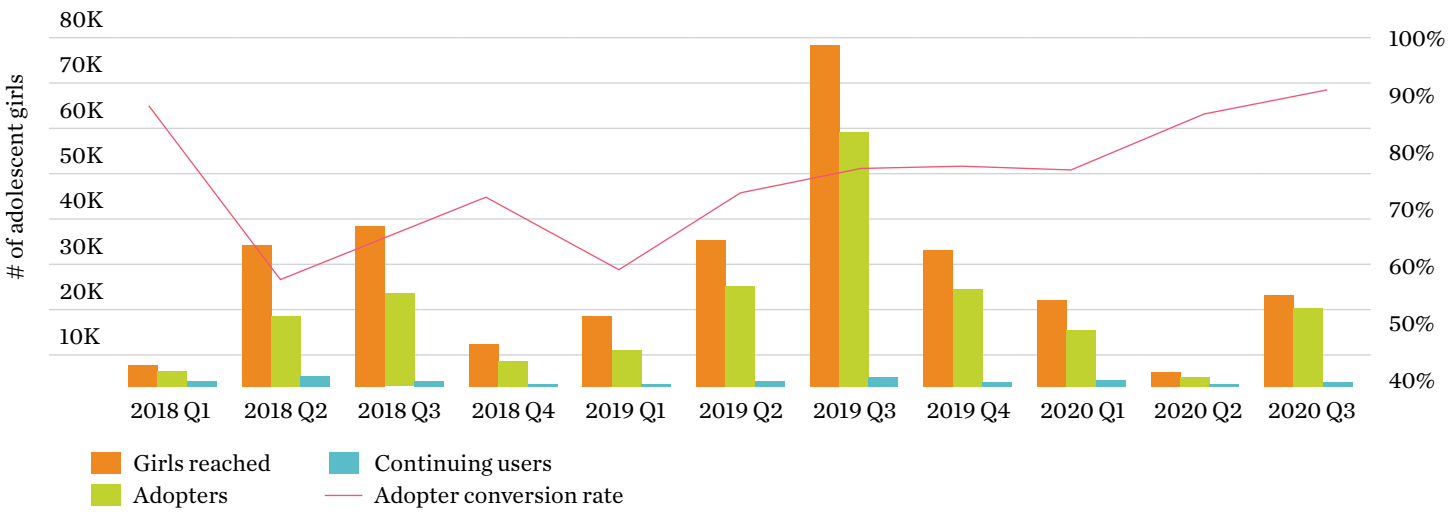
Overall, nearly half of girls adopting a method through Kuwa Mjanja have taken up LARC (Figure 8) and implants have comprised 30-55% of Kuwa Mjanja's contraceptive method mix since the beginning of implementation. This represents a significantly higher rate of LARC use than that demonstrated in the 2016 Demographic Health Survey (DHS) where 0% of unmarried 15-19 years old are currently using an IUD and 6.9% are implant users.[21] A360 has seen some variation in LARC uptake over the life of the project, primarily attributable to shifting mobilization strategies in 2019, which increased attendance from in-school girls who tend to be younger and more likely to take up a short-acting method.

Figure 8: Kuwa Mjanja method mix, January 2018–September 2020



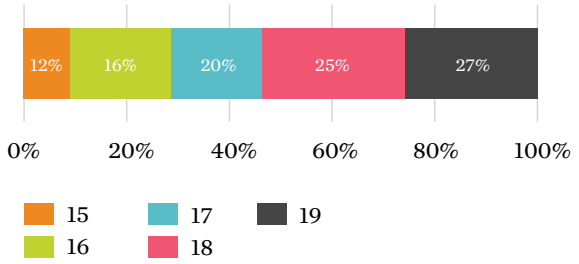
Of A360's three implementation countries, Tanzania has the most balanced age range of adopters, with nearly 50% of adopters aged 15-17 (Figure 9). Mobilization through schools instigated a greater shift towards younger adopters. However, the onset of COVID-19 pandemic in early 2020 caused the project to shift primarily to an in-clinic model, and A360 saw this trend reverse, with more 18- to 19-year-olds presenting for events, who were more likely to select long-acting methods.

Figure 7: Number of girls reached by Kuwa Mjanja, and adopters[viii]



[viii]The conversation rate reflects: Total adopters ÷ Eligible girls (with eligible girls defined as all girls reached minus those pregnant or currently using a method). In Figure 7, this would be reflected as the green bar ÷ (orange bar - blue bar).

