KEY ACHIEVEMENTS

FROM A360'S FIRST INVESTMENT PHASE

(2016-2020)

CONTENTS

EXECUTIVE SUMMARY

A360 Design Phase and Program Solutions

With funding from the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF), beginning in 2016, A360 undertook a design process to better understand the unique needs and desires of adolescent girls across its project countries – Ethiopia, Nigeria, and Tanzania. In this design process, A360 brought together a consortium of experts in public health, adolescent developmental science, anthropology, and HCD, to complement its own expertise. A360's design process adhered to two key principles: meaningful youth engagement and multi-disciplinary engagement. The project recruited 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.
A360's design phase culminated in four distinct program approaches across three countries. Within each geography, A360 partnered with young people to conduct formative research, prototyping, and adaptive implementation to develop and refine a model specific to each cultural, social, and religious context. These resulting models are primarily implemented through the public sector, both in order to promote scale and sustainability, and also to remove financial barriers for girls to access services. Public sector implementation also directly responded to girls' preferences on service delivery avenues. A360's four interventions include:

Smart Start (Ethiopia):
Smart Start works with married adolescent girls and their husbands to help them understand how delayed first birth and spaced pregnancies facilitate improved savings and capital to pursue their shared life goals. Smart Start is implemented through existing public health systems through the national Health Extension Program.

9ja Girls (southern Nigeria):
9ja Girls works with unmarried girls to make contraception immediately relevant to what a girl wants now. 9ja Girls 'Life, Love, and Health' (LLH) classes and outreach 'spice talks' engage girls first around their goals, providing low-intensity vocational and life skills, and then positioning contraception as a tool to help them achieve those goals. After engaging with a mobilizer, girls can choose to attend these LLH classes or go directly to a facility to access services.

MMA (northern Nigeria):
Matasa Matan Arewa (MMA) engages married girls through female mentors and their husbands through male Interpersonal Communication Agents (IPCAs). Girls are invited to participate in a series of 'Life, Family, and Health' (LFH) mentorship sessions with a cohort of their peers. MMA aligns contraceptive use with a girl's family and life goals.

Kuwa Mjanja (Tanzania):
In Tanzania, Kuwa Mjanja taps into a girl's self-defined priorities and helps her understand how contraception aligns with and supports those priorities. Kuwa Mjanja engages girls around their life aspirations – using a dynamic brand to encourage girls to 'stand tall, wear their crown, and be a role model.' Kuwa Mjanja sessions provide girls with a low-intensity vocational skills session to begin to give them the tools they need to balance their growing responsibility and navigate the social transition to adulthood.

A360 Implementation and Program Performance

As A360 transitioned from design to implementation in 2018, it embraced adaptive implementation as a way to continue its human-centered focus in implementation, while continuing to refine its interventions post-design phase. Early in A360's implementation phase, cost considerations and contraceptive adoption drove decisions on what program components to adapt, refine, and eliminate. Learning from A360's mid-term evaluation (MTE) affirmed what A360 suspected – that this rigid pursuit of scale and cost-effectiveness had some perverse effects. In response, A360 made a strategic pivot, moving beyond a focus on cost-efficiency to add or re-integrate intervention components to support long-term impact. As part of this, from 2019-2020 A360 invested more in capacity development for quality, and strengthening the enabling environment, with the goal of better supporting contraceptive continuation and positive youth development.

By the end of the project's investment period, A360' interventions had supported over 400,000 girls to voluntarily adopt a modern contraceptive method, despite the last year of the project being limited by the COVID-19 pandemic. A360 has seen that positioning contraception as a tool that can help girls (and couples) achieve their aspirations (inclusive of motherhood) and strengthening the broader health system to be more responsive to the unique needs of adolescents can result in meaningful outcomes for adolescent girls. A360 sees that when girls are provided with an expanded array of methods in a supportive and conducive environment, over 40% of adopters choose a LARC – significantly higher than the percentage of LARC use reported in national surveys. These results would not have been feasible without A360's commitment to design with and for adolescent girls.

Table 1: Cumulative Program Results, A360 Global Performance, November 2017-September 2020

	Ethiopia	Nigeria (9ja)	Nigeria (MMA)	Tanzania	Global
Girls Attending Program Activities	75,237	172,517	45,371	314,155	**607,280**
Adopters	35,420	119,380	35,641	220,430	**410,871**
Continuing Users	20,451	12,241	2,203	8,076	**42,971**
Pregnant Attendees	7,988	733	639	16	**9,376**
Conversion Rate	76%	75%	84%	72%	**74%**

Figure 1: Global girls reached, adopters, continuing users, and conversion rate by year, 2018-2020

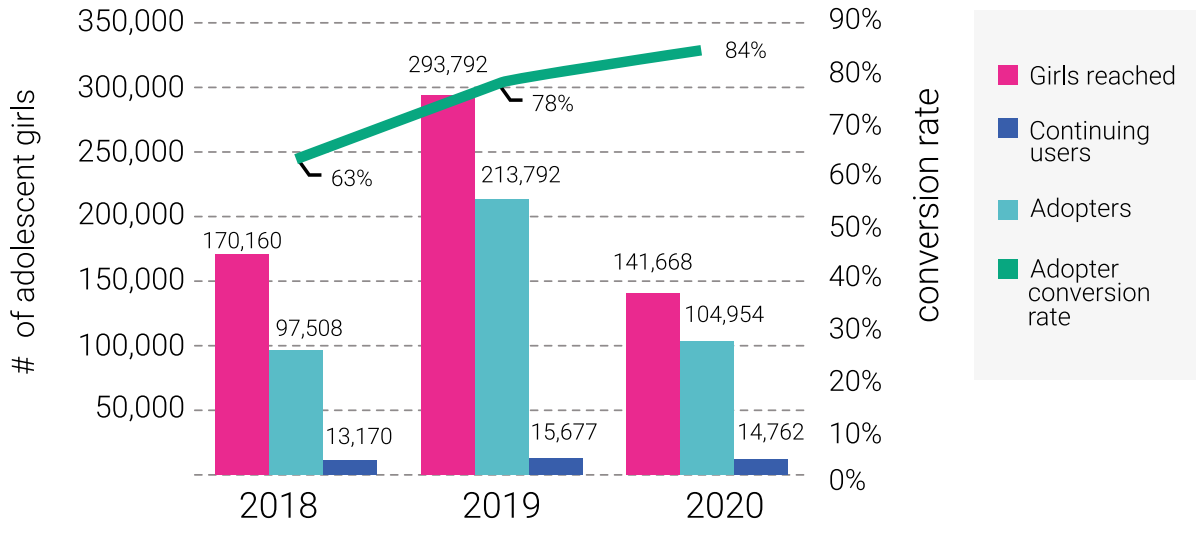
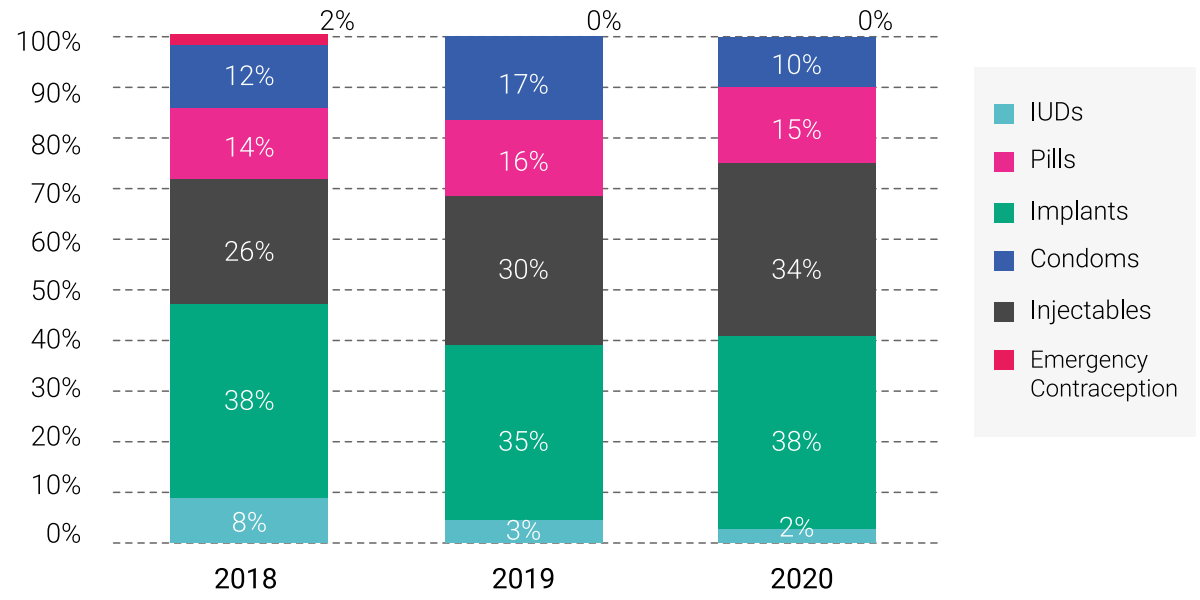


Figure 2: Global method mix by year, 2018-2020



Reflecting on A360's Key Learnings

Throughout A360's life cycle, the project has made efforts to prioritize learning that can support continuous program improvement and advance ASRH evidence and practice. A360 is supported in these efforts by a process evaluation, outcome evaluation, and cost-effectiveness study. Learnings from A360's routine monitoring, adaptive implementation 'deep dives', and process evaluation demonstrate the intervention models are effective at supporting voluntary adoption of modern contraceptive methods, particularly long-acting reversible contraceptives, at rates that exceed national figures. This learning has supported A360 to make strategic pivots throughout the life of the project to improve program effectiveness. However, the learning has also highlighted opportunities to further employ design and adaptive implementation processes to increase the effectiveness of the intervention models. These areas of improvement have become key priorities in A360's next project phase.

Figure 3: Key Learning from the A360 Investment

Continuation

A360 has learned a great deal regarding the complex array of factors that shape girls' contraceptive continuation. To fully address discontinuation, follow-up and engagement strategies are required that **beyond the provider-client relationship.**

Vocational and Life Skills

A360's **vocational skills component is critical to the success of its aspirational program model.** It fosters the approval of key influencers, helps mobilize girls, and increase girls receptivity to the program's SRH content. Girls and their key influencers express a desire for more. This aligns with the global evidence and frameworks on positive youth development.

Role of Male Parters

Engagement of Male Partners has proven to be **effective at reducing barriers to uptake.** The multidisciplinary HCD process helped create messages that often resonate not just with girls but also with their male partners and other key influencers. However, **more needs to be done to create an enduring enabling environment.**

Gender Dynamics

A360's aspirational program models engage girls around their life goals. However, there is a need to further **understand the gendered power dynamics which influnce girls' attitudes and desicion-making.** This is particularly true within the program models targeting married girls (MMA and Smart Start).

Community Engagement

After A360's midterm evaluation highligthed the need for **more active engagement with communities to address myths, misconceptions, and stigma.** A360 adapted to increase community engagement, with positive results. Nevertheless, harmful social norms are pervasive and greater intensity is required to create a more enduring enabiling environment.

Peer / Friend Influence

A360's insights show that peers can be both a positive and a negative influence on girls' SRH and agency. There is potential to **leverage satisfied clients for peer referrals and harness girls' social networks** to increase their collective power, yet this requires a greater understanding of which peers girls most trust and respect.

From A360 to A360 Amplify

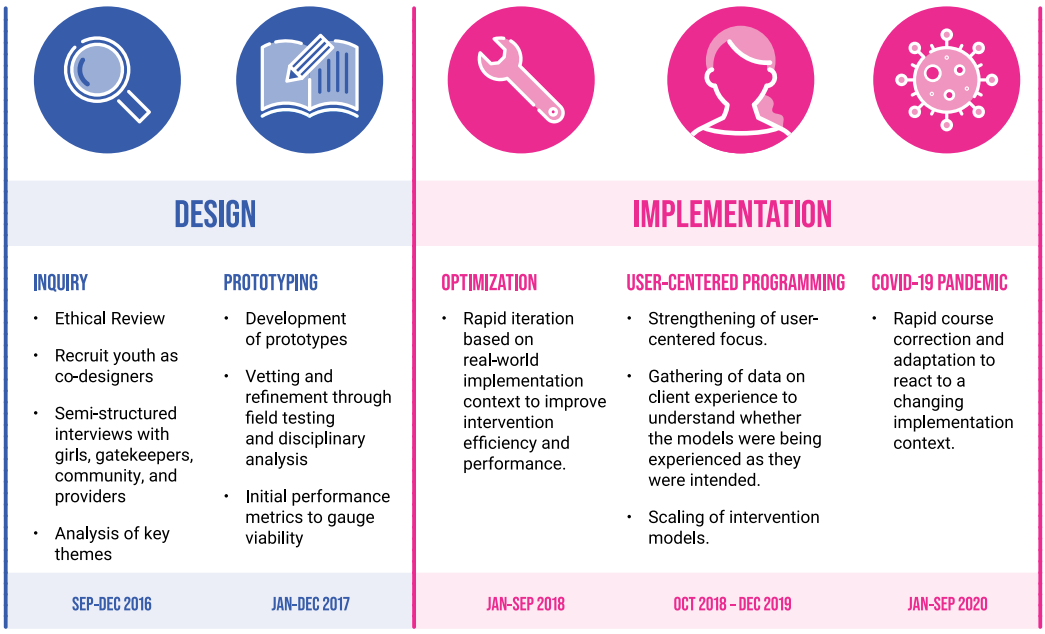
Over four-and-a-half years of design and implementation, A360 has remained increasingly focused on supporting local health system actors to better reach and respond to the SRH needs of married adolescent girls. By recognizing and supporting the needs and aspirations of girls themselves, including vocational and life skills to pursue a stable future, health systems gain a pathway to improved modern contraceptive coverage. A360 has an innovative multi-sectoral approach to ASRH in partnership with federal, state, and local governments, community leaders, and marital partners. The project aims to continue building local implementation capacity to sustain this model into the future.

Although A360's initial investment period ended in September 2020, additional funding has been secured to extend programming through 2025 under a new project, referred to internally as A360 Amplify. With this investment, the A360 consortium will focus on three key areas: **adaptation** of A360's interventions to improve effectiveness; **institutionalization** within public health structures and government-led scale to sustain implementation; and **learning and contribution to the global evidence** base to advance global ASRH. A360 will continue to strive for sustained, quality, client-centered services. The project commits to further exploring cross-sectoral opportunities that can help girls achieve their life goals, and to support girls and governments to understand how contraception can be an effective tool to delay first birth, avert unplanned pregnancy, and effectively achieve these goals.

INTRODUCTION

In 2016, with funding from the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation, PSI launched Adolescents 360 (A360), a 4.5-year project that works directly with young people to develop and deliver interventions that aim to increase demand for, and voluntary uptake of, modern contraception among girls aged 15-19 in Ethiopia, Nigeria, and Tanzania[1]. A360 was designed to follow three phases: (i) inquiry, (ii) insight synthesis and prototyping, and (iii) implementation. In so doing, A360 created space for disciplinary interrogation and testing of ideas, but also nurtured curiosity and creativity throughout its design phase. As shown in Figure 4, A360's inquiry and insight synthesis and prototyping phases took place from September 2016 to December 2017, with the project's implementation phase (largely driven by an evidence-based adaptive implementation approach) beginning in early 2018. Finally, to ensure that the program contributed to the ASRH evidence base, A360 work was paired with parallel external evaluations, facilitated by the project's external cost-effectiveness, process, and outcome evaluators (Avenir, Itad, and the London School for Hygiene and Tropical Medicine (LSHTM) respectively). Throughout the course of the investment, A360 maintained a strong relationship with these external evaluators, who played a key role in generating learning that allowed A360 to continue to grow and improve throughout the course of the investment.

Figure 4: A360 Process and Timeline



1 Geographies for the A360 investment were defined in the original RFP issued by the foundations.

PROJECT START-UP

(Jan-Aug 2016)

After signing of A360's contract in late 2015, the project moved quickly to i) establish partnerships with organizations and technical experts who would become part of the A360 consortium, ii) conduct landscape analyses across project geographies to inform prioritization and segmentation, and iii) prepare for the project's formative research.

Establishing Partnerships

A360's initial contract prioritized a number of partners that the project expected would add value as collaborators in the A360 consortium. In the initial phase of the project, A360 reviewed its partnership landscaping and made strategic decisions around which partnerships to move forward with and which were no longer applicable. These strategic decisions were informed by further insights coming out of the initial phases of design, for example insights around A360's prospective target populations in each project geography.

1. **The Society for Family Health (SFH) Nigeria** has been PSI's long-term partner and was identified during the proposal phase as A360's implementation partner in Nigeria. With four decades of experience delivering public health services in Nigeria, SFH is one of Nigeria's largest public health NGOs. SFH leads and implements all aspects of A360's programming in Nigeria, both throughout A360's first investment phase and into its second.

2. **IDEO.org** was brought on during the proposal stage as A360's human-centered design (HCD) partner, to assist with the design of program solutions across all three A360 countries. A360 moved forward with this partnership, and IDEO.org remained a member of the A360 consortium through to the end of the project, with their most intensive period of support lasting through the project's prototyping phase.

3. **The Center on the Developing Adolescent at the University of California, Berkeley (UCB)** was contracted as a partner with expertise in adolescent developmental science and socio-cultural anthropology. UCB's expertise, particularly in the area of adolescent developmental science was utilized heavily throughout A360's design phases and to a lesser extent throughout implementation.

4. A360's original contract included a partnership with **Ogilvy & Mather Africa**, who were intended to support A360 with the development of a global brand. However, early in the project's landscaping for design it became clear that the project needed to pursue country-specific brands given the diverse demographic, social, cultural, and religious landscapes. As a result, A360 mutually separated with Ogilvy & Mather Africa prior to the start of design work.

5. **Triggerise** was also included in the original project proposal as a partner who would support with digital strategies for demand creation. A360's partnership with Triggerise continued through the prototyping phase. As priority segments were identified for each of A360's prospective solutions, and those segments were identified as having low phone ownership and access, the A360 consortium determined that Triggerise's solutions were not as relevant as originally expected. After prototyping, A360 mutually separated with Triggerise as a partner.

Prioritizing Target Populations

Early in project start-up, it became clear that designing a single intervention to serve every segment of adolescent girl within the project's geographies would be infeasible given existing resources. As a result, A360 conducted landscape analyses to inform selection of the project's target segments.

