

# EXTERNAL EVALUATION MANAGEMENT RESPONSE

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## 1. PREAMBLE

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 4.5-year project working directly with young people to design and deliver interventions that increase demand for, and voluntary uptake of, modern contraception among adolescent girls aged 15-19. Between 2016 and 2020, A360 designed and implemented four interventions across three countries: *Smart Start* in Ethiopia; *Kuwa Mjanja* in Tanzania; *Matasa Matan Arewa* (MMA) in northern Nigeria, and *9ja Girls* in southern Nigeria. These interventions are described through this [series of technical briefs](#).

When A360 launched, both modern contraceptive prevalence and unmet need for contraception among adolescents aged 15-19 across Ethiopia, Nigeria, and Tanzania remained relatively low according to each country's Demographic and Health Survey (DHS), suggesting that many married or sexually active-unmarried girls were either not knowledgeable about contraception, not seeking out contraception, and/or had desired fertility. A360's formative research across the three countries highlighted, among other things, the immense value placed on motherhood even among the adolescents themselves. That said, global evidence powerfully demonstrates the risks to maternal and child health posed by too early and too frequent childbearing.<sup>1</sup> Without negating the data, nor public health principles, A360 recognized the importance of evolving more traditional adolescent and youth sexual and reproductive health (AYSRH) programming based on an understanding of girls' dreams and life goals – inclusive of and beyond motherhood. A360 pursued an expansive approach, emphasizing meaningful engagement of young people to co-design interventions that would be relevant to them within the individual country contexts, while maintaining an emphasis on continuous project learning.

The A360 investment was divided into three distinct project phases. These included an inquiry phase to understand the experiences, contexts, and underlying motivations that inform adolescent behavior; insight synthesis and prototyping phase by multi-disciplinary youth-adult teams; and an implementation phase grounded in adaptation and continuous quality improvement. A360 created space throughout its project lifecycle for interrogation and testing of ideas, but also worked to nurture curiosity and creativity. A360's inquiry and insight synthesis and prototyping phases took place from September 2016 through December 2017, with its adaptive implementation phase beginning in early 2018.

The A360 donors commissioned an external evaluation (EE) in 2016 to independently evaluate and distill lessons from the program. The EE was spearheaded by a consortium consisting of Itad, Avenir Health, and the London School for Hygiene and Tropical Medicine (LSHTM). The EE was comprised of three evaluations in one: a Process Evaluation (PE), an Outcome Evaluation (OE) and a Cost Effectiveness Analysis (CEA).

In summary, the PE's objective was to present a descriptive and analytical account of how the implementation of A360 played out in real-world settings, with the aim of developing an in-depth understanding of how and why A360 made a difference, in order to generate lessons for future policy and practice. It employed various rounds of data collection consisting of full rounds (where data was conducted at each of the countries), global rounds (where data was conducted at the consortium level) and participatory action research case studies. Data was collected using qualitative methods and tools consisting of **85** focus group discussions, **697** in-depth and exit interviews, **16** structured observations, participatory action research, **6** sense making workshops and document reviews. Cumulatively, data for the PE was collected through five full rounds in each country, four global rounds and three participatory action case studies. Analysis was conducted using a deductive approach, guided by preformed frameworks.

For the OE, data was collected through population-based surveys in selected geographies in the implementation countries. The OE employed a before-and-after cross-sectional evaluation design using an open cohort approach with a baseline in late 2017 and early 2018 and an endline in late 2020 (except for Tanzania where the endline was conducted in mid-2021). Data was localized within purposely selected geographies (four woredas in Oromia in Ethiopia, four LGAs in Nasarawa in northern Nigeria, two LGAs in Ogun State in southern Nigeria, and one district in Mwanza region in Tanzania). In northern and southern Nigeria, three of the LGAs were implementing the A360 interventions, and the other three were comparison LGAs. There were no comparison geographies in Ethiopia and Tanzania. Participants were married adolescent girls aged 15-19 in Ethiopia and northern Nigeria and both married and unmarried adolescent girls of the same age group in Tanzania. In southern Nigeria only unmarried girls were involved. Participants were sampled from households in sub-geographies (34 streets in 15 wards in Tanzania, 1,385 enumeration areas in Nigeria and 57 kebeles in Ethiopia) which were selected using probability methods (probability proportional to size or random sampling) in each study geography. Endline data was collected in the same sub-geographies where baseline data was collected except for 235 EAs in north Nigeria where baseline data was not collected due to security reasons and to attain the endline sample size. In Tanzania, 4 streets in one ward were dropped at the endline survey. Data analysis involved specifically defined sub-sets of the participant population for the various outcome measures. For the primary outcome, analysis employed Poisson regression models using robust estimation errors at the EA level in Nigeria and linear regression models for change over time for street or kebele-level modern contraceptive prevalence rate (mCPR) in Tanzania and Ethiopia respectively. These were adjusted for confounding using variables associated with contraceptive use curated from existing literature. Logistic regression analysis was conducted to determine the association between exposure to A360 interventions and contraceptive use using the endline data only.

The CEA was a two-component study closely related to the OE. The first component consisted of an estimation of the costs for designing and implementing the A360 intervention in the OE study geographies using top-down and bottom-up approaches. Costs were generated from the A360 financial records, surveys with the program staff and from interviews with government stakeholders. The costing component also included estimating the cost of designing an intervention using the DELTA approach historically used by PSI for designing marketing strategies for interventions and then estimating the cost of implementing ASRH services to maintain the status quo. Implementation costs for the status quo were estimated referencing the Gutmacher Institute's 'Adding It Up 2019' Report<sup>1</sup>. These two combined constituted the comparator costs. The difference between the A360 and comparator costs was computed to merge with the incremental costs. Incremental effectiveness was measured in maternal disability-adjusted life-years (DALYs) averted. Incremental maternal QALYs averted were calculated by computing the difference in DALYs averted from A360's interventions and the status quo by applying DALYs averted coefficients to the additional contraceptive users who would have been produced by the interventions based on the OE primary outcome results using MSI's Reproductive Choice's Impact 2 model.

Full details of the methodologies of these evaluations can be found on the Itad website through <https://www.itad.com/project/evaluation-of-adolescents-360/> under the methodology tab. This link also provides access to the full package of the external evaluation outputs spanning from the baseline evaluation, mid-term evaluation and the endline evaluation.

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<sup>1</sup> Sully, Elizabeth, et al. "Adding it up: investing in sexual and reproductive health 2019." (2020).

## 2. KEY HIGHLIGHTS OF THE EXTERNAL EVALUATION (PE, OE, AND CEA)

In this section, we present a summary version of the findings from the three evaluation components. **From the PE**, the predominant themes emerging revolved around:

- A360's appropriate use of the HCD approach, skills and mindset for innovation to generate aspirational ASRH interventions for four A360 geographies;
- Astute application of adaptive implementation for redesign, course corrections, for program improvement and to navigate through implementation complexities;
- A strong performance exceeding the program targets agreed upon with the donors driven by use of a collaborative approach involving government stakeholders at the centre of decision-making, leveraging existing structures and delivering a multi-component ASRH program;
- Engagement of youth and adolescents as a cornerstone for program implementation and decision making during the design and implementation phases and to inspire empathy from the implementers;
- Balancing the use of multidisciplinary approaches to develop a well-rounded program and the need to reduce the engagement burden to the frontline teams; and
- The necessity of meaningful and measurable engagement of adolescents and youth especially the younger adolescents.