Figure 9: Kuwa Mjanja adopter age disaggregation, January 2018–September 2020



The USSD pilot provided an opportunity for A360 to both serve girls' continuation needs and gather insight into their concerns. Since its inception in late 2019, the platform has had over 30,000 unique contacts, with one-third of those contacts from adolescent girls under 20. Among adolescent users of contraception, 55% are happy with their method, and those most likely to be unhappy with their method were implant users. This is notable, as implant is the method most frequently selected by girls adopting a method through Kuwa Mjanja. Girls frequently choose to explore questions about menstruation, indicating that this is an important topic to address in order to support continuation. Bleeding changes like irregular periods were identified as important concerns across methods.

In 2020, girls interviewed for A360's process evaluation in Tanzania reported positive experiences with Kuwa Mjanja events, though were critical of the lack of privacy in some of the out-of-clinic events that could attract participation of other members of the community, such as parents and teachers. Girls particularly enjoyed the entrepreneurship skills provided by Kuwa Mjanja and wished the events would happen more frequently. In fact, nine out of the 30 girls interviewed had attended two or more out-of-clinic events; one girl had attended four events. Girls mentioned that the facilitators were friendly and put them at ease, and felt the lessons were easy to understand. The vast majority of the girls who saw a service provider reported that they felt safe, believed the providers were knowledgeable, trusted what they heard, and indicated that they were free to speak and express themselves to the service providers during counseling.

> "You could talk about something from your heart and ask questions about reproductive health and Kuwa Mjanja, anything that troubles you."
> **–Girl interviewed for A360 Tanzania process evaluation, Itad 2020**
>
> "I felt well because we were just the two of us, the service provider and I.... I felt free to tell her everything."
> **–Girl interviewed for A360 Tanzania process evaluation, Itad 2020**

Reflections, Lessons Learned and Recommendations

As A360's initial investment in Tanzania draws to a close, there is an opportunity to reflect on project learning that can inform and strengthen future ASRH programming, as captured in the section below.

Mixed Methods Monitoring to Support an Adaptive Footing and Mitigate Risk

As with any project, expansion brings with it potential for drift from the technical strategy set during design. Excessive drift can present a risk if the project strays from essential elements. Kuwa Mjanja's adaptive implementation offers a prime example of the use of data to support rapid course-correction. The team used mixed methods monitoring to understand not only quantitative performance, but also the experiences of girls, providers, health system partners, and mobilizers during Kuwa Mjanja events, thereby helping the project team to recognize what adaptations would be beneficial. For example, to support depth and speed of coverage, the team experimented with adding district education officers and teachers into the mobilization process for Kuwa Mjanja out-of-clinic events. Attendance at these events increased significantly following this programmatic tweak. However, qualitative monitoring revealed that the shift in mobilization strategy caused unintended consequences. Some teachers imposed their own beliefs and values, such as telling girls to attend events to learn to "avoid temptation" as they disseminated information about Kuwa Mjanja events. These inserted messages conflicted with the Kuwa Mjanja messaging and brand

that emphasize respect for girls and a focus on girls' self-defined dreams rather than judgement of their decision-making. The resulting impact was confusion, adversely impacting trust in the overall experience. To address this challenge, the country team introduced rapid onboarding procedures for local actors prior to mobilization, which focused on ensuring their full knowledge of Kuwa Mjanja's girl-centered foundational principles. The A360 team also redoubled efforts to emphasize the importance of accurate, targeted, and consistent mobilization messages. A360's adaptive implementation allowed the program to experiment where needed while being able to recognize challenges in real-time and quickly course-correct.