Ethiopia

In Ethiopia, A360's landscape analysis guided the project to select rural married adolescent girls as the project's target population. Nearly 42% of adolescent girls in Ethiopia are married and 30% have given birth to a child by age 19. National survey data indicates that most sex among adolescents in Ethiopia is in the context of marriage, particularly in rural areas where child marriage is common despite legal restrictions.[2] Among adolescent girls in Ethiopia, the gap between the need for contraception and current use of modern contraception is nearly triple in rural areas compared to urban areas. All these factors combine to point clearly to the highest need among populations of rural, married adolescent girls.

Nigeria

Southern and Northern Nigeria were conceived as unique geographies throughout the A360 proposal process, given the clear divergence between these two geographies in their socio-cultural landscape and in their SRH trends and outcomes. Landscaping of the states in northern Nigeria where A360 was designing showed dramatically high rates of early marriage and adolescent childbearing and low modern contraceptive use among married adolescent girls. First contraceptive use among married adolescent girls typically only occurs after a woman has had 2-3 children. In contrast, in southern Nigeria, age at first marriage has risen in the prior decades, but the age at sexual debut has stayed the same (around 17 years old). The data implied a lengthening period of sexual activity prior to marriage for girls and young women. Among sexually active adolescents in southern Nigeria, less than half use a contraceptive method.[3] The divergence pointed to a need to focus on married adolescents in northern Nigeria and unmarried adolescents in southern Nigeria.

2 Central Statistical Agency [Ethiopia]. 2014. Ethiopia Mini Demographic and Health Survey 2014. Addis Ababa, Ethiopia.

3 National Population Commission (NPC) [Nigeria] and ICF International. 2014. Nigeria Demographic andHealth Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

Tanzania

In Tanzania, A360's landscape pointed to unmarried girls as the primary target population for the project, though married adolescents were retained as a secondary target population. In Tanzania girls have sex on average two years prior to the age at first marriage. Childbearing increases dramatically during ages 15 to 19, from less than 10% of girls having begun childbearing age 15 to over half by age 19. In some regions across Tanzania, there are high rates of adolescent marriage, and nationally 40% of all girls in Tanzania are married before their 18th birthday.[4] As the largest demographic of need, A360 focused its efforts on unmarried adolescent girls in Tanzania, though worked to design a program that also resonated with married adolescents as a secondary population.

Preparing for design

A360 closely partnered with other members of the A360 consortium, particularly IDEO.org, to prepare for the project's inquiry and insight synthesis phases. This included development of formative research protocols across the project's three countries. A360 made the strategic decision to apply for IRB approval from PSI's Research Ethics Board (REB) and local IRBs for its formative research since the data would be used for external dissemination rather than purely programmatic improvement. The exception to this was in Tanzania where the program began its design process earlier through an investment by designer Pam Scott. The decision to apply for IRB in A360's other geographies came after this design process had already begun. Partners in the A360 consortium contributed to the submitted protocol. Because of this IRB submission, A360's project timeline experienced a six-month delay. The project team opted to shorten the pilot phase to accommodate this new timeframe.

4 Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International 2013. Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International.

INQUIRY

(Sep-Dec 2016)

A360's formative research process began in Q3 of 2016 with insight gathering across the project's three geographies. Beginning in inquiry and continuing through insight synthesis and prototyping, A360 assembled a consortium of experts with knowledge and experience that would both complement and challenge its own public health and social marketing background. The aim was to ensure a broad diversity of perspectives from the evidence base, supporting rigorous analysis and interrogation of decision-making during the design process.

The A360 consortium brought adolescent developmental science, anthropology, HCD, public health, and social marketing together with meaningful youth engagement. Adolescent developmental science offered expertise on adolescents' cognitive development and its relation to shifting motivations. Anthropology lent understanding of the societal and cultural influences on girls' perception of self and choice-making across the three country contexts. And HCD provided a vehicle for enabling the disciplines to work together effectively, utilizing a structured process to integrate the disciplines' insights into action.

The project recruited young people to work as co-researchers and program designers alongside these 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.

A360's interventions were informed by and co-created with young people, supporting them to actively lead and provide insight at every stage of the design process, from situation analysis all the way to implementation, evaluation, and scale up. Young people were recruited as "youth researchers" and were trained in systematic data collection methods, including in-depth interviews and direct observation, to work with the team throughout the inquiry phase. As part of design team onboarding, adult consortium members and young designers participated in exercises to build skills in youth-adult partnership, encourage power sharing, and effectively foster respect for the contributions of young people.

The A360 team gathered insights from girls using methods intentionally designed to generate empathy with respondents. Working together, multi-disciplinary youth-adult design research teams interviewed 701 girls and key influencers across all three project geographies (365 in Nigeria, 42 in Tanzania, and 294 in Ethiopia). This included interviews with adolescent girls, their key influencers, community stakeholders, and service providers.

In addition to in-depth interviews, the team employed a variety of supplemental design research methods. This included identification of trusted sources, storytelling, and direct field observation. These approaches revealed deeper insight into respondents' lived experiences—inclusive and beyond SRH—probing to explore the motivations and feelings behind girls' behaviors and decisions.

Table 2: Number of people interviewed across A360 geographies, project inquiry phase

Group	Nigeria	Tanzania	Ethiopia
Adolescent Girls	105	20	83
Adolescent Boys	72	1	49
Mothers	34	6	55
Fathers	38		32
Male Partners	31	15	13
Community Influencers	50		35
Clinical Providers	24		6
Other Service Providers	11		21
TOTAL	**365**	**42**	**294**

Table caption: As mentioned above, A360's design process in Tanzania began earlier than the rest of A360 countries through an investment by designer Pam Scott. With a smaller budget for this initial design, Tanzania's inquiry phase included fewer numbers of girls and influencers interviewed. With additional budget from A360 for design, Tanzania built out the insights gained from these 42 interviews with a series of rounds of prototyping.

Additional Resources
All of these emerging insights were documented in partnership between A360 and IDEO.org and published through the project's country-specific Emerging Insights decks.

INSIGHT SYNTHESIS AND PROTOTYPING

(2017)

Global Insight Synthesis

Beginning in 2017, 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. Though the themes generated during this period of insight synthesis varied across the project geographies, ultimately the project coalesced around the following overarching themes globally:

Anxiety and uncertainty about how to secure a stable future:
Girls and their influencers expressed doubt about whether young people could achieve their desired futures, primarily given the results of rapidly changing social and economic landscapes across all project geographies. Girls saw few paths to employment or higher education. Having money was seen as a way of asserting control, and so girls and their influencers saw entrepreneurialism as one promising pathway to a brighter future. Yet, for many girls marriage was still seen as a protective measure. And for other girls, this economic pressure could result in greater proclivity toward transactional sex, or increased risk for coercive or forced sex.

Misalignment between sexual behavior, contraceptive use, and identity:
Adolescent girls did not see how contraception was relevant or valuable for their lives. They had questions about what was and was not acceptable when it came to sexual behaviors and contraceptive use. They desired guidance on the tensions they felt between parents' and communities' expectations of them, versus their individual needs and desires. At the same time, girls frequently indicated their strong intent to delay sexual debut or marriage to focus on education and a career. All respondents viewed unmarried girls seeking contraception as promiscuous, even as respondents sought to understand SRH information. The perception of contraception as linked with sexual activity, and therefore unacceptable outside of the context of marriage, was pervasive.

Motherhood as the achievable dream:
Although girls reported a diverse range of aspirations, many of them perceived these goals as unattainable or contradictory. Despite a multitude of aspirations early in life, girls' aspirations reduced to those perceived as attainable. Amidst scarcity of opportunity, motherhood was valued as the primary attainable aspiration for many girls and came with the promise of social standing and joy.

Contraception as a threat to dreams:
Girls and their influencers saw contraception as a cause for fear due a perceived threat to fertility, as well as social security. For unmarried girls, use of contraception was associated with sexual promiscuity. For married girls and young couples, including those who desired to delay the birth of their first child, pressure to prove their fertility negated the relevance of contraception.

Isolation and mistrust:
Girls felt that men, providers, and even friends cannot be trusted. Even when girls expressed trust in others, it was conditional. They believed their friends would lead them astray and expose them to negative influences. Girls trusted their mothers more than friends but indicated that there were clear limits to what mothers would tolerate, especially around sensitive sexual health matters.

Girls' (complex) connections to motherhood:
Some girls considered their mothers to be the most trusted source of information and support. At the same time, girls felt they needed to hide aspects of their lives from their mothers – in particular their SRH knowledge and behaviors. For some girls both things were true, whereas others saw their mothers more absolutely as one or the other.

Additional Resources
Further detail regarding how these global insights vary in country-specific contexts can be found in the A360 Case Study series on the project's Open Source website.

PROTOTYPING

Beginning in early-2017, A360's multi-disciplinary consortium of technical experts joined young designers to build low-cost, low-risk prototypes to test with end users. These mini experiments tested the project's assumptions about girls, health providers, and community mobilizers. A360 observed their reactions, then refined and improved the prototypes in response. Prototyping involved making multiple iterations of concepts to test. Prototypes were tested using a standard set of global criteria, including:

- **Desirability:** Does the target audience like and want what we're offering?
- **Impact:** What is the likelihood of achieving immediate health outcomes leading to longer-term increases in mCPR? As a proxy, is the offering aligned with strategy, existing evidence and lessons learned?
- **Feasibility:** Can we do it? Can implementers and end users afford it?
- **Sustainability:** Is the offering likely to be continued and achieve impact over the next 3-5 years? Does the business case support a reasonable cost of implementation and cost per new user of contraception?
- **Scalability:** Is the offering likely to work for large populations of girls through the project regions and beyond?
- **Culturally, Developmentally and Gender Appropriate:** Is the prototype aiming to shift harmful gender norms? Is it culturally and developmentally relevant? Is it dynamic and flexible enough to adapt to different social and cultural contexts and developmental stages? Does it support the autonomy and positive developmental of young people? Does it minimize or provide protection from potential risks to users, providers, and staff?

Early prototypes focused mainly on desirability, with other factors incorporated mainly during second rounds of rough prototyping and beyond. Prototypes which were evaluated in these rounds of rough prototyping as successful were then taken forward into live prototyping. Across each geography, prototyping took a similar approach. This approach included the following phases, with feedback and inputs from consortium members and the foundations solicited across all phases:

1. **Prototype I: Concept Testing.** A360 put posters, stories, and concepts in front of users to understand more from their reactions, focusing heavily on user desirability. These prototypes were low fidelity expressions of what the final intervention could be.
2. **Prototype 2+: Experience Testing**. A360 layered on feasibility considerations into prototypes. Building off what users found desirable, A360 tested ways to feasibly deliver what end users wanted. The project prototyped at higher fidelity, testing whether user behaviors matched what they said they wanted.
3. **Live Prototyping: System Testing.** In live prototyping, A360 brought all components together into one coherent system, running an experiment that simulated how the system would respond in real-world conditions to test whether the system can achieve results.

Additional Resources
Full descriptions of prototypes tested by A360 can be found in the project's Prototype Report Cards.

Nigeria

In Nigeria, prototyping was conducted separately in southern and northern Nigeria given the diversity of insights between the two geographies.

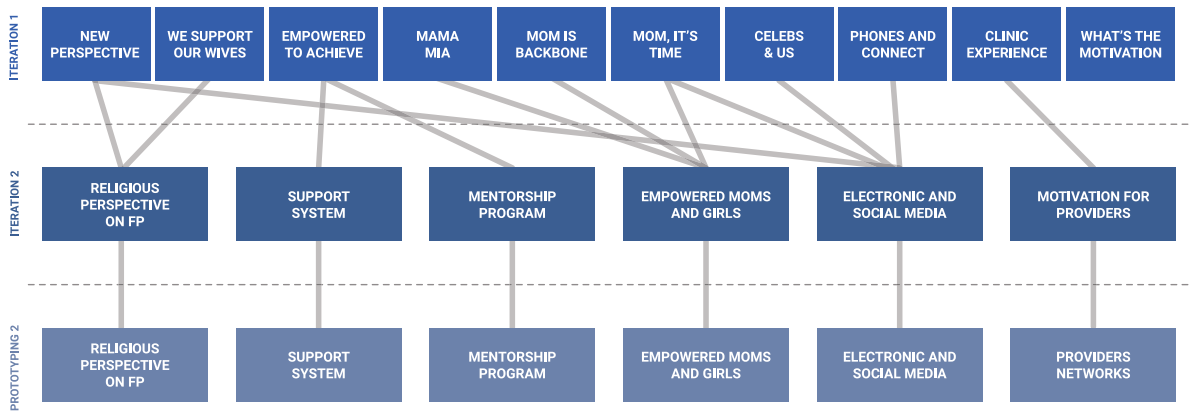
Northern Nigeria

In northern Nigeria, A360 tested an initial set of ten prototypes, narrowed to six during the second round of rough prototyping (see Figure 5).

From these rounds of prototyping, A360 gleaned some important learnings to add to the project's initial set of insights during inquiry, including:

- Adolescents wanted to be informed and empowered with SRH information and knowledge but had specific places where they preferred to receive information – including social media, religious leaders, and their mothers. Mothers needing confidence building and accurate information to support girls to be informed and empowered.
- Married girls wanted mentorship, peer support, and to be trained on vocational skills in conjunction with SRH service delivery.
- Adolescents wanted trusted support systems – including the support from their husbands, and in turn religious leaders in their communities. Providers' attitudes and support were often more important to adolescents than the standards of health facilities.

Figure 5: Prototype evolution in northern Nigeria



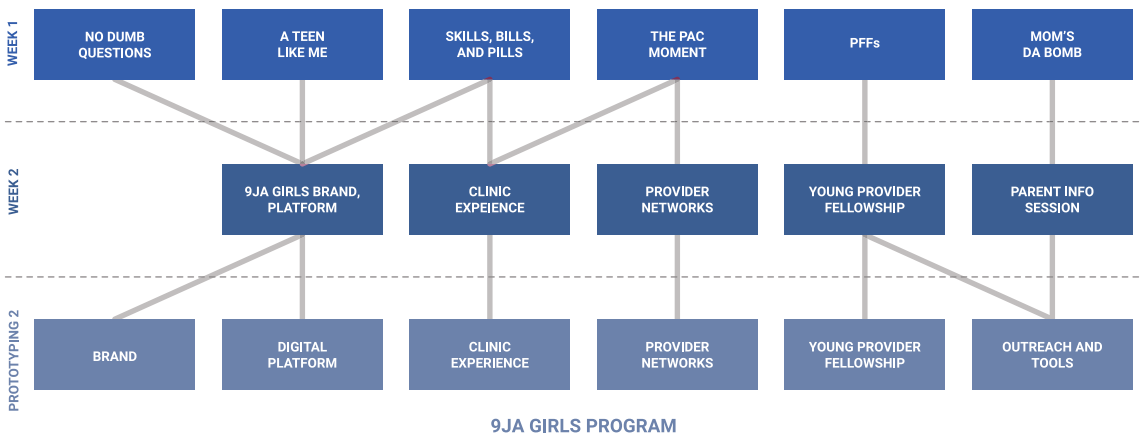
Southern Nigeria

In Southern Nigeria, A360 tested six rough prototypes, which evolved over the course of the prototyping (see Figure 6).

By the second week of prototyping, the A360 team had generated critical learnings that informed their approach.

- Girls want to learn and connect with sensitive health info through a confidential platform online, which is already where they seek information about sensitive topics. They expressed the desire to build skills that can help lead them to financial independence, both online and in-person.
- Contraception needs to be brought into girls' lives at critical moments in their journey. Abortion and post-abortion care providers should be incorporated into a larger provider training and network solution, but PAC is not an opportunity itself.
- Most providers teach abstinence to adolescent girls. Girls need a trusted support system to access contraceptive services. The provider network must be self-selecting to ensure that providers have a passion for serving adolescent girls.

Figure 6: Prototype evolution in southern Nigeria



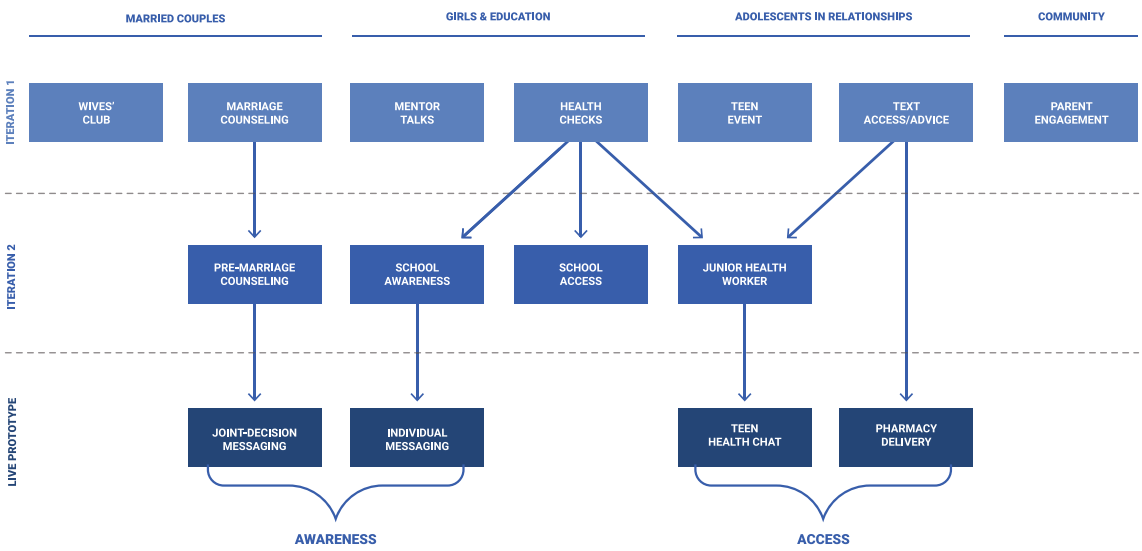
Ethiopia

During the prototyping sessions in Ethiopia, twenty-five interviews were conducted, testing ten concepts. These concepts were meant to meet girls at specific moments across their life trajectories, with three specific trajectory moments identified: girls & education, adolescents in relationships, and married couples.

Over the course of the prototyping sessions, these concepts evolved into four live prototypes centered around awareness and access. The A360 team identified three key learnings from this work.

- School is considered a safe place for adolescents. Girls are receptive to learning about sensitive topics like SRH at school, and they trust educated health professionals with a passion for adolescent health. Boys are eager to learn about SRH topics, but teachers and providers acknowledge that there are still gaps in providing comprehensive SRH education.
- Adolescents are in relationships, and those relationships are often kept secret from families. These relationships take place at schools and over mobile phones, and adolescents plan for their futures together.
- Family planning conversations do not take place until after marriage, while providers report abortion and contraception services for adolescents are high in town centers.
- Married couples confirm that there is a desire for joint decision-making regarding contraception, but husbands are left out of SRH education. Family planning decisions are influenced by finances, and couples feel that they need more information to support their discussions for future plans.