The key missed opportunities identified were:

- Clearly defining the roles and responsibilities of the consortia members,
- Limited engagement of community and key influencers,
- Low intensity of the vocational and life skills components that doesn't meet the stakeholder's and beneficiaries' needs, and
- Thinking of sustainability of the A360 interventions from the onset,
- Unaddressed resource needs and team capacity gaps in employing adaptive implementation in the countries,
- Inadequate resources to train a critical mass of providers and deeply entrenched biases towards contraceptives and their use by adolescents among providers,
- Leveraging intervention delivery within government health systems for sustained impact yet these systems are perennially constrained and,
- The unresolved puzzle of reaching harder-to-reach population segments including younger adolescent girls

**From the OE**, the results were mixed across the four intervention geographies.

- **For Ethiopia**, there was a statistically significant 5%-point improvement in mCPR and evidence of improvement in seven secondary outcomes. Further, positive trends were detected in eight additional secondary outcomes (although differences before-and-after were not statistically significant). **For northern Nigeria**, there was a 7% and 8%-point net increase in mCPR in the intervention LGAs (Doma and Karu) compared to the comparison LGAs (Toto and Nasarawa) - mCPR changed from 8% to 22% for Doma and from 21% to 47% in Karu compared with change from 13% to 20% for Toto and from 13% to 31% for Nasarawa. These changes in mCPR were not statistically significant after controlling

for confounding variables. There were detectable effects of MMA on two secondary outcomes and an unexpected significant effect on one outcome in the opposite direction than was anticipated.

- **For southern Nigeria**, there was a 3%-point net increase in mCPR in the intervention LGA compared to the change in the comparison LGA (from 45% at baseline to 49% at endline for Ado Odo Ota compared to change from 50 to 51% for Shagamu). These changes were not statistically significant after controlling for confounders in the final regression model. Only one secondary outcome was established to yield a statistically significant positive effect and three secondary outcomes were in the opposite direction to what was anticipated.
- **For Tanzania**, mCPR declined by 9 percentage points (from 51% at baseline to 42% at endline). Four of the eleven secondary outcomes assessed illustrated a positive trend that was statistically significant. Four additional secondary outcomes yielded significant changes in the opposite direction to what was expected while the remaining three outcomes were in the positive direction but were not significant.

The trends of the OE results for the four geographies and significance are depicted in Figure 1 (on Page 7)

**From the CEA**, the design phase costed \$8.1 million which were 7-9 times higher than the comparator approach (the DELTA approach) yielding incremental design cost ranging from \$15,164 for Tanzania, \$39,919 and \$73,262 for southern and northern Nigeria respectively, to \$107,684 for Ethiopia. Implementation costs were highest in Ethiopia and lowest in Tanzania and so were the incremental implementation costs when computed after subtracting the comparator costs (costs of sustaining services for adolescents at the same level) from the intervention implementation costs. Total incremental costs were highest for Ethiopia (\$970,667) followed by northern Nigeria, (\$484,900), southern Nigeria (\$513,220) and Tanzania (\$96,510). The observed changes in mCPR from the OE study geographies translated to 57 maternal DALYs as follows: 31 in Ethiopia, 17 in southern Nigeria, 5 in Tanzania and 4 in northern Nigeria. The incremental cost per DALY averted was highest in northern Nigeria (\$111,416 - 53 times GDP per capita), followed by Ethiopia (\$30,855- 33 times GDP per capita), southern Nigeria (\$30,114 -14 times GDP per capita, and lowest in Tanzania (\$25,579 -24 times GDP per capita). These figures are significantly higher than benchmarks for evaluating the cost-effectiveness of interventions based on the WHO's CHoosing Interventions that are Cost-Effective guidance and were not comparable with other family planning programs.

Figure 1: Summary of OE findings (primary and secondary outcomes) across A360's geographies<sup>2</sup>

The effect of A360 on primary and intermediate outcomes at a population level and among girls exposed to the interventions	 ETHIOPIA: Oromia region (Smart Start)		 NIGERIA: Nasarawa state (MMA)		 NIGERIA: Ogun state (9ja Girls)		 TANZANIA: Ilmela district (Kuwa Mjanja)	
	Was there an effect at population level? <sup>2</sup>	Was there a greater effect for girls exposed to MMA? <sup>2</sup>	Was there an effect at population level? <sup>2</sup>	Was there a greater effect for girls exposed to 9ja Girls? <sup>3</sup>	Was there an effect at population level? <sup>2</sup>	Was there a greater effect for girls exposed to Smart Start? <sup>1</sup>	Was there an effect at population level? <sup>2</sup>	Was there a greater effect for girls exposed to Kuwa Mjanja? <sup>5</sup>
<b>Adolescents use high-quality sexual and reproductive health products and services</b>								
mCPR (primary outcome)	*	**		**			*	***
Proportion of modern contraceptive users using a LARC	**				*	—	*	
Use of modern contraceptive in past 12 months		*		***				***
Age at first birth among girls who gave birth								
Births in the last 12 months <sup>7</sup>	—	**		*			—	—
Unmet need for modern contraception		*		*				*
<b>Adolescent girls have access to appropriate high quality sexual and reproductive health information and services</b>								
Awareness of contraceptive products	*		*	***			***	*
Awareness of where to obtain health services				***				**
<b>Contraception positioned as relevant and valuable for adolescent girls</b>								
Future aspirations <sup>1,7</sup>	—		—	*	—		—	—
Benefits of modern contraception (Benefit 1) <sup>2</sup>	*		**	**	*		***	
Benefits of modern contraception (Benefit 2) <sup>1,3</sup>	—		—		—		—	
Intention to use a modern method				***			**	
<b>Supportive environment for adolescent girls to access services created</b>								
Attitudes towards the use of modern contraceptives	**		*	***	*		**	
Self-efficacy to use modern contraceptives	***						***	*
Descriptive norms <sup>1,4</sup>	—		—	**	—		—	
Community acceptance <sup>5</sup>	**						—	—
<b>Trust and credibility of family planning products</b>								
Misconceptions about modern contraceptives								
Disadvantages of modern contraceptives <sup>1,7</sup>	—		—		—		—	—

\*\*\* Strong evidence of effect, p<0.001    
 \*\* Evidence of effect, p<0.01    
 \* Weak evidence of effect, p<0.05    
 \* Evidence of an effect contrary to the hypothesized    
  No evidence of effect    
 — Not applicable    
  Not possible to calculate due to sparse data

<sup>1</sup>Measured at endline only. <sup>2</sup>Assessed through the sentence "Using modern contraception can allow an adolescent woman girl to complete her education, find a better job and have a better life" with which the respondent agreed or disagreed. <sup>3</sup>Assessed through the sentence "Using modern contraception can allow a girl to achieve her life goals" with which the respondent agreed or disagreed. <sup>4</sup>In Northern and Southern Nigeria, effects were measured by assessing the difference between the change in outcomes over time in areas receiving A360 interventions compared with the change in outcomes over time in comparison areas not receiving A360 interventions. In Tanzania and Ethiopia, effects were measured by assessing the change over time, before and after A360 interventions were implemented. All analyses were adjusted to account for demographic changes in populations over time and between intervention and comparison areas. <sup>5</sup>The effect among girls exposed compares outcomes self-reporting exposure to A360 with those self-reporting no exposure to A360. <sup>6</sup>Assessed through a 'descriptive norms index' which asked three questions related to norms around contraceptive use, e.g. 'How many unmarried/married girls aged 15–19 years in your community do you believe discuss using a method of contraception boyfriend or partner/husband or partner?' <sup>7</sup>Outcome not measured at endline in Tanzania due to COVID-19 adaptations to the questionnaire.