Meaningful Youth Engagement to Capture User Perspectives and Promote Innovation

A360 adapted its approach to youth engagement during the course of the project. While critical during inquiry and design, some elements of meaningful youth engagement were lost during the push for cost-effectiveness. However, when the project began to anticipate increased attendance at events during the months when girls were on school break, A360 looked to youth for support. A360 recruited and trained a group of 10 young professionals (in their early 20s, recently graduated from university with experience in youth programming) to be seconded to field teams in each of A360's regions. These young professionals, termed the 'SWAT Team,' identified areas of improvement and tested adaptations to increase the efficiency of implementation of high-volume events. They observed event flow and made recommendations, supplied consistency at times of staff transition to maintain fidelity to the Kuwa Mjanja model and principles, and innovated to problem solve. For example, when the SWAT team identified a gap between the vocational training session and the opt-out counseling moment, where some girls were leaving prior to receiving counseling, they introduced games to keep them engaged while they waited for their visit with the provider, thereby improving retention. The Kuwa Mjanja Queens similarly played a vital role as trusted peers during mobilization, event implementation, and supporting client follow up. The SWAT Team and the Kuwa Mjanja Queens offer different, unique perspectives, and, importantly, continue to highlight the user perspective, ensuring the project remains relevant to what girls say they want and need. Meaningful and deep partnership with young people opened up tremendous opportunities for insight and innovation for A360, reinforcing the importance of meaningful youth engagement within the ASRH sector.

> **"We've proved a point that when we bring in the people we have designed for, the program becomes more effective and more desirable than when other people hold the steering wheel."**
> **–National PSI staff member interviewed for A360 Tanzania process evaluation, Itad 2020**

> **"To see young people involved gives [other young people] excitement that they can do something too. It is like a kind of empowerment, that 'you can do this and you can reach your goals.'"**
> **–Youth expert interviewed for A360 Tanzania process evaluation, Itad 2020**

Delivering on the Promise to Girls to Support Achievement of their Goals

Girls and their influencers saw the chance to learn a (marketable) skill as valuable in a context where skills are often hard for girls to acquire but critical in the ability to and secure a stable future. Kuwa Mjanja's vocational skills component was what excited and motivated some girls to attend Kuwa Mjanja events. Per the 2020 process evaluation, a number of key stakeholders (parents, community leaders, government officials) directly linked their support of the project to entrepreneurial skills training component, which served to provide cover for girls to attend Kuwa Mjanja programming without stigma, and helped PSI navigate the sensitive ASRH ideological terrain. In some ways, the narrative allowed girls to access much needed SRH services in a context where these services are highly stigmatized for youth.

> **"It's through life skills that a youth can avoid unprotected sex and other temptations because many of them get tempted because of money. But when she gets there and learns how to make baskets, soaps and so forth, and goes to do it, she will get money and she won't be tempted to go and have unprotected sex and such things."**
> **–National government stakeholder interviewed for A360 Tanzania process evaluation, Itad 2020**

The program continues to face an integral challenge: one of its core narratives is that Kuwa Mjanja offers girls the opportunity to be financially independent, which is important for obtaining community and government support. However, while there are some examples of girls earning money through applying the skills they learned, lack of capital, insufficient time to learn and practice, and a mismatch between the skill provided and the available market prevented most participants from applying the skills that they learned to generate income. What is perhaps more realistic is that girls learn to make products for their own (or their family's) personal use, such as how to make sanitary pads, thus reducing household expense. One parent interviewed for the process evaluation in 2020 explained how this training could still be valuable, even if it does not lead directly to employment by showing girls that other paths are possible. The dilemma for Kuwa Mjanja (and A360's other country programs) is how to provide such training within the scope of its mandate and budget. This is something that A360 is reflecting on in its next project phase.

> **"They should improve more education on entrepreneurship because other girls were complaining and saying 'We always come and only make pads...let us make other things that can help us, such as making soaps, batiks, sewing and others."**
> **–KM Queen interviewed for A360 Tanzania process evaluation, Itad 2020**

> **"What's good about Kuwa Mjanja is the life skills element. ...Considering also how the situation is with our leaders, when you come in straight away and say that you are just advocating about family planning directly, it may not be good. But, when you go in with the life skills, you can bring in the reproductive health education which will make it easier to get the support from our leaders from different levels."**
> **–National government stakeholder interviewed for A360 Tanzania process evaluation, Itad 2020**

Next Steps

Although A360's initial investment period in Tanzania has ended, additional funding has been secured to extend programming under a new project called A360 Amplify. With this investment, A360 will focus on three key areas: adaptation of its interventions to improve effectiveness; integration within government health structures to sustain implementation; and learning and contribution to the global evidence base to advance global ASRH. A360 Amplify will continue to strive for sustained, quality, client-centered services. It is committed to further exploring multi-sectoral opportunities to create space for empowered articulation and achievement of girls' life goals, aligned with how voluntary contraception can be an effective tool to delay first birth, avert unplanned pregnancy, and effectively achieve these goals.

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