Figure 7: Prototype evolution in Ethiopia



Tanzania

Prototyping in Tanzania preceded that of Nigeria and Ethiopia, as it was part of an earlier investmen led by designer Pam Scott. As a result, much of the prototyping phase for A360 in Tanzania focused on live prototyping, as concepts had already undergone initial rounds of prototyping under this initial investment. During rough prototyping, A360 Tanzania tested six service elements (see Figure 8). These concepts were tested through two approaches: the in-clinic model and the out-of-clinic model. Prototypes for the in-clinic model were designed to attract adolescent girls to girl-identified youth friendly health facilities, where they could interact with Kuwa Mjanja brand experience and receive contraceptive services. Outreach-based model prototypes were designed so that adolescent girls were invited to out-of-clinic locations where they would get an opportunity to interact with the Kuwa Mjanja brand experience.

As the Live Prototyping took place in the context of service delivery, girls had the opportunity to adopt a modern method of contraception. From the Live Prototyping, the A360 team identified several key learnings which the project took forward in order to finalize the design of the Kuwa Mjanja evention.

- The Kuwa Mjanja brand is effective in making girls feel more comfortable engaging in and learning about contraception in a broader narrative. Allowing girls to identify girl-friendly providers reduces the number of barriers for girls to adopt a method of contraception. Having the ability to opt out gives girls the space to select a provider who will support their contraceptive choices.
- IPC agents were effective in channeling demand creation, and they could be leveraged with community health workers to work with public facilities.
- Kuwa Mjanja's approach reaches beyond the clinic experience, which creates an opportunity for non-healthcare partners to be involved. Leveraging outreach teams and social franchise teams helps build providers' capacity on Kuwa Mjanja and allows continuous friendly services to girls in the community, both in public and private clinics

Figure 8: Service elements tested in Tanzania

INTERVENTION DESCRIPTIONS

By the beginning of 2018, A360 solidified the technical strategy for each of its four interventions and began its implementation phase. Across its three countries, these interventions included Smart Start in Ethiopia, 9ja Girls in southern Nigeria, MMA in northern Nigeria, and Kuwa Mjanja in Tanzania. All of A360's interventions are designed to support a unique client experience for girls, the project's 'user journey' (Figure 9). [5]

Figure 9: A360's global user journey

5 These user journeys were developed in 2019 in partnership with A360's external evaluator, Itad, to support the project's ability to understand how girls' actual experience of A360 compared with its intended journey and monitor the fidelity of program implementation against the disciplinary foundations of the project.

Smart Start (Ethiopia)

JALQABBII GAARII
SMART START

Smart Start works in rural environments in which married girls face pressure to prove their fertility early. To reach girls, husbands and family members must also be engaged. Smart Start works with married adolescent girls and their husbands to help them understand how delayed first birth and spaced pregnancies facilitate improved savings and capital to pursue their shared life goals. Smart Start is integrated within the national Health Extension Program. The Smart Start approach leverages existing community resources (including the HEW and and the Women's Development Army - WDA[6]) to generate community buy-in and support for the program.[7]

Table 3: Smart Start user journey

Mobilization	A girl (and potentially her husband) hears about Smart Start from a member of the WDA, the HEW, the Smart Start Navigator, community leaders, or a satisfied client. She is curious and agrees to receive Smart Start counseling from the HEW and Smart Start Navigator because it feels relevant to her and she feels supported by her husband (and mother-in-law).
Aspirational engagement	She, potentially along with her husband, is invited to identify and share her vision for the future and develop a financial plan. She and her husband feel inspired and delighted by the Smart Start tools and branding, and the financial planning messages. She feels listened to and supported by the HEW to make a plan for her future.
Contraceptive counselling & service delivery	She sees contraception as relevant and valuable to achieve her plans. She feels safe and comfortable to talk to the HEW through individual counseling (or counseling with her husband), without others judging her and without being rushed or pressured. She feels listened to and supported, trusts and understands what she is hearing, and feels it is relevant to her goals. She and her husband feel focused on achieving their plans and try a contraceptive method to help achieve their goals. She is provided her method of choice for free, on-the-spot, or a short time later at the health post depending on her choice of method.
Follow up	She feels able to come back to the health post whenever she has questions or needs more contraceptives. She receives follow up calls and visits from the HEW and WDA volunteers and feels supported to access the services she needs. She continues to see contraceptive use as relevant to achieving her financial plan.

6 The WDA is an official government cadre of volunteer community members who partner closely with the local public health structures to expand the reach of health information within their communities.

7 Smart Start Navigators are young women, 18-25 years old, who are recruited for their passion for community development and their experience working with adolescent and youth focused programs.

Kuwa Mjanja (Tanzania)

In Tanzania, Kuwa Mjanja ('Be Smart' in Swahili) taps into a girl's self-defined priorities and helps her understand how contraception aligns with and supports those priorities. Kuwa Mjanja provides income generating skills so girls can make their own money and gain life skills to balance their growing responsibility and navigate the social transition to adulthood. Within Kuwa Mjanja events, either through pop-up events in the community or in-clinic events, girls are supported to access contraceptive services by adolescent-friendly public sector providers.

Table 4: Kuwa Mjanja user journey

Mobilization	A girl learns about Kuwa Mjanja through public announcements within the community, IPC agents with digital counseling tools, or through a peer (Kuwa Mjanja Queens). She hears targeted messaging tailored to her developmental stage – whether open dialogue about menarche and puberty or a discussion of her life goals and desires for the future. Or 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 curious, often particularly about the vocational skills offered at Kuwa Mjanja events and agrees to attend an out-of-clinic pop-up or in-clinic event.
Aspirational engagement	She attends an event, either in-clinic or out of the clinic. The Kuwa Mjanja event starts with an introduction to the 'nanasi' story, an archetypal story which demonstrates 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 related to adolescence, and reaffirm the relevance of contraception as a tool in service of her pursuit of her life goals. If she attends an out-of-clinic event, she then receives a short orientation to a skill from a local entrepreneur (such as making soap or reusable menstrual pads) and is given an opportunity to practice that skill.
Contraceptive counselling & service delivery	She is approached individually at some point during the course of the Kuwa Mjanja event and offered the opportunity to receive a private counseling session with a provider. This 'opt-out' moment normalizes girls' care seeking behavior and reduces stigma by removing the distinction between girls seeking services and those not. She receives her method of choice, for free, and on the spot.
Follow up	She receives a card containing phone numbers of the closest service provider or other clinical staff who can answer her questions or refer for further services if needed. She is able to talk to a Kuwa Mjanja Queen if she has any questions, and be linked with a provider if she has any further needs. 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.

MMA (northern Nigeria)

Matasa Matan Arewa (MMA) uses a two-pronged approach that reaches both young married girls and their husbands through targeted one-to-one outreach by female and male interpersonal communication agents within the community. In both prongs, MMA navigates northern Nigeria's more conservative context by aligning contraceptive use with concepts of family health and stability. As with 9ja Girls, girls attending MMA are supported to receive contraceptive counseling by public sector and nested SFH young providers in public facilities.

Table 5: MMA user journey

Mobilization	A married adolescent girl learns about MMA from a female mentor, or from her husband who has been informed of the program by a male IPCA. She is curious and agrees to attend a mentored LFH course or counseling session because this service feels relevant to her and she feels supported by her partner to attend.
Aspirational engagement	She attends up to four LFH sessions or goes directly to the health center for walk-in services. In the LFH sessions, she learns about topics that are applicable to her, including nutrition, child spacing, interpersonal communication, and financial management. She gains life and vocational skills and feels confident she can use these skills in her daily life, possibly to generate income. She sees how contraception can help her achieve her plans.
Contraceptive counselling & service delivery	By design, she feels invited to share her vision for the future with the service provider (including during private walk-in appointments) and views contraception as relevant and valuable to realize her life plans. LFH sessions provide opportunities for her to meet with a service provider in a confidential setting unless she opts out. She feels heard without judgement. She trusts what she is hearing and can be supplied with her method of choice, for free, and on the spot.
Follow up	She feels listened to and supported. She is confident that she can return to the health center whenever she has questions, experiences side effects, or needs a resupply of contraceptives. She receives follow-up calls from the provider and feels empowered to access services. She continues to see contraception as relevant to achieving her goals.

9ja Girls (southern Nigeria)

9ja Girls works with unmarried girls to make contraception immediately relevant to what a girl wants now. 9ja Girls 'Life, Love, and Health' (LLH) classes and outreach 'spice talks' engage girls first around their goals, providing vocational and life skills, and then changing to positioning contraception as a tool to help them achieve those goals. The 9ja Girls brand affirms girls' aspirations by recognizing the individual choices and agency of each girl who interacts with the program. Girls are then supported to receive contraceptive counseling by public-sector providers and SFH young providers nested within public facilities.

Table 6: 9ja Girls user journey

Mobilization	A girl hears about 9ja Girls through a female mobilizer, her mother, or a peer. She feels curious and agrees to attend an LLH class or counselling session, because it feels relevant and she feels supported by her community.
Aspirational engagement	She can drop into an LLH class if she wishes (or if she prefers, she goes directly for a walk-in appointment). She outlines her goals using the 9ja Girls Life Map tool and learns vocational skills. She feels inspired, listened to, and supported to make a plan for her future.
Contraceptive counselling & service delivery	She feels invited to share her vision for the future with the service provider and is supported to see contraception as relevant and valuable to achieving her plan. Private opt-out moments or walk-in appointments make her feel safe and comfortable. She trusts and understands what she is hearing and is provided her method of choice, for free, on the spot.
Follow up	She feels comfortable returning to the health center whenever she has questions, experiences side effects or needs more contraceptive services. She receives follow-up calls from providers and feels supported to access services. She continues to see contraception as relevant to her goals.

Additional Resources
A more in-depth description of the technical strategy for each intervention can be found in the A360 Case Study series on the project's Open Source website.

IMPLEMENTATION
(2018-2020)

In early 2018, with the program's four interventions / solutions solidified, A360 transitioned into its implementation phase and began to refine and strengthen these programs in the midst of real-world constraints. A360's implementation approach involved a global focus on adaptive implementation as a way to continually improve programming for girls and health systems. The implementation phase was broken up into two distinct sub-phases.

Adaptive Implementation Approach

As A360 transitioned into implementation in 2018, the project embraced adaptive implementation as a way to continue its human-centered focus in implementation. At the same time, adaptive implementation allowed A360 to continue to refine its interventions post-design phase. Adaptive implementation uniquely aligns with the principles of HCD, sharing a few key traits. Both are:

- Guided by girls' voices, perspectives, and experiences;
- Conducted in partnership with girls, government, and other partners; and
- Informed by the global evidence base and a variety of disciplinary lenses.

This adaptive implementation approach generated considerable value. It unearthed new insights, in addition to the insights A360 had already gathered during its design phase. The refinements which came out of adaptive implementation ensured that the project's interventions 'worked' in the context of real-world implementation. It also enabled A360 to monitor implementation fidelity to its unique client experience (detailed above for each program). Involving key partners, particularly government, in this adaptive implementation process built their capacity to understand how to deliver adolescent-centered contraceptive services.

Implementation Sub-Phases

A360's implementation phase began with six months of program **'optimization.'** In this first of two implementation sub-phases, A360 prioritized speed and scale to achieve the 'minimum viable product' (MVP) for each of the program's interventions. At the end of this optimization phase, A360 reflected on the successes and drawbacks of this initial focus on cost-effectiveness, along with the learning coming out of the project's mid-term evaluation and made the strategic choice to enter into a new implementation sub-phase. In this sub-phase, A360 worked to build out a **'recommended viable product' (RVP)**, ensuring that this focus on cost-effectiveness didn't compromise the program's ability to deliver quality and provide long-term impact.

Figure 10: A360's evolution

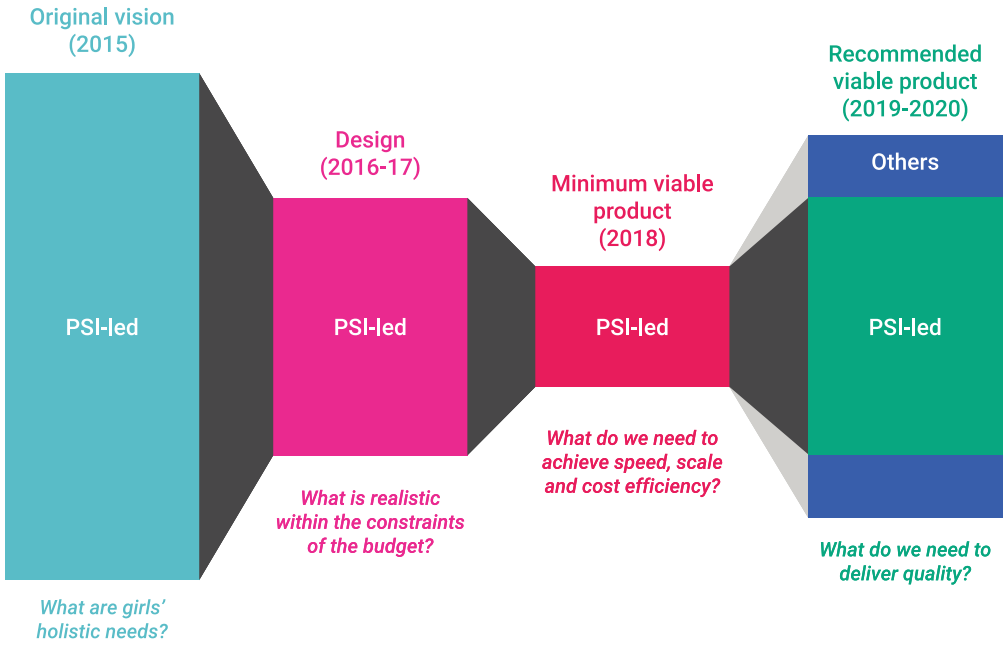


Figure description: At the outset of A360, the project's stakeholders had a broad vision for A360, with that broad vision matched by equally broad ambition on the part of PSI and other members of the A360 consortium. During the design process, this vision was paired back as design findings and other budget and implementation constraints necessarily led to key decisions and tradeoffs. As the project moved from its prototyping and pilot phase into implementation at the start of 2018, there was an expectation to prioritize speed, scale, and cost-efficiency – increasing efficiencies and driving down cost in pursuit of the minimum viable product, measured through cost per adopter. In 2019, after reflecting on the perverse incentives that may have been created through this focus on speed and scale, A360 broadened its approach to deliver quality and built out the 'recommended viable product' for each of its interventions.

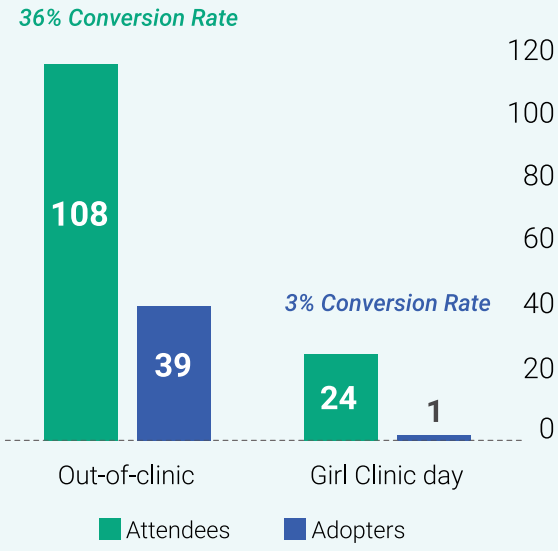
Optimization: 'Minimum Viable Product' (2018)

After completion of a short pilot phase in late 2017, A360 and the foundations jointly decided to incorporate an additional program 'phase' at the beginning of implementation – the project's Optimization phase – in order to continue refining the solutions that had been created during design and prepare for scale. The focus of this phase was on building out the business case for each solution. This was done through detailed analysis of each intervention's performance data (particularly around method mix, adoption, and conversion rates) and costing data in order to understand the most cost-effective way to implement these interventions while retaining fidelity to the original program design and intended user journey.

Deep Dive: Kuwa Mjanja's optimization journey

During this phase of cost-effectiveness and preparation for scale, A360 Tanzania did a deep dive into their program performance, comparing measures of cost-efficiency between their two program 'models' – the out-of-clinic pop-up event and in-clinic event. In analyzing performance, it became clear that though the total cost per event was much higher for out-of-clinic pop-up events, these pop-up events yielded higher numbers of attendees (over four times that of in-clinic events) and a higher conversion rate. The total cost per adopter was therefore much lower for out-of-clinic events, and as a result the A360 Tanzania team shifted their focus away from in-clinic events to pursue a strategy that prioritized scale and cost-effectiveness.