<sup>2</sup> Sourced from the External Evaluation Summative Report

### 3. BRINGING IT TOGETHER – CONTEXTUALIZATION OF THE EVALUATION FINDINGS

In this section, we provide a contextualized analysis of the external evaluation results in consideration of the vision and goals of A360, the approach employed by A360 during implementation and the environmental issues that could have shaped the nature of results obtained. We employ seven headlines to provide a nuanced description of our understanding of the external evaluation findings examining the three components of the external evaluations as a unitary piece. We also draw insights from A360-led evaluation and experiential learning activities during the external evaluation investment period. Each of these headlines are detailed below.

#### a. A360's insight-driven sub-group targeting, its impact on the OE efficacy, and the need to balance scale and equity

**Summary:** A360's HCD-informed approach led to targeting of sub-populations of adolescent girls, more often girls who were older (18-19) and for married populations those who had at least one child. Project monitoring data and OE data on exposure show this targeting was successful. However, the OE protocol was designed to assess overall population level effects among adolescent girls aged 15-19 and evaluation sampling was in many cases misaligned with the demographics of sub-populations directly targeted and reached by the programs. Although we think this was introduced by the evaluators designing an evaluation before the intervention design was completed and the implementation strategies were finalized, we believe this may have impacted the OE's ability to discern A360's impact. At the same time, A360 acknowledges the need to do more to reach harder-to-reach populations of adolescent girls, including intensifying focus on supporting an improved enabling environment for girls' contraceptive use, and is considering programmatic adaptations in its follow-on program. Yet, there is an inherent tension between this priority and the need to pursue sustainability through government integration.

Both A360's program monitoring data sources (qualitative and quantitative) and the external evaluation have affirmed that HCD and meaningful youth engagement (MYE) were valuable components of A360's programming that led to highly rigorous, innovative, relevant, and effective interventions. **Though the broad population targeted by the A360 project was adolescent girls aged 15-19 years, in some cases the application of HCD and MYE resulted in specific sub-group targeting within the program geographies.** For example, across Ethiopia and northern and southern Nigeria, **A360 more often reached older adolescents (18-19).** Throughout the project's implementation phase (2018-2020), 68-73%, 74-92%, 77-85% of new adopters annually in Ethiopia, southern Nigeria, and northern Nigeria respectively were aged 18-19 years, based on program monitoring data.

**A360's interventions targeting married adolescent girls (particularly MMA in northern Nigeria) were also more likely to reach those girls with at least one child** as they utilized messaging which focused on the relevance of child spacing to improve the health and wellbeing for a mother and her children. The interventions' emphasis on "child spacing" over "family planning" in Ethiopia and Nigeria reflects the program's responsiveness to a strong sociocultural pressure for married women to have their first child before using contraception. Data from client exit interviews (CEIs) conducted in 2020 indicated that in Ethiopia 65% of Smart Start clients had given birth to at least one child and for MMA 91% of girls had a child. These specific sub-groups often reflect where there is existing, unfulfilled demand for contraception, and by extension those sub-groups who experience less stigma and less resistance from their environment to take up contraception.



In some cases, the OE data showed some evidence of the effectiveness of this sub-group targeting. For example, the MMA OE sub-groups who were targeted were more likely to report exposure to the program. Girls who self-reported exposure were more likely to be 18- or 19-years old and more likely to have at least 1 living child. In select program geographies, self-reported exposure to the program was also associated with improved outcomes across A360's theory of change. This hypothesis could be empirically tested through additional secondary analyses of the OE data, which would evaluate program effects within targeted sub-groups (e.g., within 18-19-year-olds; within girls with at least 1 living child).

**Yet, the OE study design was intended to uniformly detect population-level effect across A360's entire target population (adolescent girls aged 15-19 years).** In some geographies the age distribution in the OE sample was more reflective of A360's sub-group targeting – for example in Ethiopia, 68% and 73% of the sample was aged 18-19 in the baseline and endline respectively. In other instances, the sample size reflected an even distribution of adolescent girls across this age range, even skewing slightly towards younger-aged girls. In southern Nigeria 27% and 30% of girls sampled were 15 years old at baseline and endline respectively and in Tanzania 24% and 23% of the sample was 15 years old at baseline and endline respectively. In the case of Tanzania given the program had to exit the OE sites 6-9 months prior to the endline these younger aged girls who were sampled may not have even been eligible to receive the program intervention. For parity similarly the OE sample size was more evenly distributed among nulliparous girls and those with one or more children – in northern Nigeria and Ethiopia 43-44% and 50% of the sample were nulliparous respectively. **This misalignment between the sub-groups targeted by A360's interventions, those eventually reached by the interventions, and the demographics shown in the OE sample is understandable given the primary objective of the OE and the fact that the evaluation protocol was finalized prior to the conclusion of A360's design process and before real-world implementation of the interventions.** Although this was not intentional from the evaluators, this misalignment still may have contributed to inconclusive evidence of A360's effect, particularly when it comes to the impact of those girls A360 reached “aging out” of the OE sample population.

**A360 acknowledges that this sub-group targeting, though effective and a natural result of the HCD process, led to a lack of reach among adolescent girls who may experience the greatest barriers to contraceptive uptake.** A key component of reaching these harder-to-reach sub-groups, as identified in the HCD process, is engaging girls' key influencers to create an enabling environment for their contraceptive use. In northern Nigeria and Ethiopia, A360 identified husbands as key decision-makers and designed solutions specifically to engage husbands using maternal and child health and financial security as entry points. This component proved useful by creating community ownership of the interventions over the course of implementation. Within A360's programmatic data, these key influencer engagement components can be linked to programmatic outcomes. For instance, 47% of MMA participants were referred to intervention sites by husbands, and girls were 1.4 times more likely to adopt contraception if referred to the program by their husbands (vs. a mobilizer). In Ethiopia, monitoring data from Smart Start shows a 20%-point increase in the proportion of girls who adopt a modern contraception method when girls are counselled with their husbands, compared to when that happens with the girls alone. Yet, results from the OE data on support from key influencers elicited mixed and inconclusive results, and A360 acknowledges that these intervention components did not reach the scale needed to see population-level shifts. Implementing these components at reduced scale with low intensity was a trade-off that the project needed to make in order to maintain focus on its core objectives. The conclusions drawn in the PE acknowledge that social-cultural norm shifts are difficult to attain, and A360 wasn't necessarily set up to make the substantial investments necessary to facilitate these shifts within the life of the project.

**A360 has consistently wrestled with trade-offs between scale and equity during implementation, one which we expect will continue to be a tension as we progress in our follow-on phase.** There is a clear demand for contraception among older, married girls who already have one child (we believe this is an important need and one we should continue to meet). But there is also a need to understand how we can reach harder-to-reach populations (e.g., younger girls, nulliparous, etc.). There is an inherent tension between reaching these populations and the project's goal to create sustained government ownership of these interventions through institutionalization. One requires often greater, more resource intensive engagement and the other streamlined implementation to fit within existing government resources and constraints. As a result, we know that these sub-populations won't constitute the majority of program reach. Yet, we also know that by reaching these girls we enhance our ability to see sustained impact (by increasing age at first birth, increasing educational attainment through school completion, etc.) The project has taken steps to finding a balance – understanding who we are currently reaching through CEIs, defining what we mean when we say 'harder-to-reach' populations, undertaking HCD processes to refine and strengthen our enabling environment components – and we anticipate we will continue to iterate and adapt as we balance this tension.

## b. Alignment of A360's adaptive implementation strategy with evaluation approaches

**Summary:** There is an inherent difficulty in utilizing traditional evaluation approaches to assess the impact of a project which uses HCD and adaptive implementation. This is something the sector more broadly must contend with as HCD becomes more of a standard practice. The timing of the finalization of A360's OE protocol, before the finalization of the project's interventions themselves, combined with inadequate fine tuning of the evaluation approach to comprehensively accommodate shifts that have occurred at various points in the project's implementation strategy, may have contributed to an inability to see results in the evaluation.

A360's implementation strategy was not static over the course of the project's implementation phase. **Continuing the foundation established through the project's design process, A360's adapted and iterated on its interventions and its strategy throughout its implementation phase (2018-2020) in response to program learning, changing contexts, and insights from the PE.** In the project's early implementation phase, also termed the project's 'optimization' phase, A360 focused on adapting its interventions and implementation strategy for higher performance at the lowest cost. Key examples of adaptation included a) shifting to a time-bound implementation model in Ethiopia where the project had active presence in each intervention site for a 6-week intensive period and then transitioned to the public health structures to continue implementation and b) shifting to an implementation strategy in Nigeria centered around health facility catchment areas. More detail on these shifts is provided later in this section.

**Designing an intervention for a project grounded in HCD and adaptive implementation is inherently challenging** – as HCD grows and becomes part of evidence-based practice this challenge is being illuminated not just in A360's experience but in that of other projects as well. The design of the evaluation methodologies for A360's OE were finalized prior to the final design of A360's interventions and prior to these implementation strategy shifts. A360's protracted design process contributed to this delay, and we acknowledge that this required the evaluators to choose between making progress and waiting for these shifts to happen. The delay prohibited the evaluation team from having the final intervention components at the time of designing the evaluation methodologies. **This forced presumptive decisions about the evaluation design, some of which ended up misaligned with the final project implementation approach.** This misalignment can be illuminated through a few pointed examples:

1. **Site Sampling:** The evaluation protocol does seem to have assumed that A360 would be implementing the interventions uniformly and expansively to fully cover all communities within the OE geographies and chose to implement a community-based sampling approach. This is implied by the fact that the evaluation used random sampling approach to select study units in the study geographies. However, A360 was only implementing in specific pockets of communities these geographies. For example, in Nigeria where the evaluation was conducted in LGAs, MMA and 9Ja Girls were only implemented in specific communities that served as catchment areas for the intervention facilities. Since enumeration areas (EAs) were randomly selected from the entire LGA without specifically selecting from a list of the EAs closest to the specific communities where A360 implemented, this might have resulted in reduced impact. Under ideal conditions, random selection should have been conducted only among EAs in the communities where A360 was implemented, to optimally position the evaluation where results were likely to be found. Sampling of individuals residing far from implementation sites would have contributed to the low observed exposure and limited impact. This challenge could have been averted by delaying the design of the study until after the implementation strategy for the interventions was solidified.
2. **Intervention Exposure:** Over the course of its implementation phase, A360 utilized adaptive implementation to refine and strengthen its interventions. Yet, the frontline implementers at the country-level who had a good understanding of how the interventions are delivered on the ground and how messaging for the interventions was framed during demand creation were not provided adequate opportunity and time to validate the exposure metrics used for the evaluation (except for Tanzania). A360 admits to failing to adequately facilitate this process. That notwithstanding, it appears that the metrics may not have been subjected to rigorous pre-testing to determine their sensitivity and specificity before they were fielded. A360 observed some misalignment between these exposure metrics and the aspects of the program which were most readily identified by girls. For example, use of a page from the Smart Start counseling aide which the project knew was less well recognized than others, or use of the MMA logo when it closely resembled and could be mistaken for another logo for youth services used by the government in northern Nigeria. Preliminary analysis post-survey uncovered gaps in pre-testing since there was substantial unexplained exposure in comparison geographies. As a remedial measure, the exposure metrics for Nigeria and Ethiopia had to be reviewed and revised retroactively aligning metrics and how the interventions were implemented in the field. These revisions were conducted through a consultative process involving A360 (global and country teams), the evaluators and the donors. Despite these revisions, the inherent faults of the metrics could not be addressed since data had already been collected and the weaknesses of these metrics persisted hence contributing to the underestimated exposure to the project's interventions.

### A360 Implementation Strategy Shifts by Country:

In **Ethiopia** after a community kick-off meeting in Kebeles was conducted, the project maintained implementation presence for a six-week period followed by an event to transition implementation over to government. After this point only low-dose support for continuation was provided to transitioned kebeles. This approach assumed that kebeles reach some degree of saturation and continued presence in the saturated kebeles was not efficient. There were delays in starting implementation in the OE woredas and below 50% of the kebeles had started implementation before end of 2018, leaving them with a much shorter implementation period, Activities were scaled down in Q1 2020, to prepare for set up of the Roadmap for Integrating Smart Start (RISE), A360's follow-on program in Ethiopia.

In **Nigeria**, A360 implemented in specific sites in the intervention LGAs using a hub and spoke model which was adopted by the program starting in early 2019. The scale of implementation was limited to specific locations in the LGAs and there were no intentions to attain full geographic scale within the intervention LGAs since A360 was also reducing implementation costs. For instance, in Nasarawa's Doma and Karu LGAs which have 315 facility wards (261 for Doma and 54 for Karu), A360 was implemented in only ten facilities (2 hub and 8 spoke sites). Because A360 did not receive funds to scale its northern Nigeria intervention until late 2019, implementation in those ten facilities was phased, with some starting implementation in early 2018 and some sites not activated until September 2019- at most a year before the endline survey. Additionally, MMA operated in 4 facilities until Quarter 3 in 2019 when they expanded to the additional facilities upon receipt of approval and funding from the donors. As a result, some communities had a much shorter implementation duration. For Ogun's Ado-Odo/Ata LGA, A360 implemented in only 13 facilities (3 hub and 10 spoke) out of the 147 facilities in the LGA and similar to Nasarawa, implementation did not reach all the sites until July 2019. Services were consistently available in the hub facilities and were provided using an outreach model in the spoke facilities. All spoke facilities were not activated until in 2019.

In **Tanzania**, implementation was focused on two models: an outreach model using pop-up events conducted in the districts using a migratory approach, returning to the districts every three months and an in-clinic model where events were convened in static health facilities. Early during the project's implementation phase, A360 identified that pop-up events were yielding more adopters and were cost-effective, therefore shifted its approach to focus more on pop-up events and less on in-clinic events. In the initial phase, A360 implemented in 10 regions (Kagera, Geita, Mwanza, Arusha, Tabora, Tanga, Dar es Salaam, Mbeya, Iringa and Morogoro). A360 stopped implementation in these regions from October 2020 onwards in line with MOH priorities and shifted focus to three regions (Katavi, Rukwa and Ruvuma).

**COVID-19** presented A360 implementation as a unique challenge. Service delivery in all geographies was disrupted to align with Ministry of Health guidelines in the respective countries. This disruption was reflected in the slump of program attendees and adopters in the period between March and July 2020. To foster continuity of implementation, A360 made programmatic adaptations, some of which enabled continuity of engagement although with reduced program visibility in the geographies. Return to the delivery of the A360 interventions using the 'business as usual' approach for each of their components is still pending even at the time of this report in May 2022.