Figure 11: Attendees and adopters by Kuwa Mjanja program model (Q4 2017)*



**Note numbers presented here represent what was analyzed during the time of optimization, as such conversion rates represent what was seen during the pilot phase. A360 current conversion rates for Kuwa Mjanja are generally between 65-75%.*

Figure 12: Adopters by A360 intervention, Optimization phase (Q1-Q3 2018)

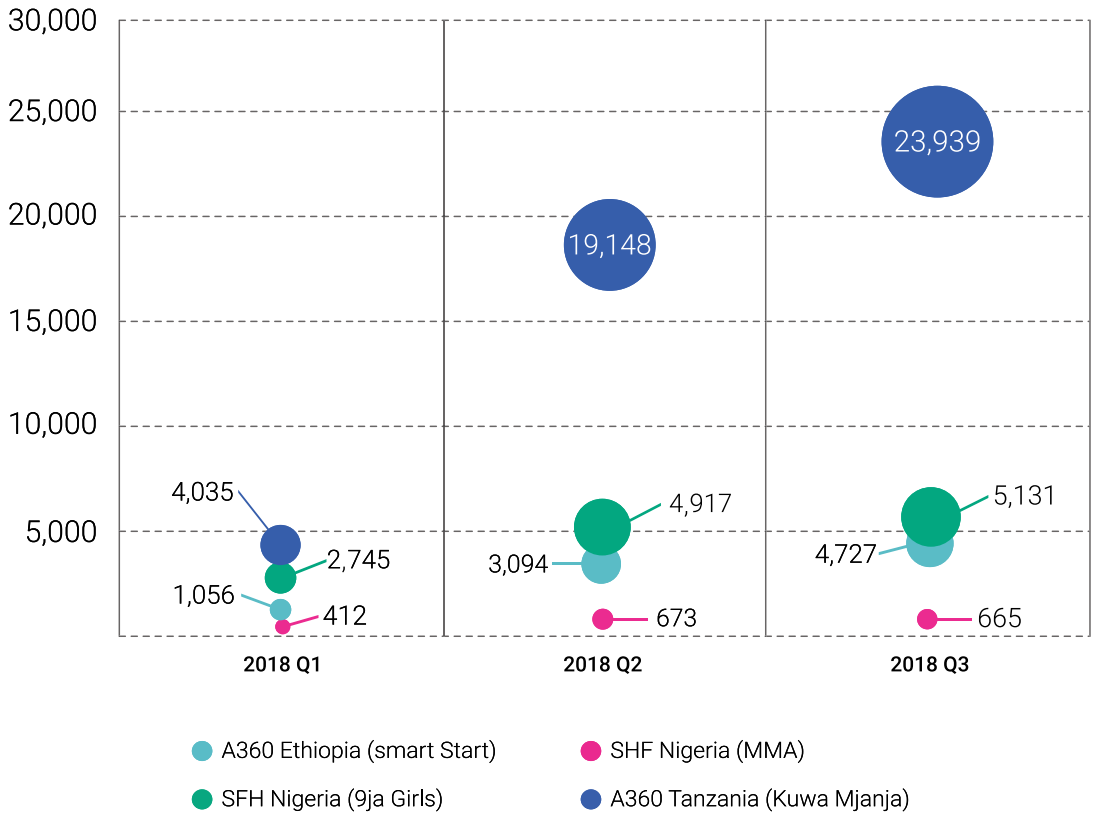
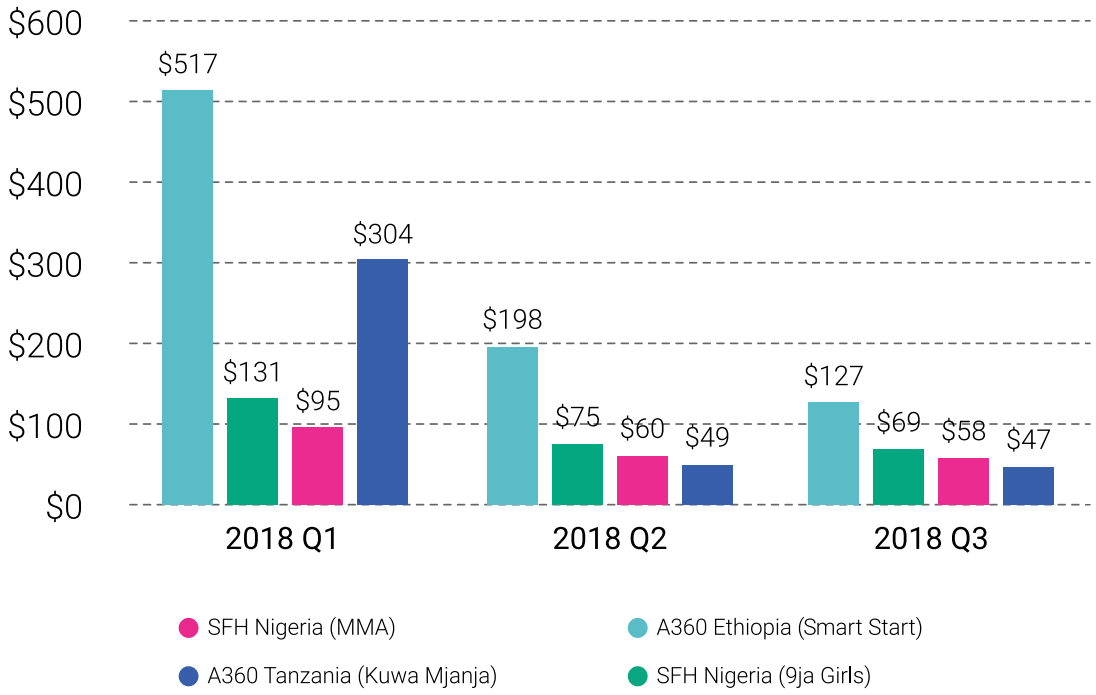


Figure 13: Cost per adopter by A360 intervention, Optimization phase (Q1-Q3 2018)



Ultimately, this process of optimization saw improvements in intervention performance (Figure 12) and a significant reduction in the cost per adopter for each intervention (Figure 13). In shifting emphasis to those program components which had a direct impact on contraceptive uptake, all of A360's interventions saw an increase in adopter performance throughout the first three quarters of implementation.

As the design process for Kuwa Mjanja began earlier than the other interventions, A360 Tanzania was already poised to begin scaling its intervention and as a result saw the most dramatic improvement. This was also partially due to strategic decisions made about program implementation (as mentioned above). During this time MMA was the only intervention which did not significantly increase its scale – given that at the time A360's program budget in Nigeria only included funds to scale 9ja Girls in southern Nigeria. Each intervention also saw decreases in cost per adopter, with the most significant reductions in Ethiopia and Tanzania which decreased their cost per adopter by 400% and over 600% respectively. 9ja Girls and MMA also each cut their cost per adopter in half during this optimization period.

'Recommended Viable Product' (2019-2020)

Though the prioritization of speed and scale during the project's optimization phase succeeded in increasing the adopter performance while reducing costs in 2018, it also at times created a perverse incentive to eliminate intervention components which may have otherwise contributed to better, more holistic programming for girls. A360's mid-term evaluation (MET) findings (distributed in late 2018) acknowledged that the ambitious targets set for A360 put pressure on implementing country teams to meet adopter projection goals, resulting in a decision to reduce or eliminate intervention components that could not be immediately seen to contribute to adoption and conversation rates. In pursuing the MVP, A360 similarly observed movement away from such

activities, which include those designed to address adverse gender and social norms, and support girls' continuation after initial method adoption. The MTE confirmed A360's understanding that this may prioritize "short term results over efforts to establish a more supportive enabling environment for girls to access contraception in the long term." A key finding of the MTE pointed to the need to ensure that a focus on meeting targets did "not detract from building enabling environments and resourcing quality programming."

As a result, in 2019 A360 began to broaden its approach, moving beyond this minimum viable product (MVP) to consider what changes needed to be made (and program components needed to be re-introduced or newly adapted) to deliver quality in the broadest sense and build out a recommended viable product (RVP). These priorities included the following:

1

Build out support within A360 interventions for girls not just to take up methods but also to continue method use.

Examples of activities initiated in 2019 included learning visits and data analysis to understand (dis)continuation trends, a call center and USSD pilot in Tanzania, and improved provider follow-up mechanisms in Nigeria.

2

Strengthen existing or introduce new ways to engage key stakeholders in support of A360 interventions.

Examples of activities initiated in 2019 included refining and/or re-instating parents days and mom's sessions and refining community kick-off processes.

3

Thoughtfully consider the impact of gender and adapt accordingly to promote gender transformative approaches.

Examples of activities initiated in 2019 included facilitation of a gender workshop in Tanzania and rollout of a gender assessment and ethnographic research study for A360's programming in northern Nigeria.

4

Continue to expand and enrich A360's involvement of youth leaders and build our capacity to engage representative youth in program design and implementation.

Examples of activities initiated in 2019 included continuing to build the capacity of project young designers to innovate and serve as key stakeholders in adaptive implementation.

Reintroducing these program components helped A360 make strides towards building out a holistic package of services for girls. Inevitably, it also pointed to areas where the project could and should do better. The lessons learned in this process were carried forward into 2020 and became the foundation on which A360 and its funders' jointly created the strategy for A360's follow-on investment.

Additional Resources
More detail on the project's response to the findings detailed in the MTE can be found in the technical publication A360's Learning and Growth since the 2018 Mid-Term Evaluation.

2020: Adapting to COVID-19 and Project Close

As A360 began its final year of implementation, the focus of the project shifted to synthesizing and disseminating learning from the investment (highlights provided in country sections below), strategizing for potential follow-on funding, and closing out the investment.

COVID-19 Adaptation

Beginning in March 2020, the COVID-19 pandemic created a created a host of challenges for the A360 global and country-level staff. Restrictions on in-person events and mobilizations in Ethiopia, Nigeria, Tanzania, and the United States required A360 staff to regroup and adapt its 2020 workplan, accommodating the changes necessary to abide by local laws and protect the health of staff, girls, and partners. Each A360 country had different, evolving service delivery context over the course of the pandemic.

- In Ethiopia, COVID-19 was mainly centralized in urban areas, and as such restrictions on group gatherings and travel from the capital of Addis Ababa was limited. Service delivery was still permitted, particularly important in rural areas where girls lack options for health care. Restrictions to A360's programming mainly entailed lack of travel for oversight from central level staff.
- In Nigeria, the pandemic restricted larger group gatherings, which affecting group-based programming for 9ja Girls and MMA. Service delivery continued, but the Nigeria team pivoted providing some of the most

innovative and dynamic adaptations during this period across all of A360's countries (more detail provided in the Nigeria section below).

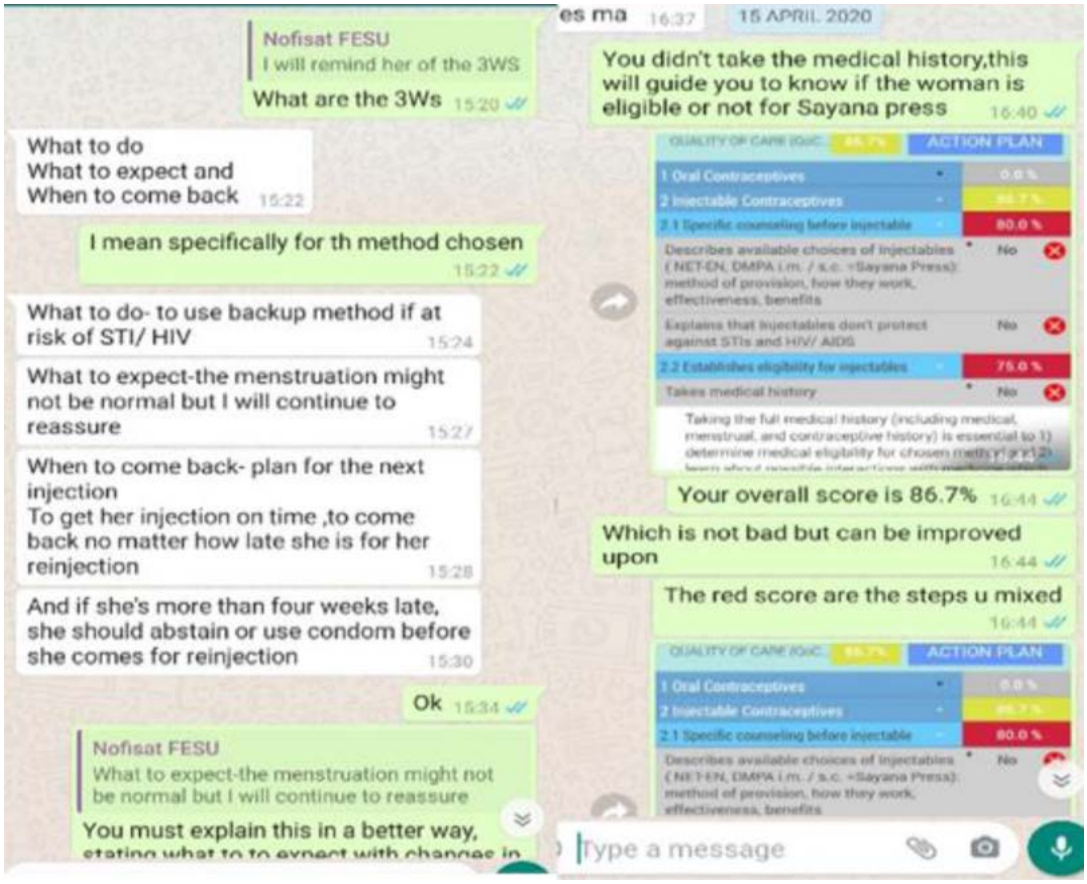
- In Tanzania, the government restricted all service delivery activities for NGOs, and so all of A360's activities were discontinued for a period of two months until the project was able to negotiate with the government to safely resume activities.

Despite these challenges, A360 finished 2020 strong, adapting during the restrictions posed by the pandemic and reaching nearly 130,000 girls, supporting 95,000 of these girls to voluntarily adopt a modern method of contraception.

Synthesizing A360's Learning

Though A360 is continually reflecting on what it has learned in order to adapt and strengthen its programming, the last year of the project provided a unique opportunity to consolidate high-level learnings in preparation for developing a technical strategy for the project's follow-on investment.

Figure 14: Virtual Supportive Supervision through Whatsapp during COVID-19 pandemic, SFH Nigeria (A360)



Snapshot of A360 Key learnings

1 CONTINUATION

A360 has learned a great deal regarding the complex array of factors that shape girls' contraceptive continuation. Fully addressing discontinuation will require follow-up and engagement strategies that reach beyond the provider-client relationship.

A360 is wrestling with the same challenges as the broader ASRH sector – global evidence suggests adolescents may discontinue at rates 25% higher than those for older women.[8]

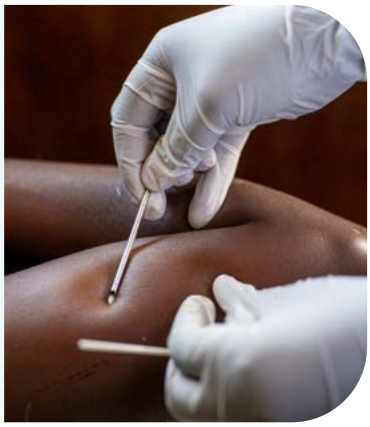
There is some indication that A360 adopters are continuing method use at higher than usual rates. In Ethiopia, data from a sample of sites where A360 has transitioned implementation to government indicates 12-month continuation rates as high as 60%. Additionally, there is compelling evidence of high-quality youth-friendly service delivery and positive relationships between providers and youth in A360 sites that are effectively supporting girls' continuation.

> **"Since I was counselled, I know if anything should happen, I have a place to come…I know that if I don't want to get pregnant, I should come here and I will be protected."**
>
> Girl, Ogun; Process Evaluation Nigeria, 2019, Itad

Yet even with high service quality, girls' decisions to continue using contraception are influenced by an array of other factors. A360's MERL and process evaluation echo the global evidence that side effects are a primary driver of discontinuation. For instance, in A360 Tanzania's unstructured supplementary service data (USSD) pilot, among dissatisfied contraceptive users aged 15-19, 32% / 34% of IUD and implant users respectively report side effects as their primary reasons for dissatisfaction. Girls need a wide array of contraceptive choices and strong counseling so that they can find the method that has the side effects that they can tolerate.

8 Blanc, A. et al. Patters and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons with Adult Women. Guttmacher. Vol 35, No.2, June 2009.

"One of my neighbours got an implant, and her next menses was problematic, she bled so heavily that she had to come and remove it, that experience was so discouraging to other women."
Husband, Nasarawa; Participatory Action Research Nigeria, 2019, Itad



A360's MERL and process evaluation also point to several **key secondary factors influencing discontinuation – including opposition from key influencers such as partners, mothers, and mothers-in-law.** This is most acute when girls' use of contraception is 'discovered' after their experience of side effects became observable.

"She really made life difficult for me, the moment she was aware of my contraception use"
Discontinuer, Southern Nigeria; Participatory Action Research Nigeria, 2019, Itad.

Girls and health systems need effective follow up systems for tracking and supporting continuation. A360 has been piloting a variety of client follow up systems but there remain practical challenges – these are labor intensive and difficult to implement at scale.

"No one asked me why I discontinued; I just discontinued by myself and no one asked me. It is you who should respect and come on your appointment date, otherwise no one worries about you"
Discontinuer, Oromia; Participatory Action Research Ethiopia, 2019, Itad

2 VOCATIONAL AND LIFE SKILLS

The **vocational skills component of A360's aspirational model captures girls' interest and motivates them to engage with A360 and its SRH programming.**

"The mentor came to our compound to invite us, she told us that we will be learning about how to take care of our family, about nutrition, FP but what got me interested was that she said at the end, we will learn a skill....Hearing that ... I became so interested."

Girl, Nasarawa; Process Evaluation Nigeria, 2019, Itad

This component has also played a critical role in **building community buy-in for girls' participation in the program and provides 'social cover'** for girls to access SRH services.

"The women and all of us are so happy, we appreciate it, because they are providing FP services for our girls free of charge, they are also teaching them how to do something, cream, pomade, perfume."

Community leaders, Nasarawa; Process Evaluation Nigeria, 2019, Itad

Providing girls with more substantive support to achieve their financial and life goals can have multiple benefits. A360's MMA user journey inquiry shows that girls have high expectations for the vocational skills component of the program and for some, the reality falls short of their expectations. Similarly, girls and their key influencers both indicated a need for a more diverse skills training curriculum. When expectations are not met, girls report diminished support from their key influencers.

"They should be teaching us a variety of skills at a time because parents do stop their girls from participating once they discovered that they are only teaching them just one thing for a long time."

Continuer, Otun-Ota PHC; Participatory Action Research Nigeria, 2019, Itad.

Evidence suggests that providing more substantive vocational and life skills may improve girls' economic empowerment, power, and SRH outcomes. This type of adaptation would enable A360 to align with and leverage global evidence on positive youth development (PYD).[9]

3 Engaging male partners - as

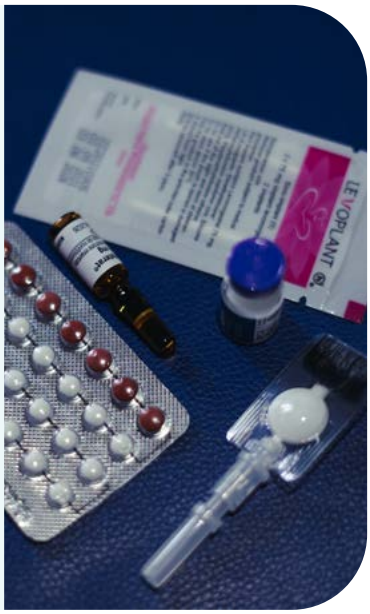
A360 currently does in Ethiopia and northern Nigeria – has proven effective at reducing barriers to uptake. The multi-disciplinary HCD process helped create messages that often resonate not just with girls but also with their male partners and other key influencers. However, more needs to be done to create an enduring enabling environment.

Male partners are often either barriers or facilitators to girls' uptake and continuation of contraceptive use. In Ethiopia, monitoring data from Smart Start shows that 3 out of 5 girls girls counseled without their husbands adopt a method of contraception. This increases to 4 out of 5 girls girls when counseled with their husbands. However, getting husbands to attend counseling sessions is challenging; husbands attend only a third of counseling sessions. A360's MMA user journey inquiry demonstrates that husbands are most often the primary decision makers in relation to girls attendance at MMA events. If they are not provided with comprehensive information on the program's content, husbands can be a barrier to girls' attendance.

9 YouthPower2 Learning and Evaluation. Positive Youth Development (PYD) Framework. https://www.youthpower.org/positive-youth-development-pyd-framework

"I have not done it because my husband has not been around and he said I should not do it until he is around"… "My husband said I can't do it now, because I have just one child."…"I and my husband want to do it, but my mother-in-law said no, my husband promised to talk to her but he has not discussed with her"…"My husband wants me to have at least a child, before I will do it"…"My husband travel for 6 months and he said that until he comes back and settle, I cannot take any method"

Girls, Nasarawa; Process Evaluation Nigeria, 2019, Itad



Meaningful male engagement is effective. A360's aspirational messages often resonate with both girls and their male partners. For example, insights generated in the design phase for Smart Start's husband engagement adaptation show that husbands desire to improve their families by earning money and delaying or spacing children. But only those husbands who believe they can succeed are motivated to consistently use family planning. Husbands of MMA participants likewise find the income generating skills their wives learn as part of MMA highly compelling.

"My husband interrupted [the counselling session] and said, 'we will start using family planning after we have 4 children', laughing … [the SSN] said she was not joking and…advised him that you have nothing now that can be used for child care. This time, since he knows that he has nothing at hand, he was convinced and agreed to use contraception."

Adolescent girl, Oromia; Participatory Action Research Ethiopia, 2019, Itad

4 GENDER DYNAMICS

A360's aspirational program models engage girls around their life goals. However, there is a need to **further understand the gendered power dynamics which influence girls' attitudes and decision-making.** This is particularly true within the program models targeting married girls (MMA and Smart Start).

Girls' expectations and desires regarding skills development, as well as their contraceptive decision-making, are highly influenced by gendered expectations. This is particularly acute in northern Nigeria. Results from the project's ethnographic research (part of its gender assessment for MMA) show that most girls and their husbands believe men must have the final say on timing and number of children. When women did take up contraception, community members often thought this was emasculating to their husbands. As a result, some women discontinued contraception in order to maintain their husband's reputation.

"If women practice all that they have learnt from MMA – cook good food, clean the house –the husband can readily attribute the changes to the program. This then spreads the positive news about the program in the community."
Girls, Nigeria sensemaking workshop, 2019, Itad

Engagement of male partners also reveals how gendered power dynamics influence how girls, their male partners and health workers interact with A360's interventions.

On the other hand she was only looking at the husband throughout the counselling session, it was a kind of one way communication, she seems only interested to discuss with the husband. The guy was very dominant throughout the session, the girls were very shy when they respond to her question.
Observation in Lome, Process Evaluation Ethiopia, 2019, Itad

There are promising opportunities to promote girls' agency through joint decision-making with their male partners. However, it is important to be attentive to the risk of reinforcing harmful gender norms and the differences in each cultural context. For example, in Ethiopia current generations of young, married couples demonstrate a latent desire for shared life planning and goal setting—distinctive from previous generations' gender dynamics. Because of this distinction, young couples lack role models or familiar pathways to more equitable life decision-making. Through Smart Start and its goal card, HEWs now have an effective 'nudge' to validate and support couples' desire for shared planning and decision-making. In northern Nigeria, conversely, though there is some indication from girls served through MMA that the knowledge and negotiating skills they acquired have supported them to speak to their husbands about contraception and begin spacing births, the majority of girls still indicate that their husbands should be the final decision-maker on contraceptive use.

5 COMMUNITY ENGAGEMENT

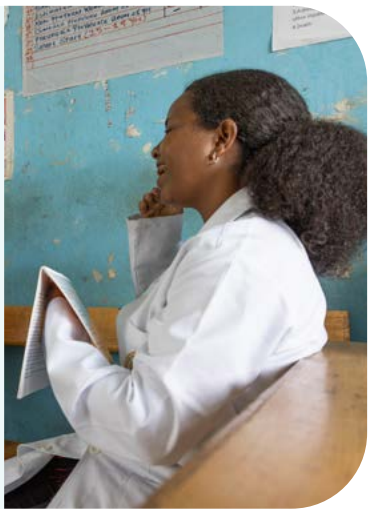
After A360's midterm evaluation highlighted the need for more active engagement with communities to address myths, misconceptions, and stigma, **A360 adapted to increase community engagement, with positive results. Nevertheless, harmful social norms are pervasive and greater intensity is required to create a more enduring enabling environment.**

A360's midterm evaluation highlighted that A360's approach of flying 'under the radar' to navigate community stigma was effective at supporting contraceptive uptake, but did not effectively address community buy-in.

> **"The A360 solutions allow adolescent girls to access modern contraception 'under the radar,' helping them circumnavigate entrenched community stigma… However, while evidence from monitoring data and the process evaluation suggests that 'flying under the radar' does work to increase uptake of contraception in the short term, this may be at the cost of actively addressing harmful community myths, misconceptions and stigma around contraception for adolescent girls."**
>
> Midterm Evaluation, Itad, 2018

The multi-disciplinary HCD process helped create messages that often resonate with girls, their male partners, and other key influencers. A360 was able **to use the same messages which resonated with girls – around future security and goals – to reach community stakeholders**.

"We are able to create a supportive environment because of this positioning [financial planning alongside contraception]. If we came with a different message, it is because it is relevant to not just girls, but husbands and communities. The communities are intimately aware of their poverty and struggle so when someone comes in with a tool to live better lives, that resonates"
PSI Staff, Process Evaluation Ethiopia, Itad, 2019



However, A360 still encounters communities where these messages do not resonate. Adaptations need to be made to overcome this, while continuing to safeguard girls and program staff.

"We had to walk away from some communities where we wanted to do Reach Out events. We met with the community leaders they didn't welcome the idea and so we had to move away from such communities."
SFH staff, Nasarawa; Process Evaluation Nigeria, Itad, 2019

6 PEER / FRIEND INFLUENCE

A360 insights show that peers can be both a positive and a negative influence on girls' SRH and agency.

There is potential to leverage satisfied clients for peer referrals and to harness girls' social networks to increase their collective power, yet this requires a greater understanding of which peers girls most trust and respect.

Insights demonstrate that **adolescent girls (and boys) in Nigeria in particular do not trust their friends** – feeling that they can lead them astray or betray their secrets.

"A friend can expose your secrets, put you into something bad in the community."
Unmarried Girl, Epe, A360 Insights Deck, 2016

"Friends are dangerous; they can lead you astray."
Boy, Surelere, A360 Insights Deck, 2016

"Your worst enemy might be your best friend."
Unmarried Girl, Epe, A360 Insights Deck 2016

Within A360's implementation phase **peers seem to have both positive and negative influence.** Peers and friends may be a more significant mobilization channel for girls than mothers in Nigeria and girls indicated that group classes provided them space to socialize with their peers. Likewise, in Ethiopia some girls prefer to receive group Smart Start counseling as opposed to individual counseling. Yet, unmarried girls still faced stigma from their peers if they were seen to adopt a modern method of contraception, and therefore were considered to be sexually active.

"As the mobilizer left our compound that day, I called all the other girls and told them that they should not take all that she said as rubbish, that it is good, so they said okay, that they will tell their husbands."
Girl, Nasarawa, Process Evaluation Nigeria, Itad, 2019

Social and peer relationships may have potential to be expanded within A360's program models, yet **there is more that the project needs to understand about what type of peer relationships girls most trust and respect.** Global evidence suggests, for example, that girls may respond better to slightly older, more accomplished role models who they can emulate in comparison to their peers of same age. (Source: Population Council)

COUNTRY PERFORMANCE, IMPLEMENTATION, AND LEARNING HIGHLIGHTS

By the end of September 2020, A360's interventions had served nearly 600,000 girls across the project's three countries and had supported over 400,000 girls to voluntarily adopt a modern method of contraception. Despite paring down the project's ambitious mandate at the beginning of the project's design phase, by the time A360 concluded its investment period, it had met not only its final adopter projection goal of 285,000 adopters but had even surpassed the original ambitious mandate of the project to support 360,000 girls to adopt modern contraception. These successes are due in large part to the dedication and leadership of A360's country teams.

Ethiopia

Performance Highlights

Over the course of the A360 investment, A360 Ethiopia reached more than 75,000 girls across all program regions through Smart Start. 3 in 4 girls reached through Smart Starts adopted a modern method of contraception (35,000 adopters). Despite lower adopter performance numbers in Ethiopia compared to A360's other geographies, the impact of Smart Start in Ethiopia has been catalytic – engaging government buy-in to institutionalize and scale Smart Start with the opportunity to reach over 1 million girls with the program over the next five years through a follow-on investment. Smart Start was implemented in nearly 1,000 rural kebeles across four regions (Amhara, Oromia, SNNPR, and Tigray) over the course of the A360 investment, supporting Health Extension Workers (HEWs) in each of those kebeles to provide a unique, relevant SRH service delivery offer to married adolescent girls, a population which had been previously underserved. In 2020 Q1, A360 Ethiopia transitioned over to its next five-year follow-on phase, Roadmap to Integrate Smart Start in Ethiopia (RISE).

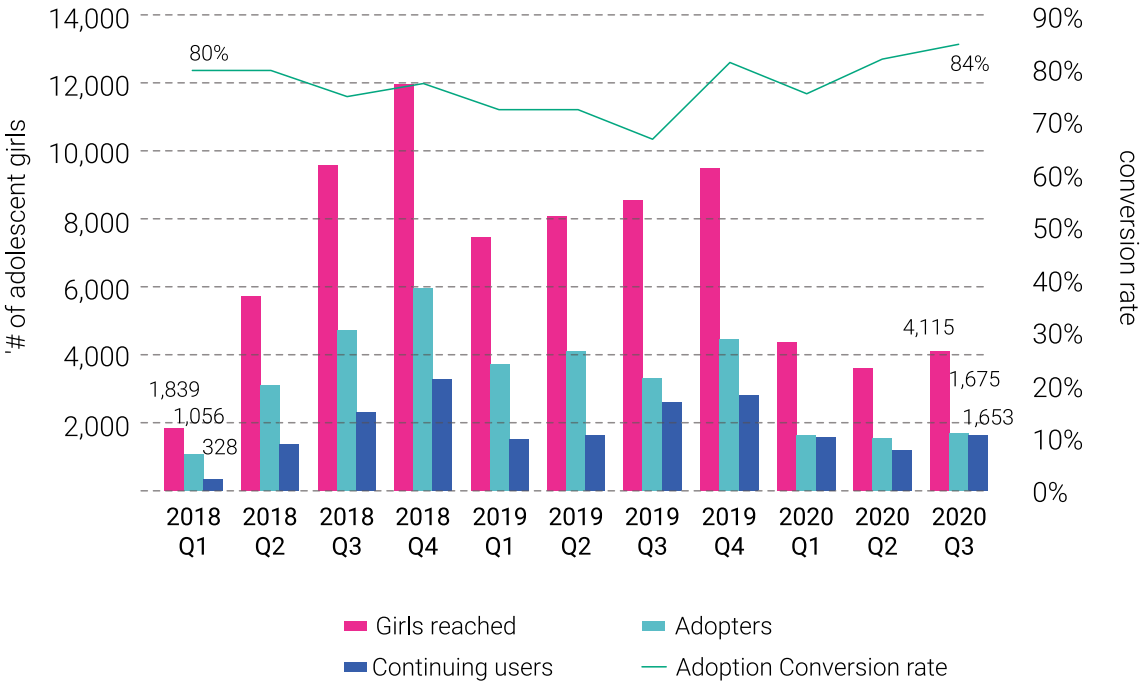
Table 7: Key performance indicators for Smart Start (2018-2020)

	Ethiopia
Girls Attending Program Activities	75,237
Adopters	35,420
Continuing Users	20,451
Pregnant Attendees	7,988
Conversion Rate	76%

Method Mix: Methods selected by Smart Start users remained relatively consistent over the life of the project. In Ethiopia, injectables remain the primary choice of contraception for three out of every four girls between the ages of 15 and 19.[10] Myths and misconceptions about long-lasting methods like IUDs and implants are still pervasive and reduce the number of girls willing to take up LARCs. Despite these myths and misconceptions, around one in five girls who adopted a method through Smart Start adopted a LARC, which compares favorably with LARC usage demonstrated nationally among married adolescents (~18%).

Age Distribution: Smart Start's programming is designed to appeal to married adolescent girls. Over the life of the project, the age distribution among Smart Start adopters remained relatively consistent, with roughly two-thirds of girls aged 18 to 19. These age distributions varied across regions with Amhara, where the the average age at marriage is younger reported a higher proportion of younger girls adopting a modern method of contraception compared to Oromia or SNNPR, observed a higher proportion of younger girls adopting a modern method of contraception through Smart Start. Under RISE, more investigation is being conducted to determine how to reach younger girls through Smart Start.

Figure 15: Key performance indicators for A360 Ethiopia (Q1 2018-Q3 2020)



10 Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016.

Figure 16: Method mix by year (2018 - 2020)

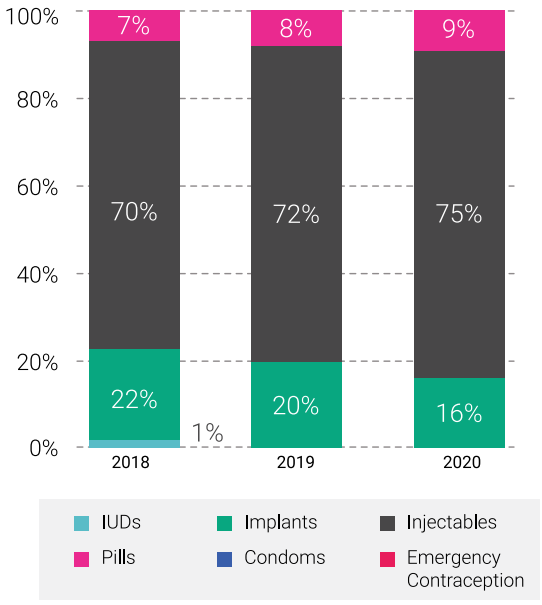
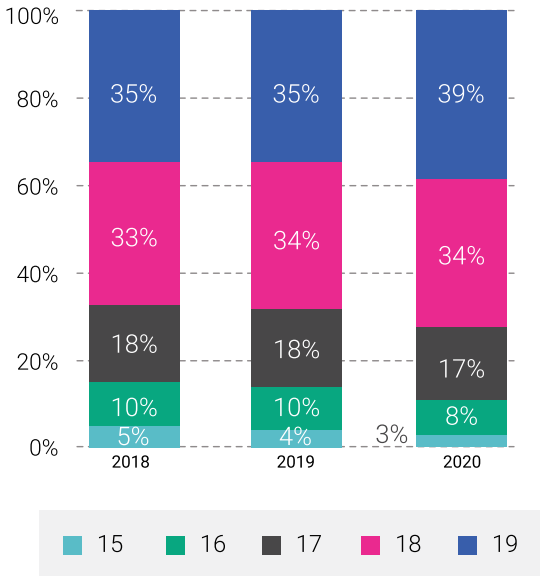


Figure 17: Adopter age by year (2018 - 2020)



Implementation and Learning Highlights

A360's programming in Ethiopia experienced a number of notable successes. Incredible effort on the part of the A360 Ethiopia team succeeded in generating buy-in and ownership of Smart Start by the Ethiopian MOH and commitment to scale Smart Start nationally, alongside leveraged funds to expand the reach and scope of Smart Start. Highlights are provided below.

Adapting for the HEW as the User (2018): Findings from Itad's process evaluation in the early part of 2018 highlighted a critical action point for A360 – when A360 transitioned out of a kebele, HEWs often returned to the counseling practices in which they were originally trained. In response, A360 set out to understand how Smart Start might be further optimized for fit with HEWs' own motivations and real-life constraints, as primary users of the intervention alongside girls. A360 conducted a review of the literature, and reached out to its external evaluator, Itad, to partner for participatory action research (PAR) generating complimentary evidence on the experiences and priorities of HEWs in Smart Start's catchment area. HEWs indicated that the most rewarding aspect of their work was the ability to actively help families be healthy and thrive. Amidst a complex and challenging workload,

when tradeoffs had to be made to manage their responsibilities, HEWs readily reported prioritizing MNCH tasks whenever possible. The clear convergence for fit within HEWs desires and limitations was to craft a program which was both simple and easy for them to implement, but also clearly connected to their desire to safeguard the health of mothers and families.

"If you are a mother, I think you would understand what a mother feels when her child gets sick and what she feels when he gets better. So, I am very satisfied when I see a mother's happy face."
Health Extension Worker, Itad PAR Ethiopia 2018

In July 2018, the A360 consortium hosted a design sprint to kick-start a process of identifying and testing adaptations to respond to these insights. Smart Start, as it is today, reflects these adaptations. Following this design sprint, A360 moved to optimize the intervention to reduce any additional burden for HEWs to implement Smart Start. This also involved crafting messaging to promote better understanding for HEWs regarding Smart Start's contribution to helping mothers and babies thrive – addressing both HEWs' intrinsic motivations and the limitations of their already high workload. As a result, A360 reduced the Smart Start counseling message to less than half its original length, making it more realistic for HEWs to implement and less likely that they would revert to standard counseling messages once A360 was no longer present to actively support them. This adaptation effectively preserved Smart Start's core message – girls indicated that the abridged counseling was as resonant as in previous iterations.

"On the training we were resistant to accept and implement the Smart Start program, we mentioned that we were very busy, and we had very much work loaded in other HEP activity, but later we believed that it was our responsibility to serve the community… I will consider Smart Start as part of my routine job so that I can get mental satisfaction, I will do it not to be judged by my conscience."
Health Extension Worker Itad PAR Ethiopia 2018

Leveraging funding to expand and strengthen Smart Start (2018): Insights from A360's design phase clearly pointed to a desire on the part of both adolescent girls and their husbands for joint decision-making around contraception. Yet couples did not have the tools or knowledge to initiate these conversations themselves. Moving into implementation, analysis of performance data reinforced this desire – girls who were counseled with their husbands adopted modern methods of contraception at rates nearly 15 percentage points higher than girls who were counseled alone.