**This is an area where A360 and its evaluators can contribute valuable learning to the global evidence base.** For example, proposing recommendations on evaluation sequencing – so that OE and CEA methodologies are finalized when interventions are fully formed and major adaptations have stabilized. There are trade-offs to this approach, leaving less time between baseline and endline to see program impact, though it also leaves

evaluators space, time, and confidence to generate a robust evaluation design. **An iterative project strategy also requires clear communication. It is essential that evaluators and implementation teams are more intimately engaged, in a symbiotic arrangement.** This ensures that evaluation questions, tools, subjects, and approaches are those most relevant at each time point in the evaluation process. Further, this engagement enables the implementers to actively engage and own the results coming from the evaluation, which is a prerequisite for rapid translation of the findings into programmatic actions. While A360 did experience great collaboration in some cases, for example engaging with Itad to improve the utility of the PE for program improvement, there were missed opportunities, since the evaluators wanted to maintain some level of being 'external'. This created a tension into the degree to which the implementers and the evaluators could meaningfully collaborate. Collaboration was harder for the OE component, which had limited ongoing and structured engagement with implementers. A360 also acknowledges that it could have dedicated greater project time and resources for this engagement, instead of underestimating the level of effort needed to inform and engage with the evaluators to make sure they were aware of major project strategic shifts.

### c. Difficulty in reaching sustained impact among populations of unmarried adolescent girls

**Summary:** Performance data for A360's interventions with unmarried adolescent girls indicate high reach and resonance of the project's interventions. Yet, there was inconclusive program effect demonstrated among these populations in the OE and the PE pointed out tensions between the project's aspirational program content and its transparency about its SRH components. This indicates that A360 has not fully unlocked an approach which will create sustained improvements in outcomes among unmarried girls. This is not a unique struggle to A360 but is shared across the sector.

A360's performance data indicated that the program had some success at reaching unmarried adolescent girls. Out of the over 314,000 girls in Tanzania and 172,000 girls in southern Nigeria who were reached by the program, approximately 80% and 77% respectively were unmarried. Conversion rates<sup>3</sup> in these geographies remained high at 72% in Tanzania and 75% in southern Nigeria. Method mix between these countries was different but promising since 50% of adopters were using a LARC method in Tanzania compared to 25% in south Nigeria. **These data point to the resonance of A360's interventions and the project's aspirational program approach with unmarried girls, something also reinforced by insights generated from the PE.**

The OE shows some evidence of promising program effects along A360's TOC for MMA (northern Nigeria) and Smart Start (Ethiopia), which both target married girls, particularly when looking at self-reported exposure vs. non-exposure. In contrast, the **OE findings for 9ja Girls (southern Nigeria) and Kuwa Mjanja (Tanzania) which target unmarried girls are less conclusive and suggest a lack of broad program effect.** There are some limitations to the conclusions that can be drawn from these evaluation results. For example, the primary OE results in Tanzania seem to be heavily influenced by a decline in condom use at endline, despite detailed analysis highlighting a positive trend in the use of other methods in the study population.<sup>4</sup> The abrupt shift in method mix calls into question whether there were other factors which influenced the

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<sup>3</sup> A360 calculates conversion rate as the number of girls who received contraceptive counseling through the project's interventions who were not pregnant or already using a method who adopted a modern method of contraception through the project's intervention.

<sup>4</sup> For instance, implants contribution to method-mix in the OE increased from 6 to 14%, standard days method from 16 to 28%. Condoms which contributed to 67% at baseline dropped to 29% at endline.

overall program results, for example differences in how the questions were fielded and how the responses were captured between baseline and endline. A detailed investigation on methodological differences between baseline and endline and a sub-analysis considering non-barrier methods may be warranted. While it has been difficult to obtain national data on condom supplies, key informants and grey literature reference a major disruption in the condom market between the baseline and endline. This disruption was associated with a shift in the Global Fund's implementation modality and funding, away from social marketing and toward public sector condoms. This resulted in a collapse in the market and stock-outs of the leading national condom brand, Salama, and others. Projections conducted in a consultative meeting in 2018<sup>5</sup> evidence this looming shortage. Such pronounced shocks to the market could have contributed to the results.

Despite these limitations, the conclusion which can be drawn by these OE results is that **programming for population-level impact among unmarried adolescent girls remains a challenge, one which A360 has certainly not solved**. Unmarried girls experience unique stigma around contraceptive use, reinforced by harmful norms around sexual activity prior to marriage as well as in some cases legislation which restricts unmarried girls' agency in seeking out contraceptive services. In the contexts where A360 is working with unmarried adolescent girls, particularly in southern Nigeria, the project has had to lead demand creation with its aspirational program messaging to create 'social cover' for girls to access the program's SRH components. There is evidence from the PE that in southern Nigeria A360 wrestled with the balance between emphasis of the aspirational program / skills-based component and transparency about the SRH program content.

**While A360 did accomplish something crucial in creating messaging that both inspired girls and was effective at circumventing stigma to allow them to access services, more would be needed to transform the negative norms which prevent unmarried girls from continuing to use contraception according to their fertility preferences and aspirations.** As such, A360's light touch focus on the enabling environment and limited time in its first investment phase would not have been sufficient to yield population-level impact and attain progress in most of the secondary outcomes assessed in the OE.

Though the project's focus within the follow-on investment phase has narrowed primarily to populations of married adolescent girls, as the project seeks to transition its southern Nigeria program to parallel funding, we have committed to triangulating the evidence from the OE and other internal learning to understand what adaptations need to be made to adapt the 9ja Girls intervention to achieve greater, sustained impact. We are already clear that strengthening meaningful engagement of girls' key influencers is a critical aspect of program improvement. As a result, we pursued an HCD process in 2021 to strengthen the enabling environment components for our southern Nigeria programming.

#### d. Adolescent girls' unique experiences and the relevance of mCPR as a primary outcome metric for ASRH programming

**Summary:** Triangulation of the data from A360's performance, the OE, and other global sources reveals the immense complexity in adolescent girls' patterns of sexual activity and need and how this relates to their fertility intentions. It is becoming more apparent that traditional SRH outcome metrics – such as mCPR – are not sensitive and specific to adolescent girls' needs.

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<sup>5</sup> [Tanzania-Condom-Total-Market-Approach-2.pdf \(unaids.org\)](#)

A360's formative research echoed the global evidence base – adolescent girls aged 15-19 are not homogenous in terms of their needs and experiences. Girls' needs and experiences vary based on demographic factors such as marital status, age, schooling, and parity. Their experiences can also be segmented by life stage, and A360 did pursue segmentation studies within its formative research phase particularly in Tanzania and southern Nigeria to inform message segmentation within its interventions. Designing a program which could equally reach every girl within this broad population would have been a herculean task given this diversity of experiences. As a result, as mentioned above the design process necessarily focused in on certain segments of this overall population and may not have been equally relevant across the entire population.

From the results of various project data sources, we have a **good understanding of what those segments are and whether A360 is effectively reaching those segments**. Overall, A360's interventions resonated best with **older adolescent girls** and in its interventions for married girls with those who **have at least one child** (described above). Additionally, girls reached by the program were **more likely to be out-of-school** (in Ethiopia 86%, 72% in northern Nigeria, and 60% in Tanzania). Southern Nigeria is the only geography which shows a more balanced schooling status among girls reached (48.5% out of school and 51.5% in school). However, unlike the other geographies, most of the girls reached through 9ja Girls have attained above high school education.

**Comparing the fertility intentions of the girls reached through A360's interventions and their contraceptive adoption patterns provides an interesting contrast**. For example, most girls want to delay getting pregnant for at least three years since their interaction with the interventions (80% in Tanzania, 75% in Ethiopia, 69% in southern Nigeria and 60% in northern Nigeria based on CEI data) yet a substantial proportion of girls opted to receive counseling only without taking up a method. Whether or not these girls take up methods elsewhere the project cannot determine – from the OE between 20-35% of girls report alternative channels for receiving contraception such as hospitals or clinics. Of those girls who took up a method through A360, the percentage who took up a long-acting reversible contraceptive (LARC) method varied across project geographies (20% in Ethiopia, 28% in southern Nigeria, 35% in northern Nigeria, and 45% in Tanzania based on program monitoring data). While this is higher than what might be expected when looking at LARC use across this population in nationally representative surveys, it still is perhaps less than expected given girls' expressed fertility intentions.

The conclusion that can be drawn is that **there is still much to learn about how adolescent girls understand and articulate their own contraceptive need, particularly as it relates to the interplay between their fertility intentions and sexual activity**. This is an insight reinforced by the OE data. Frequency of sexual intercourse in the OE was varied geographically and based on evaluation time points. Recent sexual activity (in last 30 days) among participants ranged from 76%-97% in various woredas in Ethiopia, 48-55% in northern Nigeria, and 6-9% in southern Nigeria and Tanzania. Although reporting sexual behaviors can be subjective among participants due to its sensitivity, these provide cues about how relevant contraceptives might be to the population of adolescent girls 15-19 years.

A360 recognizes that within the scope of the OE, the primary outcome of mCPR was set far in advance of this learning being generated. However, A360 would propose that there needs to be **more intentional consideration of the appropriateness of this and other currently validated contraceptive use metrics within populations of adolescent girls**. There is no existing global consensus on which measures are most appropriate for evaluating ASRH programmatic success. Current contraceptive prevalence is a potential measure, and the DHS uses it to track national progress. Sexual contact in the last 12 months is used as a determinant variable for inclusion in the denominator for unmarried adolescent girls. Yet, sexual activity

among adolescents is unpredictable and non-regular, so separating out girls 'in need' for estimating key outcomes such as mCPR is inherently difficult (particularly for unmarried adolescents).

Even for married adolescents though, the OE data reinforces that patterns of sexual activity may not be as predictable as expected – in some sites in northern Nigeria nearly half of the married adolescents surveyed reported no sex in the past month. A360 supports access to information and services as a relevant outcome for all adolescent girls irrespective of their sexual activity (and messages provided in A360's interventions reinforce this). Yet the question remains whether our core objective as a project should be to advocate for all girls to be currently using a contraceptive method even if it does not align with their current need or sexual behaviors. In regard to the OE, including all sexually active girls in the 12 months period prior to the OE in the mCPR outcome estimation is likely to have decreased the study's sensitivity to detect change. Detailed sub-analyses comparing the key outcomes of the OE using recency of sexual activity as a determinant are warranted to generate more insights on this area.

The OE findings have reinforced what is becoming clearer in the evidence base, that there is a **demonstrable need for new measurement approaches that are sensitive and specific to adolescents' SRH needs**. mCPR, which has historically been used with all women of reproductive age (WRA), may not be well attuned to the fluctuating, unpredictable patterns of sexual activity which influence whether or not girls are actually at risk of pregnancy.

#### e. A360's TOC, OE secondary outcomes, and their reflection of broader program effectiveness.

**Summary:** Despite the lack of conclusive effect on the primary outcome of mCPR, A360's monitoring data and the OE and PE show some promising trends on other secondary outcomes along A360's TOC. A360 acknowledges that the project's pursuit of scale and cost-effectiveness may have compromised broader program impact. These were unavoidable trade-offs that needed to be made as a result of the project's objectives and targets, yet still provide valuable reflection as A360 looks to create sustained impact in its follow-on investment. The promising trends in these secondary outcomes also indicate that considering metrics of success which are applicable to all adolescent girls – not just those currently 'in need' – would potentially be more indicative of broader program effectiveness and potential future impact.

A360's theory of change (TOC) starts with positioning contraceptives as relevant and valuable for the project's users. The TOC also includes creating an amiable environment that supports adolescent girls to voluntarily access contraceptive counseling and take up contraceptive methods. This occurs in parallel with building trust and credibility of contraceptive products and increasing the availability, quality, and sustainability of SRH services. When these are attained, it is expected that girls would use services and methods in line with their preferences and needs and this would be translated to population-level impact on current contraceptive use.

**A360's performance data provided some indication of how relevant and effective these messages were as well as the high quality of service delivery which was provided by the program.** Between January 2018 and September 2020, the project's four interventions reached over 600,000 program attendees, supporting over 400,000 girls to voluntarily adopt a modern method of contraception, yielding over 100,000 adopters above the projected targets for that investment. CEI data affirmed that adolescent girls engaging with the interventions were able to identify and articulate goals for their lives and conveyed confidence in their ability to pursue them. In addition, over 90% of clients in CEI data across all project geographies reported that they



were treated well at the service delivery points and most clients (72% and 78% in Nigeria and Ethiopia respectively) affirmed that they wanted to wait three years before becoming pregnant, an indication that the interventions were relevant to them. As a result of this alignment, we observed that uptake of LARC was beyond national benchmarks, and this was affirmed by the positive trends observed in the OE.

**The OE additionally points to promising trends along the pathway to change for the indicators within A360's TOC, even if some of these outcomes were not statistically significant findings.** Positive trends on current contraceptive use among adolescent girls along with a substantial number of secondary outcomes in the geographies where the study was conducted were observed. The PE adds to these insights, describing how A360's interventions leveraged the existing health infrastructure, personnel and management systems, coupled with diverse mobilization structures to create an effective ecosystem for reaching adolescent girls effectively. These include flexible, easily accessible, on demand and free services delivered by trained youth-friendly providers. This approach resulted in commendable progress on the part of the project in reaching many underserved adolescent girls. These important changes in health system capabilities to remain responsive to the adolescent girls' needs were not directly measured by the OE but emerged from the PE.

The contrast of some A360's positive performance data, some promising trends in the OE, and insights from the PE with the lack of conclusive evidence of A360's population-level impact creates a few points of reflection. First, that as a project A360 did experience challenges which made it difficult to attain population level impact. Even though there are critical limitations to the OE's conclusiveness stemming from the misalignment with A360's reach and implementation strategy as mentioned above, there is an **important lesson for A360 on what it takes to impact change at scale which are important to consider as we move forward in our follow-on investment.**

A360's efforts, particularly during optimization, to pursue cost-effectiveness and meet the targets assigned to the project, resulted in an approach which more effectively targeted 'low hanging fruits,' in other words girls who already had existing need. This approach focused on high reach and conversion, supporting as many girls to take up a contraceptive method as feasible while maintaining quality and informed choice. This approach is exemplified by the approach used in Ethiopia where the team would move between kebeles when some degree of saturation was assumed to have been reached, the spoke model in Nigeria, and the outreach-based model using pop-up events in Tanzania. This approach has several limitations – it limits sustained engagement with girls to support continuation. It results in intermittent presence in these geographies, perhaps reducing girls' exposure to the project's messaging over a consistent, long-term period. **Had the project's approach been focused on consistent engagement, better intervention outcomes may have been attained. Yet, this would have been at the expense of A360's objectives and targets.**

The duration of A360's implementation in each geography appears to have been a key determinant of which components of the A360's TOC the project saw promising effect. Implementation in A360 geographies was varied, longest in Tanzania and shortest in some LGAs and kebeles in northern Nigeria and Ethiopia. Creating a conducive environment for adolescent girls to use contraceptives and changing deeply entrenched attitudes, norms and perceptions towards contraceptives is a long process. A360 acknowledges that its intervention components meant to address norms and attitudes were light-touch, were not clearly defined as 'core', and were not thoroughly monitored and measured. It is possible this contributed to a less detectable effect on relevant elements of the TOC. The PE concurs with this observation and goes further to present case studies about how A360 encountered backlash due to these pervasive norms and policies. As A360 and the donors have previously acknowledged, though this is something A360 has begun to intensify under its follow-on investment, approaches which transform norms are resource intensive, long term, and often fundamentally at odds with a focus on government ownership for sustainability.