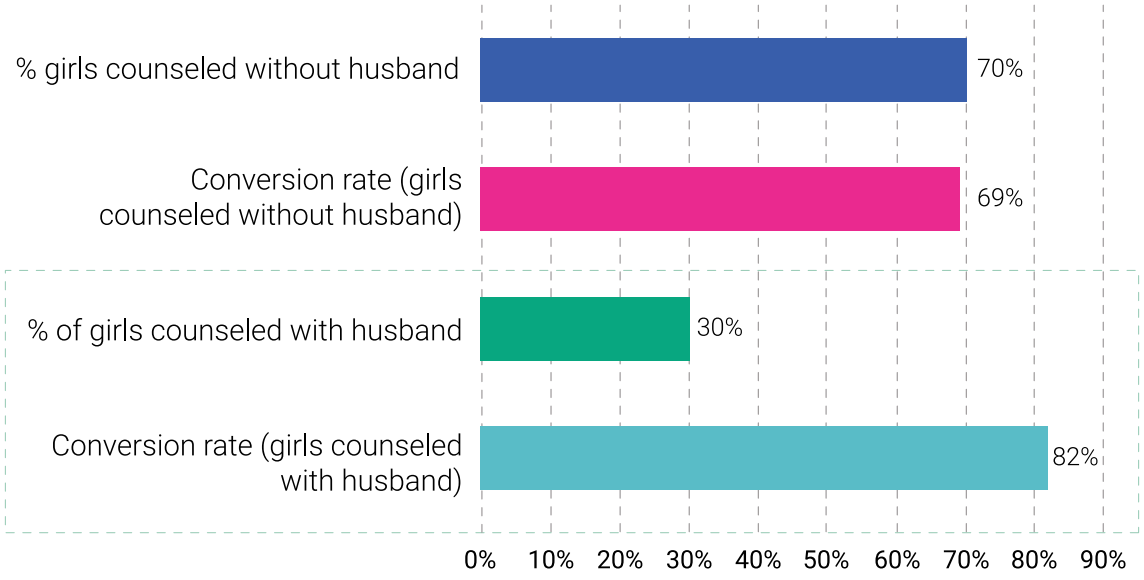
PSI Ethiopia took this learning and at the end of 2018 crafted a proposal for additional funding through Maverick Next, a consortium of young philanthropists, to adapt Smart Start to better engage husbands in joint counseling sessions with their wives. By the end of the initial A360 investment, under this parallel funding stream, the live prototyping for this male engagement adaptation had been concluded, with promising results. PSI Ethiopia is seeing exciting opportunities to mobilize men through community gatekeepers for weekend sessions that use the Smart Start messaging.

"I am the one who negatively influence my wife to stop contraceptive because of poor knowledge and understanding about contraceptive but now after the session I will go and tell her she was right."
Husband who participated in Smart Start men's journey, Maverick Next inquiry phase

Under this same funding through Maverick Next, PSI Ethiopia also received funds to adapt Smart Start to build out the program's economic empowerment component for girls. As of the end of Q3 2020, remote research and design synthesis had concluded for this adaptation.

In 2018, PSI Ethiopia partnered with MSI Ethiopia to submit a proposal to Global Affairs Canada that included expansion of Smart Start in partnership with MSI's mobile clinic model. Though the project experienced some delays, this award kicked off in early 2020.

Figure 18: Husband engagement and impact on conversion rates for Smart Start



Learning from the client experience (2019-2020): In 2019, A360 partnered with Itad to conduct a round of process evaluation data collection in Ethiopia to map girls' experiences against the intended Smart Start user journey for girls. Key findings included:

- Smart Start is successfully using existing, trusted local structures to reach rural girls. Girls' curiosity is sparked through the introduction of financial planning concepts. Trust and familiarity with HEWs and WDAs also drives attendance for Smart Start. (Mobilization, "I'm intrigued")
- Smart Start's financial and family planning messaging resonates strongly with girls, husbands, and their communities, raising awareness and shifting girls' attitudes towards contraception. The fidelity to this aspirational program component is at risk when A360 transitions out of communities, as the project often leads on delivering this component. (Aspirational Engagement, "I feel inspired and motivated")
- Contraceptive counseling is helping to dispel some myths and misconceptions around side effects. However, even after counseling some fears still remain, particularly concerns around fertility. (Contraceptive Counseling, "I feel respected and safe")
- Both girls and their husbands generally said they felt comfortable reaching out to HEWs if they had questions or concerns about their method choice. There were some concerns HEWs weren't getting enough support when A360 transitions out and were too busy to follow up consistently. (Follow up, "I feel supported")

A360 Ethiopia also conducted client exit interviews (CEIs), interviewing 250 girls. Topline findings were mapped against the user journey to inform continued program improvement.

As RISE continues to reflect on the findings of these CEIs, there is clear opportunity for greater intervention to dispel myths and misconceptions around LARC methods, particularly given that over 75% of girls want to delay or space their next pregnancy by at least 3 years. Regional variations in quality of counseling reinforce the focus that RISE has taken on supporting not just institutionalization of Smart Start approaches but support of the government to implement these approaches with quality. Lastly, RISE continues to consider how the program can reach out to younger married adolescents, given that the median age of a Smart Start attendee is 17.7 years old.

Figure 19: Smart Start CEI findings mapped against the user journey

A360 is reaching mainly out of shool, married girls in late adolescence with children

N=250

Mobilization	Most girls became aware of SS through door-to-door outrecah by HEWs (60%) or other not HEW/WDA (39%). Fifty percent of girls discussed the session with someone before attending especially husbands (56%) and friends (44%), but with regional variants. Of those, 97% felt the person that they discussed the session with was supportive of them attending.
Aspirational engagement	After attending SS sessions, 96% of girls had a specific goal for their life/future, 99% felt they could achieve this goal, and 94.5% felt they had the support they needed to achieve this goal. Girls want to delay their pregnancies by 3-5 years (38%) or more than 5 years (38%).
Contraceptive counselling & service delivery	Of the girls counselled, 52% chose a contraceptive method, mainly STMs. Ninety eigth percent of girls said providers respected them as a person and 98% of girls who received a FP method said they were told about other methods, with some variation by Region.
I feel respected & safe	Eighty-six percent of girls were told about side effects ans 78%said they were told what to do if they experienced side effects with some variation by Region. Girls intended to continue to use FP for the next year, 70% definitely plan to seek future FP information and services, and most have a plan fro follow up services (91% of injectable users and 85% of pill use). Nearly all will recommend SS to a friend.

From A360 to RISE (2019-2020): In 2018, A360 Ethiopia began to shift focus away from pursuing scale towards "proof of concept" for Smart Start, optimizing the intervention for integration within existing government structures (specifically the national HEP). This included tremendous advocacy to generate government ownership over the intervention as well as adaptations to make Smart Start more feasible and appealing for HEWs to implement, as mentioned above. At the end of 2018 into the beginning of 2019 these advocacy efforts coalesced into a co-creation process between the FMOH, PSI, and CIFF to design a follow-on project for A360 in Ethiopia, called the Roadmap for Integrating Smart Start in Ethiopia, RISE. Under this follow-on project, Smart Start will be institutionalized as part of the HEP and be incorporated within the curriculum for HEWs at a national level, rolling out the program in all pre-service and in-service trainings moving forward after 2020. Program performance will be tracked through governmental systems of data collection and supported through regular quality checks by all levels of the Ministry of Health.

PSI Ethiopia under RISE made significant strides toward achieving this institutionalization in 2019, even prior to the official start of the RISE program. Training of HEWs has already been piloted through Integrated Refresher Trainings (IRTs) and in pre-service trainings in one region. Additionally, the PSI Ethiopia team was involved in drafting the refreshed Health Sector Transformation Plan, which sets the national health strategy. Smart Start has been acknowledged as one of the "innovative approaches" recommended by the plan and details on implementation will be included in the adolescent health section. RISE was officially launched in February 2020.

Nigeria

9ja Girls Performance Highlights

9ja Girls has seen consistent, strong performance over the life of the project. Over 170,000 girls attended a 9ja Girls event, either an LLH class or a walk-in directly to the facility, with nearly 120,000 girls voluntarily taking up a modern method of contraception since the start of the project. Starting in Q1 2019, the proportion of girls reached who adopted a method for the first time surpassed 80%, which continued for the remainder of the project. Key adaptations during the first year of implementation for 9ja Girls saw dramatic improvements in performance for the project, nearly doubling the girls reached and adopters for the program each quarter.

Table 8: Key performance indicators for 9ja Girls (2018-2020)

	Nigeria (9ja)
Girls Attending Program Activities	172,517
Adopters	119,380
Continuing Users	12,241
Pregnant Attendees	733
Conversion Rate	75%

Method Mix: Though method mix for 9ja Girls initially favored short-term methods (with less than a quarter of girls adopting a LARC method and 23% of girls adopting only a condom), SFH/A360 Nigeria identified key areas of improvement during the last six months of 2018 which resulted in a dramatic shift over the remaining two years of the project. By applying PSI's Counseling for Choice (C4C) methodology to improve quality of counseling, SFH/A360 Nigeria saw girls take up LARC methods and injectables at much higher rates in 2019 and 2020 than in the first year of implementation. C4C is a PSI initiative, now supported through a robust evidence base, that contributes to a positive narrative around contraceptive choice. C4C pulls from existing counseling best practices and is intended to maximize client satisfaction and reduce method discontinuation among girls and women in need of contraception. In this period SFH/A360 Nigeria also began to provide more intensive support to providers on how to discuss long-acting methods, reducing provider bias and ensuring provider comfort around provision of LARCs.

Age Disaggregation: Though initially there was more representation of younger girls among girls who adopted methods through 9ja Girls (~25% of adopters aged 15-17), as the project progressed, adopter age shifted to reflect an older population adopting contraception through 9ja Girls. Disaggregation of the data notes that younger aged girls are more likely to attend 9ja Girls LLH courses and older girls are more likely to walk in directly to the facility for services.

Figure 20: Key performance indicators for 9ja Girls (Q1 2018 - Q3 2020)

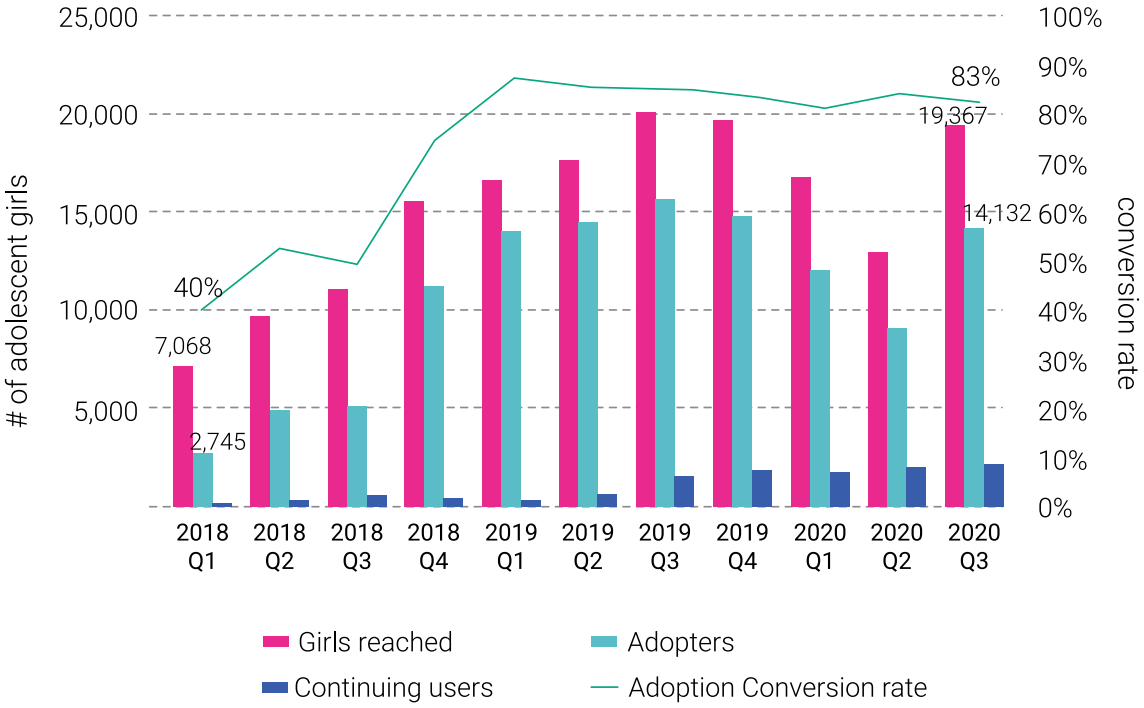
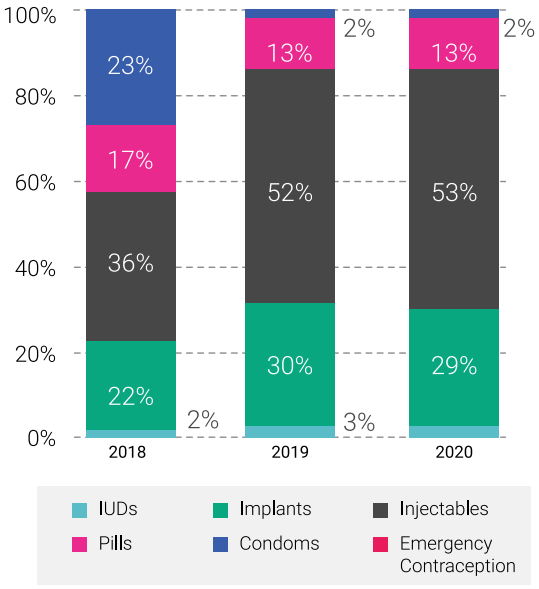


Figure 21: Method mix by year (2018 - 2020) for 9ja Girls

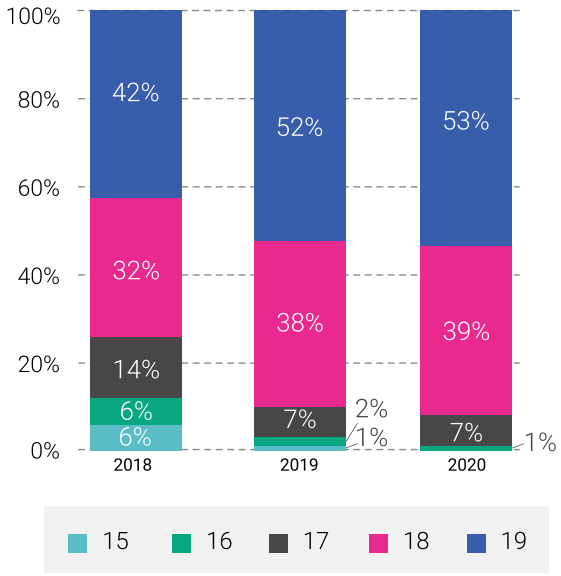


9ja Girls Implementation and Learning Highlights

Innovation, adaptation, and learning have been the hallmarks of SFH's implementation of A360 in southern Nigeria. Efforts to continually improve the 9ja Girls model have resulted in **higher quality, more cost-effective service delivery that is responsive to girls' experiences and feedback.** Through adaptation, SFH worked to support the health system to deliver an improved, resonant user journey for girls.

Enabling empathetic service delivery (2018): When A360's original design period ended, the 9ja Girls intervention had been designed with a service delivery model based on integration of a new and highly branded experience into existing stand-

Figure 22: Adopter age by year (2018 - 2020) for 9ja Girls



alone, youth friendly, and girl-only spaces. These spaces were introduced to offer girls what they said they wanted: a space just for girls, where services were available any time, without judgement, and with highest levels of discretion and confidentiality. Given the information available at the time—the evidence on the value of safe spaces for girls, the ineffectiveness of stand- alone youth centers, and live prototyping findings that demonstrated girls' strong desire for these separate spaces[11]—there was intense debate among the consortium about this design decision. As a result, at the start of its adaptative implementation period in 2018, A360 prioritized rapid testing of the stand-alone safe spaces. Though desirable to girls, a combination of factors—the upfront start-up costs, challenges maintaining infrastructure, and low client flow—meant the stand-alone spaces were not cost-effective, nor scale-able.

This rapid testing and inquiry revealed actionable learning. Rather than the service delivery space, it was the attentiveness and commitment of the young providers to girls that girls consistently reported as transformative in their client experience. Young providers believed in the mission of the project and were highly motivated to reach adolescent girls with contraception, with reports of some providers working extended hours in the evening so girls could access services after school. In response, the SFH-led 9ja Girls team eliminated the stand-alone spaces and integrated adolescent contraceptive service provision within the broader PHC operations. Young providers became a nested model, reflecting a close partnership between SFH, PHC, and health system leaders in participating states. Despite feedback in the inquiry phase that girls would not feel comfortable seeking contraceptive services in public clinics, in practice this proved less important than the attitude of the provider and the quality of the counseling experience.

Understanding and addressing bias (2018-2019): In 2018, external PAR findings from A360's process evaluator, Itad, identified that despite enthusiasm and commitment from providers, positive attitudes alone were not enough to ensure provision of fully unbiased services. At the individual level, many providers experienced a gap between their desire to serve adolescent girls, versus what they do in practice that led them to limit girls' choice of and access to methods.

11 A360 Nigeria: Prototyping Report Card. May 13, 2019. Retrieved from https://a360learninghub.org/resource/report-card-nigeria/

“Take care of themselves, abstain from sexual intercourse so that no man can take advantage of you.”
Service provider, Nasarawa, Itad PE Nigeria 2018

For example, the PAR found that some service providers integrated discussions around abstinence and ‘self-control’-- promoting a message that abstinence is best—during LLH classes and counseling sessions. To address these issues, A360 added to its existing initial intensive trainings-- introducing a supportive supervision system that emphasizes provider coaching and mentorship around implicit bias and commitment to empathetic service. Executed by SFH Quality Focal Persons, supportive supervision occurs through routine quality assurance visits. All visits are conducted using a standardized checklist to assess quality. An electronic scoring system supports quality focal persons to tailor and target their coaching efforts to the areas of greatest need for each individual provider. Findings from the 2019 PE round in Nigeria demonstrated that this strong emphasis on capacity building of service providers has helped to promote higher quality counseling. Girls overwhelmingly said they felt safe, comfortable, and supported by providers.

At a systemic level, biases were driven through structural issues posing challenges to the provision of a full range of contraceptive options, particularly stock-outs of consumables and commodities. In response, A360 strengthened its partnership with state governments to address commodity and infrastructure challenges. The Quality Focal Persons liaise with Family Planning Managers in the government to assess stock levels and advocate for the availability of all methods for adolescent clients. SFH partners with state governments to accurately project commodity needs for adolescent clients by sharing timely, accurate data on commodity use at the facility-level. The program also addresses immediate challenges by arranging transfer of commodities from PHCs with low demand to those with high demand to alleviate localized stockouts. Complimented by refined counselling approaches, such as the integration of C4C, 9ja Girls’ adaptive implementation experience is one that has remained focused on quality services for adolescents that ease the pathway to contraceptive uptake and continuation.

“Since I was counselled, I know if anything should happen, I have a place to come…I know that if I don’t want to get pregnant, I should come here and I will be protected.”
Girl, Ogun, Itad PE Nigeria 2019

Learning from the client experience (2019-2020): Beginning in 2019, A360 intensified efforts, both through its partnership with its external process evaluator, Itad, and through mixed methods monitoring data, to better understand and respond to adolescent girls' experience of A360's interventions. Itad's PAR to assess the fidelity of 9ja Girls implementation against the project's user journey revealed many useful learnings which supported the project to assess and improve its programming in response to the client experience.