A second point of reflection considers how **some secondary outcomes reflected in A360's TOC and the project's OE might be applicable not just to girls currently 'in need' but to the entire population as they touch on critical factors such as attitudes towards contraception and self-efficacy towards use of contraception.** The promising trends in the OE in some of these secondary outcomes is reassuring. We know that A360's approaches created curiosity among girls broadly, not just those who were sexually active. Project and PE learning reinforced that unmarried girls, in particular, were drawn to the life and vocational skills components of the project interventions – particularly in Tanzania and southern Nigeria. These components may have attracted girls to the program who were not sexually active and to whom contraceptive use was not as relevant at the time of interacting with the interventions. Yet this engagement provided an opportunity to support girls to understand the value and relevance of contraception, even if they did not expressly adopt a method after their engagement.

Using contraceptive uptake as the most important metric of project performance, and current use as the project's primary outcome metric, may negate the impact of these interactions with girls who may now be more informed and prepared to use contraception when the need arrives. In contrast, these secondary outcomes are relevant and can be used now to understand the project's effectiveness. A360 also notes that within the OE, the analysis of some of the secondary outcomes may have been more sensitive if relevant and applied to all girls (not just those assessed as in need of contraception).


## 4. KEY ACTIONS TO APPLY LEARNING FROM THE EXTERNAL EVALUATION


As a learning project, A360 works to intentionally pause and reflect on insights that can inform program improvements and increase program effectiveness. Throughout the course of the first project investment, we found insights generated through the PE to be immensely valuable in informing project adaptation and strategic shifts. Although we have been clear and forthright about what we perceive to be the limitations in the OE and CEA which stem from misalignment between the evaluation and A360’s strategy, there are still valuable learnings that A360 can apply in its follow-on investment. Some of these are already stated within the summative report itself, others A360 has drawn from its own experience digesting and responding to the evaluation results. Both of these are presented below.




### a. Apply the evaluators recommendations

Initially, as a project we know it is important to directly respond to the recommendations presented in the summative evaluation report. These are presented in Table 1 below. The traffic light system denotes A360’s assessment of how difficult these recommendations will be to incorporate within the existing project resources and scope.

Table 1: Summative evaluation report recommendations and A360’s response

Evaluation Recommendation	A360 Response
<p><b>Strengthen the focus on addressing social norms and building community engagement</b> to reduce barriers for girls to access contraception...[Girls] continued to face powerful sociocultural barriers.</p>	<p> The external evaluation highlights what A360 has long considered to be an important learning from our first investment phase – one that is highlighted in our <a href="#">recent publication on Gates Open Research</a> as well as other knowledge products A360 has published. <b>Adolescent girls’ enabling environments play a significant role in their ability to access and use contraception in line with their fertility intentions and aspirations.</b> The significance of A360’s program components which were designed to engage girls’ key influencers for a more supportive environment were downplayed early in the project’s implementation phase in favor of speed and scale. Though A360 course corrected in 2019 in response to project learning and its mid-term evaluation results, these components remained low intensity and may as mentioned above have contributed to inconclusive evaluation results.</p> <p>A360 began to adapt to strengthen these enabling environment components at the beginning of its follow-on investment phase, acknowledging the need to intensify efforts to meaningfully contribute to shifting harmful norms and power structures that limit girls’ opportunities and aspirations. This is a key part of our follow-on strategy. <b>Yet, we also continue to flag for our donors and partners the inherent tension that this creates with the project’s mandate to pursue integration into government systems for sustainability.</b> This is a process which may require some streamlining – high dose</p>

	<p>influencer and community engagement approaches will be difficult for government to take up and own. We will continue to explore the balance between these two opposing priorities and dialogue with the foundations and our partners on how best to pursue sustained impact.</p> <p>A360 has also incorporated intentional research and learning activities to understand the efficacy of the key influencer engagement / enabling environment components it has designed. These components will be evaluated to generate insights on what works and what doesn't work and how successful these components are at attaining measurable outcomes among the key influencers who are reached. The impact of A360's enabling environment work on the behaviors of adolescent girls will be measured through our planned effectiveness research involving adolescent girls in Ethiopia and Nigeria.</p>
<p><b>Harness the value of the empowerment components</b> by making them more central and responsive to girls' needs, while being alert to the risks of light-touch approaches that attract more than empower.</p>	<p> Again, this recommendation echoes insights A360 has reinforced in its own synthesis of project learning, drawing heavily also from the PE. We recognize that these aspirational program components capture girls' interest and motivate them to engage. They were a key part of A360's success at reaching girls and supporting them to understand the relevance of contraception. At the same time, <b>A360 acknowledges that the low-dose of these components was sufficient to inspire rather than to empower and that the project lacked rigorous metrics to understand the effectiveness and value of these components in and of themselves, not just on the project's SRH outcomes.</b></p> <p>The value of expanding these components was clear and A360 was able to <b>mobilize resources to design and pilot expanded economic strengthening program components</b> which could meaningfully support girls to pursue their goals. Simultaneously we looked at our low dose aspirational program components to understand how they could be improved (for example for market relevance and the types of skills provided) so that even if they needed to be maintained at low dose they would be as effective as possible.</p> <p>We still anticipate there will be trade-offs. We <b>do not currently have the resources to scale the expanded economic strengthening components designed in 2021 and we foresee an inability to integrate them fully into government systems</b> in the same way we are pursuing for our SRH interventions. This is echoed in the global evidence base which clearly demonstrates how time and resource intensive these types of program designs are to scale.</p>

<p>Manage, monitor and regularly feedback learning from the institutionalization of A360 into public health systems. This will help to <b>manage tensions and trade-offs between quality implementation, reach and gov't ownership.</b></p>		<p>We believe the <b>PE added tremendous value to our evidence-based adaptation processes within the first A360 investment. We knew we wanted to apply this same rigor of learning within our government institutionalization workstream under the follow-on investment.</b> We tested out the application of qualitative research to understand the barriers and enablers to successful institutionalization in Tanzania in 2021. The learnings from this will hopefully be published in a journal article soon and were greatly useful in understanding how much progress the project was able to make on institutionalizing Kuwa Mjanja over the course of its exit period. We intend to pursue PE activities in Nigeria and Ethiopia to similarly understand barriers, enablers, and progress towards institutionalization.</p> <p>Though this is an integral part of our strategy and the foundation of our pursuit of sustainability, we still believe that there is <b>more to do to truly sensitize the donors, in particular to, the trade-offs and tensions that we anticipate we will face</b> in pursuit of government institutionalization and ownership.</p>
<p>When applying HCD, design processes or adaptive implementation, <b>build in sustainability considerations from the outset; considering trade-offs between reaching high numbers of adopters and integrating into health systems.</b></p>		<p>Like the recommendations above, A360 called this out as an explicit recommendation within our <a href="#">summary of the key lessons</a> we learned as a project in the first investment phase. <b>Institutionalization in government health systems is a critical aspect of our sustainability strategy.</b> We are also intentionally considering sustainability as we design new complementary program components around MNCH and economic strengthening, though we have been clear on the limitations of institutionalizing these components given the short time frame we have to implement them before the project concludes.</p> <p>Yet, A360 continues to be a project with a heavy mandate and expectations. As we experienced under our first investment phase, <b>orienting the donors and other key stakeholders to these trade-offs can be complex.</b> We value that this recommendation from the evaluators explicitly calls out the tension between high reach and institutionalization for sustainability. This provides support to A360 as we look to navigate the tensions we anticipate we will encounter in this follow-on investment phase.</p>
<p>Continue <b>to leverage the 'mindsets' that were built during A360</b> to design and deliver programs focused on the needs of adolescent girls and to <b>involve young people in the program.</b></p>		<p>A360 is deeply aware of the value of maintaining its roots in HCD and adaptive implementation. <b>The most important aspect of the foundation that the first investment phase set was an intentional focus, not just in design but also in implementation, on understanding and responding to girls' experiences and needs.</b> This manifested itself in a number of</p>

	<p>ways within this first project period – including application of user journeys to routinely understand girls’ experiences with the project interventions, prioritization of people-centered quality of care within service delivery, and meaningful youth engagement (MYE).</p> <p>Though we know that there is always room to improve, we are proud of the foundation that we set in this first investment. We have also <b>intentionally built on this within our meaningful adolescent and youth engagement (MAYE) strategy for the follow-on investment</b>. As with all these recommendations, we anticipate a tension between continuing these priorities and creating a program which can be sustained through government integration, but hope that through our integration work we can advocate for public health structures to be more routinely focused on the needs of adolescent girls.</p>
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#### f. Understand girls’ unique needs and program for continued support for them to pursue their fertility intentions and aspirations

A360 appreciates even more after digesting the results of the OE the difficulty in designing a program which effectively supports adolescent girls, not just to take up contraception once but to have the agency to use it when and how they choose. It is even harder to support them without a good understanding of their unique needs and how these drive their desires and motivations to use contraception. The OE gave us even more data points that emphasize the complexity of girls’ needs, but also pointed out further gaps in our knowledge. **A360 has committed in this next project phase to understand what experiences and factors drive girls’ patterns of contraceptive use – this is a pre-requisite for being able to strengthen our interventions to reduce discontinuation while still in need.**

A360 has planned a longitudinal cohort study in Nigeria to examine, prospectively, how girls make decisions to seek services, adopt, stop, restart, and refill their contraceptive methods. To complement this effort, A360 also plans to submit a request to our donors to approve and grant access to the OE data. This will facilitate A360 to execute detailed sub-analysis of the primary and intermediate outcomes and uncover relationships between selected variables and contraceptive use including age, sexual behavior/frequency, and geographic proximity to the A360 intervention locations. This understanding will assist A360 to determine ways to reconfigure the implementation strategy to further improve the resonance of A360’s interventions.

#### g. Investigate appropriate metrics for program success

Building from above, A360 also acknowledges the importance of understanding how to measure its success at supporting not just contraceptive use generally but contraceptive use that is actually aligned with girls’ unique needs. The use of mCPR presents clear challenges as mentioned above. For married girls, the presumption of need just because of marital status ignores the continued intermittent patterns of sexual activity demonstrated even by married adolescent girls. To date, there is no consensus on which is the most reliable metric. **A360 seeks to support addressing this gap in the evidence base and will explore alternative metrics within its effectiveness research, such as contraceptive use at last sex, which might be more**

relevant and responsive to adolescents' SRH needs. This includes doubling down on some of the secondary outcomes that the project believes might be more relevant to the entire population of adolescent girls – including those who are not currently sexually active. These include changes in their knowledge, comprehension, relevance and benefits of contraceptive use. A360 will leverage additional research such as the continuation cohort study and secondary analysis of recent DHS data from countries in sub-Saharan Africa to understand adolescent girls' unique patterns of use as a key first step in identifying which measurement approaches might be most responsive. A360 will also convene conversations with players in the ASRH sectors to create a movement that will invest in unravelling this dilemma. These alternative measures will be used for the planned effectiveness research in north Nigeria and in Kenya.

#### h. Lead the global community of practice towards more effective evaluation methods for HCD and adaptive programs

There is learning to apply from A360's external evaluation that can inform implementers, evaluators, and donors alike. Though we have been critical of what we consider some of the failings of the evaluation to effectively measure the project's impact, we also recognize that **the evaluators were put in a tremendously difficult situation trying to apply traditional evaluation methods to a program so fluid and iterative.** This presented no small task. We also know there were **missed opportunities on our part to proactively engage the external evaluation team, particularly the OE team, in ways which might have maximized the usefulness of the OE despite its limitations.** The importance of transparent and open communication between implementers and evaluators is one we have already emphasized in various forums, including in our presence in a recent [HCD Exchange webinar titled "Evaluating a Moving Target."](#)

We hope to continue to prompt the global community of practice to align on better methods for evaluating these types of programs. This includes evaluating a program's ability to adapt and learn, not just its program outcomes. We hope that the external evaluators will add their own perspectives and learning to our own.

We also intend **within the current investment to develop evaluation approaches in close collaboration with country-level implementation teams who have in depth knowledge of implementation strategies, while still finding a balance that allows the project to stay on track with agreed-upon timelines for research studies during study design and implementation.** For planned effectiveness research (SRH, MNCH, economic strengthening), we recommend using a sampling frame defined using a maximum distance from implementation sites (and comparable health facilities as comparison sites), in order to improve the likelihood that individuals sampled in the intervention areas have had a possibility of interacting with the intervention. We are still considering what else can be done to ensure planned effectiveness research acknowledges the iterative and adaptive nature of A360's programming.

## 5. CONCLUSION

The investment in the external evaluation components has yielded a useful contribution to the ASRH sector and illuminated some of the gaps that the ASRH sector continues to experience. A360 promises to proactively engage in the efforts to disseminate these insights to the sector. As a first step, A360 will immediately share the evaluation findings to the A360 Global Advisory Panel to evoke their interpretations and reflections of the findings, draw on their expertise to identify areas for optimization and validate the

planned evaluations in the research and learning agenda for their relevance. A360 will also disseminate the findings to government stakeholders and relevant players in the ASRH sectors in the respective countries.

As the primary benefactor of these findings, A360 will track how well the insights generated from the evaluation contribute to stronger, agile and highly effective interventions. Despite the funding constraints, A360 will explore some of the unanswered questions surfacing from the external evaluation as part of the planned evaluations in the research and learning agenda during the current investment.

A360 will also participate in advocacy efforts to influence donors to finance evaluation activities to close the existing evidence gaps that were uncovered by the external evaluation, and which have endemically persisted in the ASRH sectors.



**Disclaimer:** The views expressed in this document are those of Adolescents 360. Views presented here do not represent those of the A360 donors (Bill & Melinda Gates Foundation and Children’s Investment Fund Foundation). A360’s External Evaluators (Itad, LSHTM, and Avenir Health) reviewed a draft of this management response and provided feedback prior to its submission, and A360 made revisions accordingly.