- The life and vocational skills training components of the 9ja Girls program were an important motivator for girls choosing to attend the program. Community stigma remained a key reason why younger girls were not accessing services even after speaking with a mobilizer. (Mobilization, "I'm intrigued")
- 9ja Girls messaging, running throughout the LLH sessions, resonates with girls. Yet many girls (particularly older girls) still chose to bypass the classes and access services directly at the facility. Anecdotal reports show that some girls have used the skills they gain from the LLH classes to earn money. (Aspirational Engagement, "I'm inspired and motivated")
- The quality of contraceptive counseling was generally high, with the providers even incorporating 9ja Girls messaging into contraceptive counseling – reinforcing the link between contraception and girls' goals. Girls who opt to go directly to the facility for services are were more likely to adopt a contraceptive method than girls attending LLH classes. (Service Delivery, "I feel respected and safe")
- Follow-up protocols seem to be working well. Ongoing high levels of community stigma suggests girls often keep contraceptive use secret from the wider community. (Follow-up, "I feel supported")

I will come back to the facility, I may call the provider before coming. We were encouraged not to be afraid, that we are safe and that we can come back at any time. Even if the provider has been transferred, I will discuss with whoever is here.

Girl, Ogun

SFH/A360 Nigeria also conducted CEIs, interviewing over 400 girls. Topline findings were mapped against the user journey to inform continued program improvement.

Recommendations stemming from these CEIs which the program will bring into its next project phase include:

- Few girls in lower wealth quintiles make a clear case for assessing 9ja Girls site context and using data to target facilities in rural areas. This also makes an approach which utilizes community-based distributors (CBDs) essential.
- Similar to wealth quintiles, targeting younger girls through a revised mobilization strategy that includes considerations of demographics (such as age and parity).
- Low uptake of LARC coupled with 7 in 10 girls wanting to delay pregnancy for at least 3 years shows clear opportunities for greater LARC use, and a need to continue to build LARC skills of providers, supporting them to counsel girls effectively on the benefits of LARCs without compromising client informed choice.

Figure 23: 9ja Girls CEI findings mapped against the user journey

A360 is reaching mainly **unmarried** girls in **late adolescence without children** and in the **highest two wealth quintiles**

Sample size=433

Mobilization	Most girls hear about the 9Ja Girls event through mobilizers (77%), followed by peers/friends (16.5%). Sixty three percent of girls discussed the event with someone before attending, especially mothers (48%) and friends (31%). Of those, 98.5% felt the person that they discussec the event with was supporting of them attending.
Aspirational engagement	After attending events, 98% of girls had a specific goal for their life/future, 98% felt they could achieve this goal, and 90.5% felt they had the support they needed to achieve this goal. Girls want to delay their pregnancies by varying gaps but mostly by >5 years (46%) or 3-5 years (23%).
Contraceptive counselling & service delivery	Of the girls counselled, 53% chose FP method, mainly STMs. Ninety.five percent of girls said providers respected them as a person and 96% of girls who received a FP method said they were told about other methods.
I feel respected & safe	Eighty-one percent of girls were told about side effects ans 70.5%said they were told what to do if they experienced side effects. 79% of girls intend to continue to use FP, 78% definitely plan to seek future FP information and services, and most have a plan for follow up services (80% of injectable users and 53% of pill users). Nearly all (98%) will recommend 9Ja Girls to a friend.

MMA Performance Highlights

Over the course of A360's full program implementation, MMA saw many shifts in performance. The program was scaled up in Q3 2019 through catalytic investment from a private philanthropist, which resulted in nearly six times the previous number of girls reached with MMA program activities. The program scaled from just 4 sites to over 40 sites within the span of a few months. Overall, program performance remained consistently high throughout the course of the A360 investment, with the project's conversion rate above 85% for most of 2019 through the end of the project. The COVID-19 pandemic contributed to a reduction in activities in 2020, with in-person activities severely limited (see 9ja Girls & MMA: Adapting to COVID-19 below). MMA experienced success in implementing a "hub-and-spoke" model, which allowed spoke facilities to bring services closer to girls and increase their overall access to contraception.

Table 9: Key performance indicators for MMA (2018-2020)

	Nigeria (MMA)
Girls Attending Program Activities	45,371
Adopters	35,641
Continuing Users	2,203
Pregnant Attendees	639
Conversion Rate	84%

Figure 24: Key performance indicators for MMA (Q1 2018 - Q3 2020)

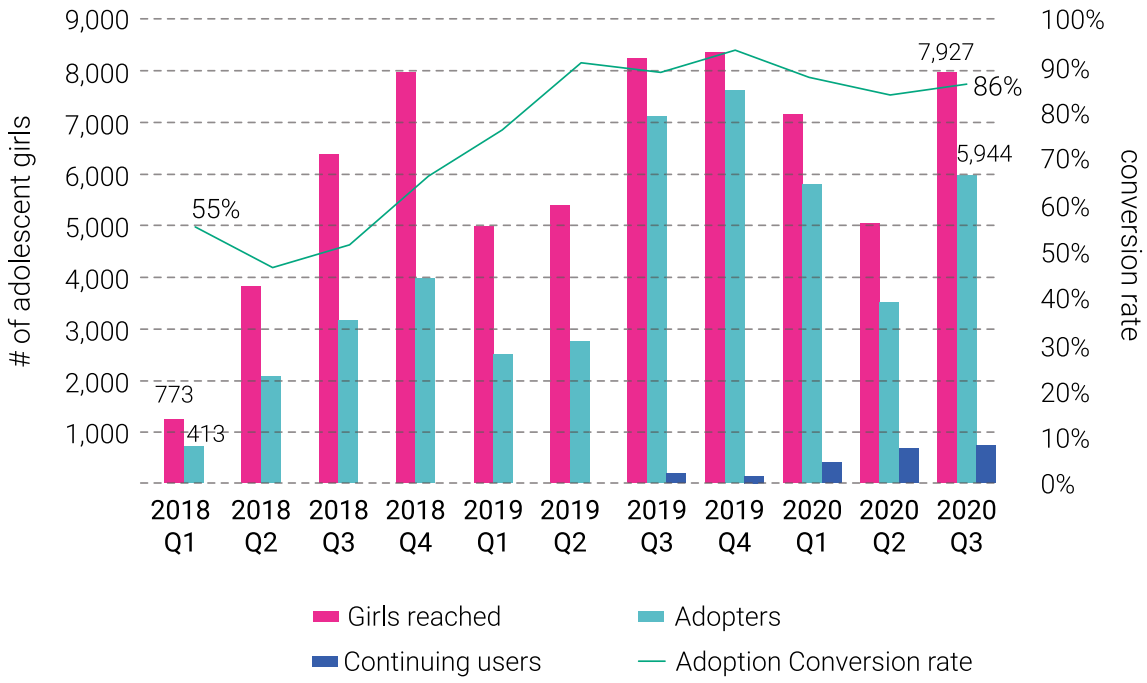


Figure 25: Method mix by year (2018 - 2020) for MMA

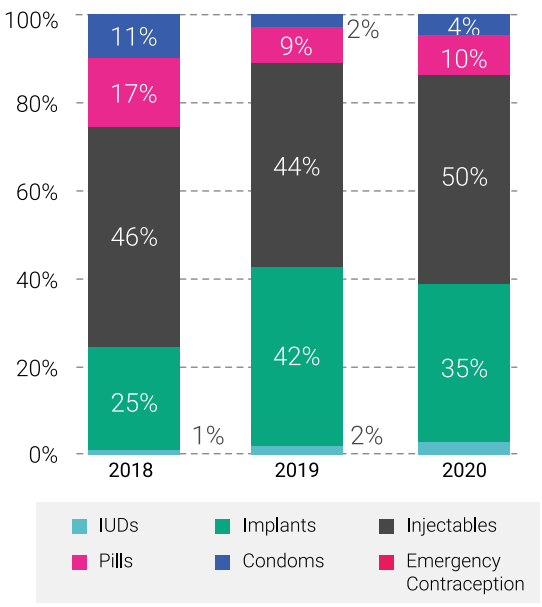
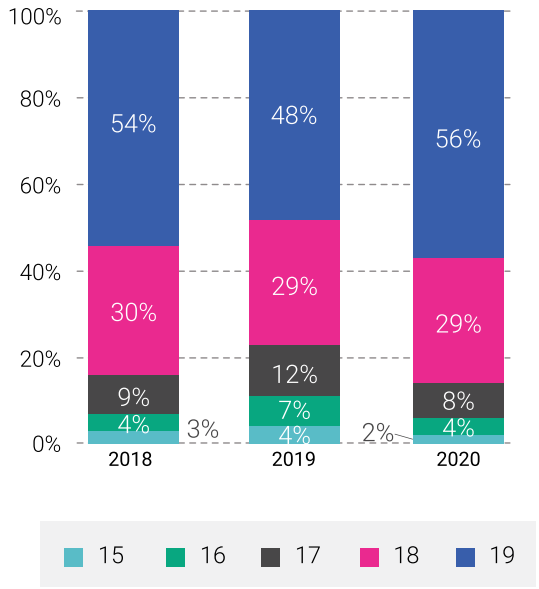


Figure 26: Adopter age by year (2018 - 2020) for MMA



Method Mix: As with 9ja Girls, MMA saw a shift in method mix over the life of project in favor of LARC methods. SFH/A360 Nigeria also incorporated C4C counseling protocols into MMA programming, contributing to stronger contraceptive counseling for girls. Oral contraceptive pills are the most popular method of contraception among married girls between the ages of 15 and 19 in Nigeria in national survey data. In contrast, through MMA, over one third of adopters selected a long-lasting method, with implants being the most frequently selected LARC. Injectables comprised nearly 50% of all services provided, which were made more accessible by the introduction of self-injectables through community-based distribution agents in 2020.

Age Distribution: MMA saw variation across age levels among adopters. While over 50% of users are aged 19, MMA still managed to reach girls as young as 15 and 16 with the LFH curriculum. Under A360 Amplify, SFH Nigeria plans to continue reaching younger girls with LFH classes, with the goal of making contraception more accessible to this population.

MMA Implementation and Learning Highlights

SFH piloted MMA in four sites beginning in January 2018 through until mid-2019. Given limited funding to scale two interventions, SFH/A360 Nigeria strategically chose to focus efforts on scaling 9ja Girls. In August 2019, A360/SFH received funding from an anonymous donor to also scale MMA.

Learning from the client experience (2019-2020): Like 9ja Girls, SFH/A360 Nigeria partnered with Itad to gather robust data on adolescent girls' client experience in order to monitor the fidelity of A360's implementation to the disciplinary foundations of the project (described through the MMA user journey). Participatory Action Research (PAR) data from Itad revealed:

- In northern Nigeria, lack of autonomy was a key barrier to effective mobilization – with girls requiring permission by their husbands or in-laws in participant in MMA activities from participating in MMA. Like with A360's other programs, the vocational and life skills components of the program were important motivators for girls' participation in the program – and for their influencers' support. (Mobilization, "I'm intrigued")
- MMA's LFH curriculum included less of a focus on goals or dreams than A360's other programs. There were some concerns that the sessions were reinforcing harmful gender norms. Generally, girls were highly appreciative of the skills they learned as part of their participation in LFH classes. (Aspirational Engagement, "I'm inspired and motivated")
- There were signs that contraceptive counseling is beginning to shift prevalent myths and misconceptions around side effects among girls and their husbands. A key barrier to adoption was that girls lack the autonomy to make their own choices about whether to use contraception. (Service Delivery, "I feel respected and safe")
- Girls interviewed felt comfortable returning to the facility if they had questions or needed more contraceptives. Follow-up was clearly embedded within contraceptive counseling. (Follow-up, "I feel supported")

"Before now, I was told that anyone who takes contraceptives will not give birth again, but now I know is not true that contraceptive is for child spacing and not child stopping"

Girl, Nasarawa

"The mentor came to our compound to invite us, she told us that we will be learning about how to take care of our family, about nutrition, FP but what got me interested was that she said at the end, we will learn a skill."

Girl, Nasarawa

Figure 27:MMA CEI findings mapped against the user journey

A360 is reaching mainly **out-of-school girls in late adolescence** who are in **monogamous marriages with children** and amongst the **highest two wealth quintiles**

Sample size=428

Mobilization	Most (75%) girls hear about the MMA event through Mentor and over 2/3 (69%) of received mentorship before attending the event. Girls discuss with their husbands (93%) and are supported.
Aspirational engagement	Nearly all (99%) girls have a life/future goal and feel they can achieve it. Girls want to delay their pregnancies by varying gaps but mostly by 1-5 years (80%).
Contraceptive counselling & service delivery	8/10 girls choose an FP method, largely hormonal short-term methods (STMs). Girls feel they are respected by providers (92%) and are informed on the range of Family FP options (96%).
I feel respected & safe	Girls intend to continue to use FP (98%) and have a plan to follow up services, but only 2/3 repor definetly planning to seek future information and services. Nearly all will recommend MMA to a friend (98%).

SFH/A360 Nigeria also conducted CEIs, interviewing over 400 girls. Topline findings were mapped against the user journey to inform continued program improvement.

Recommendations from these CEIs that the project will bring into its next phase include:

- Similar to 9ja Girls, there is a need to target facilities in more rural areas so as to reach the hardest to reach girls, while employing a CBD approach to expand the reach of the program.
- Some concerns with program quality were balanced by girls' feeling that the provider was often talking at them. Training in counseling to sharpen providers listening skills might support more girls to adopt LARC methods and continue method use.

Understanding the gender context (2020): As a project focused on adolescent girls, A360 is acutely aware of the challenges these girls face in accessing health services or making decisions within their families and households. The project recognized its failure to include gender as a specific disciplinary lens during the design process for its interventions. In 2019, findings from A360's process evaluation pointed to a critical need to further understand the role of gender norms in influencing girls' agency and contraceptive decision-making within MMA. A360 partnered with a local Nigerian organization, the Center for Girls Education, to implement a mixed methods research study (conducted in 2020) which aimed: i) to understand the landscape and gendered context which influences the lives of married adolescent girls in Kaduna state in Nigeria, and ii) to assess the impact of this gendered context on the user journey for MMA clients. This research has generated a rich body of evidence on how girls' interactions with MMA are mediated by gender norms that inform their attitudes and shape their experiences.

"After the mentoring group each day I told my husband what I had learned. I told him about how birth spacing will reduce his burdens. He thought about it and said we are poor and didn't want our children to suffer so we should begin after our first child. He said he'd give me the money, but I told him that the only thing I need is his permission because it's absolutely free."

MMA Participant, CGE MMA Gender Assessment

Across the user journey, some of the key findings of the research included:

Table 9: MMA gender assessment key findings mapped against the MMA user journey

Mobilization

A girl's husband is the ultimate decision-maker around her attendance at MMA. Where husbands were reluctant, support from influential community or religious leaders was pivotal. The skills building content of the MMA mentorship groups sessions was an important inducement for program attendance, both with girls and with their influencers. Engagement with male IPCAs was often effective in addressing myths and misconceptions held by husbands about contraceptive use.

"My husband was uninterested in birth spacing but after he met with the IPC, he changed his mind. It would have been difficult for me to convince him, but he listens to other men."
MMA participant, CGE MMA Gender Assessment

Aspirational engagement

While some participants used the skills they developed to sell products they learned to make, the vocational skills content of the program didn't always meet expectations. However, participants also saw value in the other topics contained in the MMA curriculum. A number of husbands, particularly those who were more educated, said they appreciated better overall communication with their wives due to the skills they learned in the MMA sessions. Girls often said they were more comfortable initiating a conversation with their husbands about contraceptive use after participating in MMA's programming.

"I thought my husband knows everything and whatever he says is what I must do. After MMA I began talking with him about what I thought, and I was surprised to see that he was happy with this. Now if he is doing something that I am not happy with I am able to tell him in a way that he will accept."
MMA participant, CGE MMA Gender Assessment

Contraceptive counselling & service delivery

Service providers delivering MMA counseling were seen as trusted and discreet. Girls indicated that prior to attending MMA, many health personnel did not discuss side effects with them. In contrast, MMA participants reported awareness of side effects, and knew that they could seek help at the health center to manage them. If girls anticipated that they would not have support from their husband for using contraception, girls often either did not adopt a method, or accessed one covertly.

> **"My husband followed my judgement and followed me to the hospital so we could start spacing our children."**
> MMA participant CGE MMA Gender Assessment

Follow Up

70% of girls in one research site where MMA had been implementing longer had discontinued method use. While participants were generally well-informed about contraceptive side effects, this was still the primary reason for discontinuation. Girls often visited the facility when they experienced difficulty, something which is not common among the general population of adolescent girls, but if the issue was not resolved within one to two visits, many discontinued.

9ja Girls & MMA: Adapting to COVID-19: During the early days of the COVID-19 pandemic, the government of Nigeria began imposing limitations on in-person gatherings and travel. To ensure that girls had access to providers and were able to continue attending LLH classes, the SFH Nigeria team pivoted programming to be held via a live text-based WhatsApp class run by health providers. Interested girls were connected to the classes by mobilizers and through the 9ja Girls Facebook channel. During the session, girls had opportunities ask question as a group or invited to message the provider 1:1. Over the next several months, providers continued to hold virtual classes and Q&A sessions with girls, who could ask questions in real time or be connected with a provider for confidential follow-up questions. These girls would also be directed on how to access their nearest clinic for services. SFH/A360 Nigeria additionally expanded social media presence for 9ja Girls through its Facebook page, creating the opportunity for girls to access regular aspirational content that alternated between SRH and life skills. Live chat sessions were held on Fridays where girls could engage directly with providers and mentors.

Once restrictions began to ease, community-based distribution agents were trained to access communities as part of the modified outreach strategy to distribute oral contraceptive pills and self-injectables. These agents would be connected with a clinic, but could meet with girls in one-on-one, socially-distanced settings at their convenience to limit the girls' exposure to others at clinics. Providers and mobilizers were provided with Personal Protective Equipment (PPE) and girls were given information on how to prevent COVID-19 transmission.

"I am happy with the WhatsApp LLH as I can ask questions in emergency situations and get response without anyone knowing who I am."
Adolescent Girl, southern Nigeria

Tanzania

Key Performance Highlights

Over the life of the project, Kuwa Mjanja accounted for over 220,000 girls voluntarily adopting a modern method of contraception. This program had some of the earliest adopters, with implementation beginning early under the investment from project designer Pam Scott. Program performance through Kuwa Mjanja reflects over half of A360's total adopter performance for the entire project globally. Kuwa Mjanja was able to reach a tremendous number of girls in its three years of its implementation. The peak of Kuwa Mjanja's performance came in mid-2019 as the program shifted its strategy to conduct mobilization through schools, and saw tremendous numbers of girls attending events as a result.

Table 10: Key performance indicators for Kuwa Mjanja (2018-2020)

	Tanzania
Girls Attending Program Activities	314,155
Adopters	220,430
Continuing Users	8,076
Pregnant Attendees	16
Conversion Rate	72%

Method Mix: LARC methods account for nearly half of all uptake among Kuwa Mjanja adopters. Most girls in Tanzania between the ages of 15 and 19 rely on condoms as their preferred method, in contrast to high rates of implant uptake among Kuwa Mjanja adopters. However, condoms remain a popular option among some Kuwa Mjanja users, particularly younger aged adopters. Though Kuwa Mjanja saw even greater LARC uptake near the beginning of implementation (2018), increased mobilization through schools had an impact on shifting the project's method mix towards greater short-term method uptake.

Age Disaggregation: Among A360's programs globally, Kuwa Mjanja had the most balanced method mix – nearly 50% of Kuwa Mjanja adopters were between the ages of 15 and 17, compared to predominantly 18 to 19 year olds within A360's other interventions. Increased mobilization through schools in 2019 contributed to the shift in age demographics to favor younger adopters, just as it also contributed to a shift in method mix towards short-term methods. As A360 transition into its next project phase and considers how to strengthen engagement with schools, this will be a key area of focus.

Figure 28: Key performance indicators for A360 Tanzania (Q1 2018 - Q3 2020)

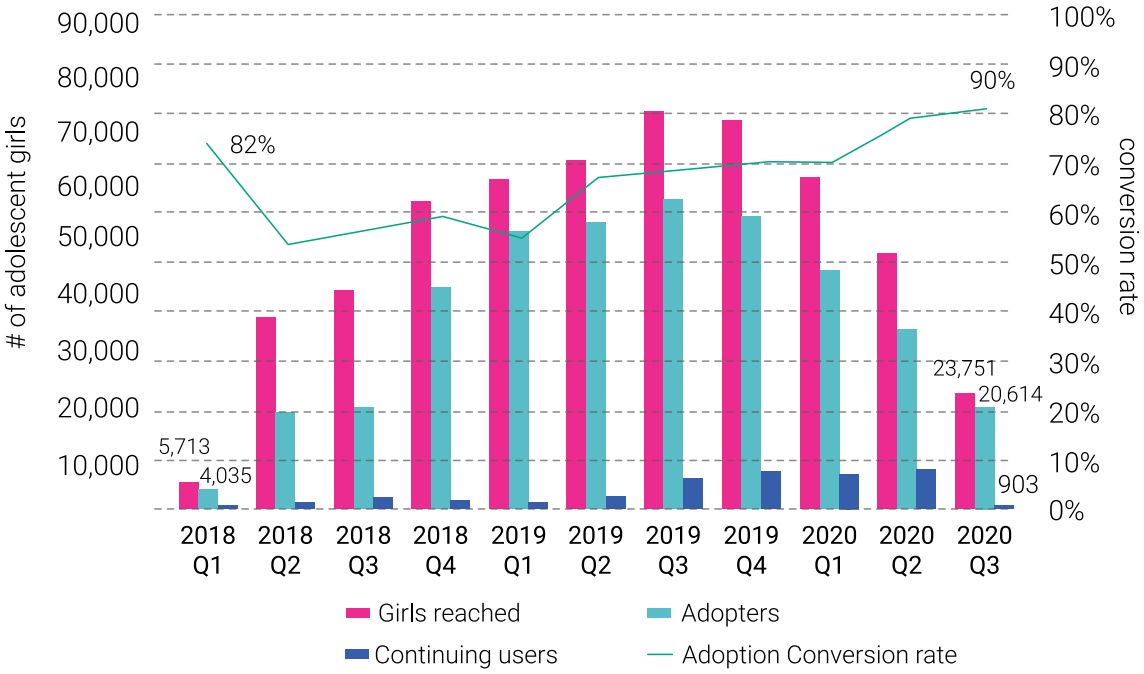
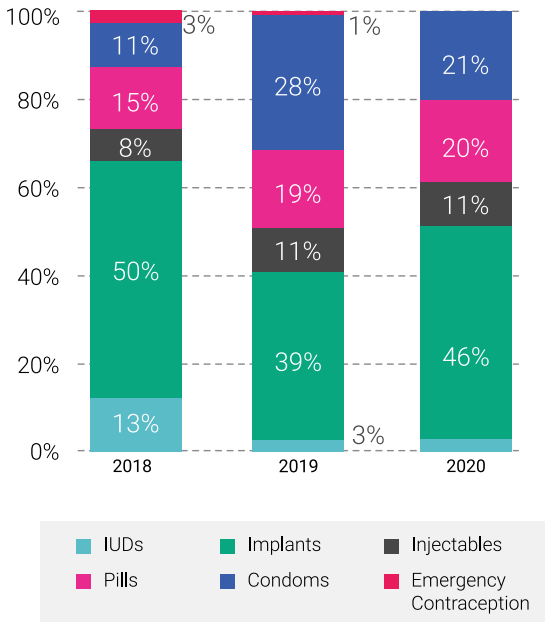


Figure 29: Method mix by year (2018 - 2020) for Kuwa Mjanja

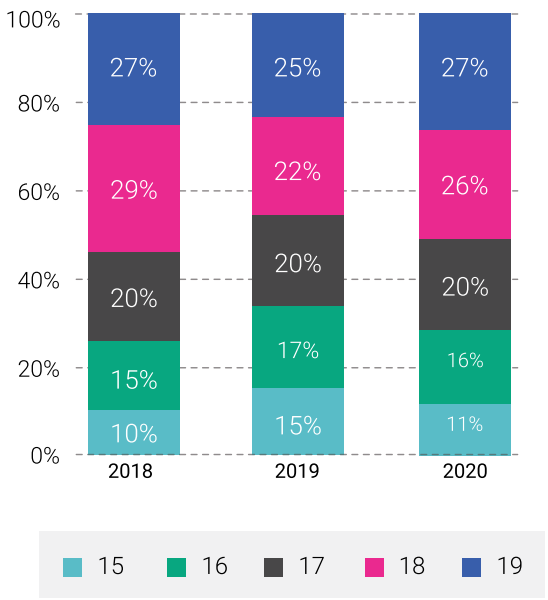


Implementation and Learning Highlights

Among A360's country programs, Tanzania was the quickest to move to scale – reaching over 300,000 girls and constituting half of the project's global adopter target. A360 Tanzania was also a hub for innovation – particularly around approaches for continued meaningful youth engagement and use of digital tools.

Meaningful Youth Engagement (2018-2020): MYE and youth-adult partnerships have been part of A360's core strategy since the project's inception. Youth were meaningfully involved throughout the project's design phase as co-researchers, data collectors, and analysts. These contributions were vital to developing

Figure 30: Adopter age by year (2018 - 2020) for Kuwa Mjanja



the program models. As A360 Tanzania moved into implementation, it continued to build on these priorities around youth engagement.

Kuwa Mjanja Queens: During A360's design phase, the project began to consider how it would like to meaningfully engage adolescent girls, involving them in program implementation beyond the initial design phase. As a result, the project created a special cadre of adolescent co-implementers – Kuwa Mjanja Queens. Kuwa Mjanja Queens are adolescent girls, usually 18-19 years old, who previously attended an A360 event and have indicated an interest in continuing to support the program. KM Queens function as mobilizers before events and implementation support during events. Early in A360's implementation phase, KM Queens functioned as critical support structures, particularly during out-of-clinic pop-up events which often had greater attendance. As the project moved to the latter stages of its implementation period, the team expressed a greater desire to do more to support engagement, retention, and capacity building for this cadre. During A360 Tanzania's gender workshop, the A360 team discussed this desire to expand its engagement of Kuwa Mjanja Queens – both to make them a more concrete part of program implementation and also to give further training and support to their development of self-efficacy and agency. In response, A360 Tanzania decided to create a second "tier" of Kuwa Mjanja Queens ("Super" Queens) who received an expanded training curriculum to prepare them with greater knowledge of SRH topics and leadership skills to enable them to take on greater responsibility for organizing other Queens in their geographic area. This training was rolled out in early 2020, though further action was delayed given the onset of the COVID-19 pandemic.

SWAT Teams: In early summer 2019, anticipating high attendance at Kuwa Mjanja events during the summer months, A360 Tanzania took the opportunity to engage youth in a key way. The team knew that field teams needed impartial observers to help them manage and improve event flow and efficiency so that all girls received the same quality programming at Kuwa Mjanja events regardless of the high volume of attendees. With new teams joining A360's roster there was also a need for support to these teams to maintain fidelity to the Kuwa Mjanja model. To meet these

needs, A360 Tanzania recruited and trained a group of 10 young professionals (in their early 20's, recently graduated from university) to be seconded to field teams in each of A360's regions. Playfully termed the youth SWAT team, these young professionals organically evolved to play a key role in A360's commitment to adaptive implementation.

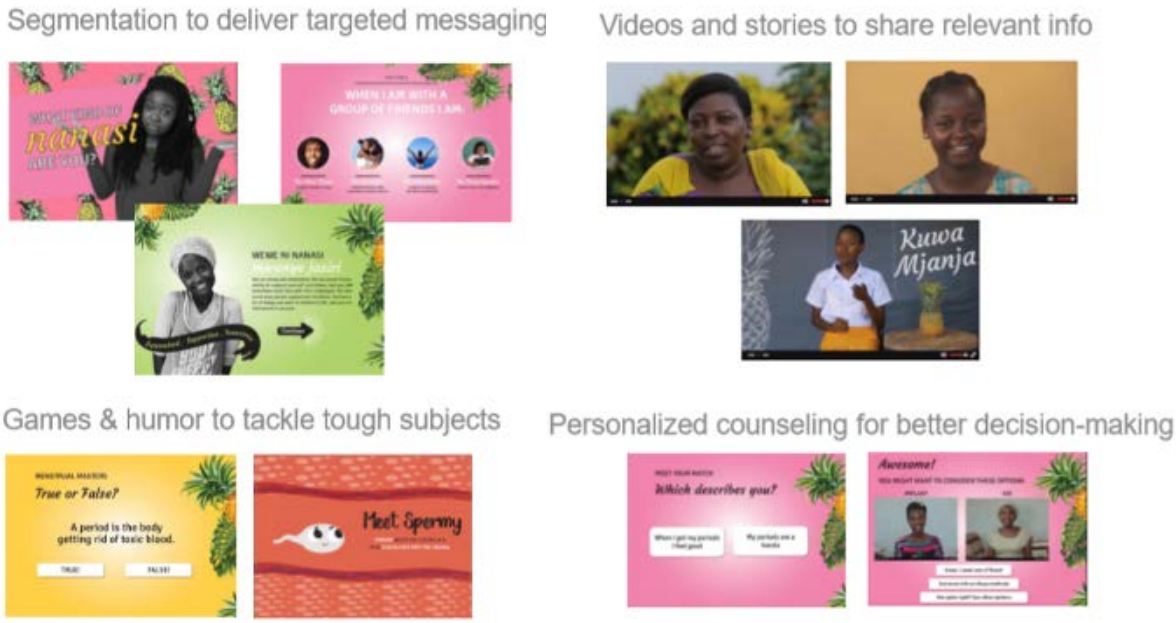
SWAT team members played a role in implementing Kuwa Mjanja events, simultaneously recording observations on problems and areas of improvement. These observations were channeled through a WhatsApp thread, shared between SWAT team members and A360 Tanzania staff, where participants could validate and share similar observations and brainstorm solutions to improve girls' experience at events and ensure that teams were able to manage high volumes of attendees.

As an example of how insights from this team informed adaptations to Kuwa Mjanja, SWAT team members noticed that once girls had moved from the vocational training session through the opt-out counseling moment, there was a gap in programming. Girls at that point, without anything to keep them occupied while they waited for their friends to make their way through the counseling moment, were often reconvening with their friends and leaving before each of them had a chance to receive counseling from a provider. SWAT teams innovated to introduce games during this point, keeping girls engaged while waiting and reducing the chance that girls may desire to leave before engaging with the full program.

Digital Innovation (2018-2020): Implementation of Kuwa Mjanja through A360's programming included use of various digital solutions to reach clients, provide health information, and issue referrals for services. These digital solutions are a part of PSI Tanzania's Interpersonal Communication (IPC)-centered approach.

Mjanja Connect: In 2018, through leveraged investment from the Vodafone Foundation, PSI Tanzania built on the design insights from A360's formative research to develop Mjanja Connect, an interactive pre-counseling Android app that supports community health mobilizers to connect with and refer girls aged 15-19 to reproductive health services. Mjanja Connect delivers PSI Tanzania a new way of reaching girls with SRH information, and then tracking how and when they engage with the health clinic for contraceptive services. Mjanja Connect fills in the gaps in how A360 reaches its consumers with SRH information that speaks to girls' concerns and needs. The app includes:

Figure 31: Images from A360's Kuwa Mjanja application

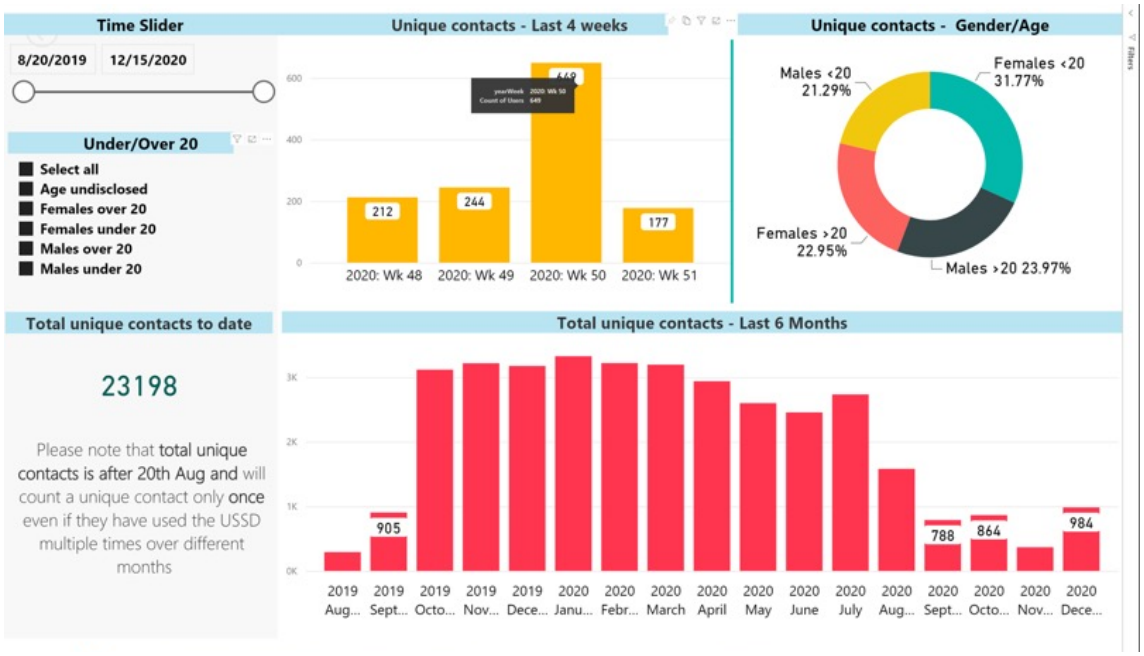


- Buzzfeed style quizzes which inspire girls to consider their aspirations in a fun and inviting way.
- Testimonial videos from "girls like me" speak to, to debunk the myths around modern contraception.
- The app gives community health mobilizers youth-resonant language to connect the dots for how contraception can help girls reach their self-defined life plans.
- The app closes out with suggested method options, and then a referral which girls can redeem at a clinic. This tracks girls' pathway to care, ensuring no information is lost, nor duplicated, between visits.

A360 Tanzania has continued to adapt and innovate around use of Mjanja Connect throughout the project's implementation phase.

USSD: Beginning in Q3 2019, PSI Tanzania expanded the use of these digital solutions by rolling out an unstructured supplementary service data (USSD) pilot to reach more adolescent girls and boys with contraceptive information in a cost-effective and efficient way. As an added benefit, the data generated as clients access information within this USSD will inform A360's continued pursuit of improved services for adolescent girls through its programming. Under this pilot, clients use mobile phones to access information or seek further care

Figure 32: Dashboard displaying reach from A360 Tanzania's USSD code



through a free and accessible USSD portal that enables discreet access to health education and information. To create demand, A360 included a free number on existing health promotion materials directing clients to the platform. This low-touch intervention led to approximately 100 platform users per day. To better understand the consumers, identify and address emerging gaps, data management and analytics was done using PowerBI software that captured clients' engagement data on a real-time basis, allowing for continuous improvement of services.

Since the USSD pilot was rolled out in early Q3 2019, there has been over 25,000 unique contacts with the platform (comprising 32% women < 20 years old; 23% women > 20 years old; 21% men < 20 years old; and 24% men > 20 years old). In partnership with the SIFPO2 project, funded by USAID and implemented by PSI Tanzania, A360 conducted an evaluation of the USSD platform, assessing whether use of the platform had any impact on method satisfaction among contraceptive users (aged 18+). Though results of that evaluation were inconclusive, further adaptation and strengthening of this platform remains a key potential focus of the digital strategy for A360's follow on investment.

FROM A360 TO A360 AMPLIFY

Over four-and-a-half years of design and implementation, A360 has remained focused on supporting local health system actors to better reach and respond to the SRH needs of married adolescent girls. By recognizing and supporting the needs and aspirations of girls themselves, including vocational and life skills to pursue a stable future, health systems gain a pathway to improved modern contraceptive coverage. A360 has worked to advance an innovative multi-sectoral approach to ASRH in partnership with federal, state, and local governments, community leaders, and marital partners, and aims to continue building local implementation capacity to sustain this model into the future.

Although A360's initial investment period ended in September 2020, additional funding has been secured to extend programming through 2025 under a new project called A360 Amplify. With this investment, the A360 consortium will focus on three key areas: adaptation of A360's interventions to improve effectiveness; institutionalization within public health structures and government-led scale 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. The project commits to further exploring cross-sectoral opportunities that can help girls achieve their life goals, and to support girls and governments to understand how contraception can be an effective tool to delay first birth, avert unplanned pregnancy, and effectively achieve these goals.

KEY ACHIEVEMENTS

FROM A360'S FIRST INVESTMENT PHASE

(2016-2020)

A360 psi SFH