ADOLESCENTS 360

Supporting Scalable, Youth-Powered Programming at the Community Level in Ethiopia:

The Case of *Smart Start*

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In the past three decades, global health programs aiming to improve adolescent and youth sexual and reproductive health (AYSRH) have yielded a number of notable successes.[1] As the field of AYSRH evolves, however, questions remain about how to best design and implement youth-powered programming—demonstrably responding to the needs and experiences of youth, allowing them to equally partner in programs aimed at their health and well-being, and ultimately enabling their meaningful advancement in health, livelihood, and development. At the same time, the AYSRH field continues to advance its understanding of how to shape and refine these youth-powered programs to be implemented sustainably at scale.

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 program 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. This technical brief presents the case of Smart Start, A360's intervention in Ethiopia, offering lessons for similar AYSRH programs seeking to design and implement scalable, sustainable, community-based programming for adolescents.

Context

Adolescence Globally

Adolescence—the stage of life between ages 10 and 19—is defined by paradoxes. Adolescents establish vital behaviors, skills, and mindsets that will endure throughout their lives—at a time during which they are at heightened vulnerability to adverse outcomes. During this period, the dynamic, developing brain is primed for learning, presenting programs with a unique opportunity to intervene early and support adolescents in gaining critical health-related knowledge and establishing healthy behavior patterns.[2,3] Yet, adolescents face a range of social, systemic, economic, and political barriers that prevent them from accessing information, services, and support—inclusive of and beyond sexual and reproductive health (SRH)—at a time when they are most in need.[4]

Adolescence is also a vital period for defining life aspirations—relating to education, economics, and livelihoods, and family—which are critically important for adolescents' capacity to effectively shape and pursue a stable future for themselves.[5] Marriage and, even more so, pregnancy, can have significant effects on girls' aspirations—with self-directed hopes and dreams often dramatically reduced or redirected to aspirations for their children.[6] However, evidence suggests that when adolescents have positive educational, economic, and/or relational aspirations, they are more likely to use modern contraception.[7, 8]

Adolescents' health needs do not exist in a vacuum. Global AYSRH programming has come to acknowledge that young people's problems are interconnected—across the spectrum of fields and disciplines—and require a holistic approach.[9] The evidence base demonstrates that factors such as robust pro-social relationships (those which benefit others either individually or collectively); belief in the future and self-determination; and various forms of cognitive, social, and behavioral competence are all protective factors for health outcomes among adolescents.[10,11] Yet, adolescents' future orientation, self-efficacy, and competence are impeded by a myriad of hurdles which face young people in their quest for a stable future—from high levels of unemployment to resource scarcity and inadequate support networks.[12] Just as the problems young people face are intertwined, so their solutions must be, too.

The unique restrictions that married adolescents face regarding contraceptive use—often as a result of social and religious norms around fertility—have considerable downstream effects on their health and wellbeing.[13–16] Many of the nearly one third of girls in low- and middle-income countries (LMICs) who are married or in a union before age

Table 1: Sexual and Reproductive Health Landscape in Ethiopia

For the nearly one-fifth of adolescent girls in Ethiopia who are currently married, the likelihood of poor maternal and reproductive health outcomes is higher than for all women of reproductive age. Girls who are married before age 18 have higher rates of adolescent births and worse maternal and neonatal outcomes. These inequities are heightened among rural adolescents, who are four times more likely to have given birth by age 18 as their urban counterparts. A high proportion of rural women live in close distance to a health post but use of contraception is still significantly impacted by even two kilometers of additional travel required to seek services at the health post, pointing to the importance of community-level access to SRH services.

National trends	
Median age at first sexual intercourse, women aged 25-49[26]	**16.6**
Median age at first marriage, women aged 25-49[26]	**17.1**
Median age at birth of first child, women aged 25-49[26]	**19.2**
Total fertility rate (Number of births per woman): rural, urban[26]	**5.2, 2.3**
% of girls currently married or in union, aged 15-19[26]	**17.4%**
Contraceptive use and fertility among adolescent girls and young women (AGYW)	
Total demand for contraception, currently married girls aged 15-19[26]	**52.5%**
Modern contraceptive prevalence rate (mCPR), currently married girls aged 15-19[29]	**36.5%**
Median age at first contraceptive use, women aged 25-49: rural, urban[30]	**24.2, 21.6**
Average number of children at first use of contraception: rural, urban[30]	**3.1, 1.2**
% of adolescent pregnancies occurring in the context of marriage[26]	**82%, 9% – 83%**
Women aged 20 to 24 who gave birth by age 18: rural, urban[31]	**25.9%, 6.2%**
Health outcomes and access to services	
Pregnancy-related mortality rate, per 100,000 live births[26]	**412**
Neonatal mortality rate, per 1,000 live births: women aged 15-49, girls <20[28]	**28, 62**
% of unintended adolescent pregnancies ending in abortion: legal, illegal[32]	**29.4%, 16.6%**
% rural women living within 5km of nearest health post[33]	**93.9%**
mCPR among rural married women 14-59: living <2km away from a health post, living 2-3.9km away from a health post, living 4km or more away from a health post[33]	**41.2%, 27.5%, 22%**

(26) Demographic and Health Survey 2016; (28) WHO, UNICEF, UNFPA, United Nations Population Division and the World Bank 2015; (29) Mini Demographic and Health Survey, 2019; (30) PMA2020, 2016; (31) Ethiopian Federal Ministry of Health and Population Council 2017; (32) Sully et al, Journal of Adolescent Health, 2018; (33) Shiferaw et al, PMA2020, 2017

18 experience cycles of rapid and repeat childbearing that result in poor health outcomes and future instability for themselves and their families.[17] Complications during pregnancy and childbirth are the second leading cause of death among adolescent girls, and children born to adolescents have higher mortality rates and inferior health and nutritional status.[18–22] Furthermore, girls married during adolescence experience adverse future economic outcomes, such as lower educational attainment and higher rates of poverty.[23,24] Given the historically limited programming designed specifically to help young married couples in LMICs delay first pregnancy, it is little surprise that a recent analysis concluded that married adolescents without children present the lowest modern contraceptive prevalence of any group in all world regions, ranging from 2.9% in West and Central Africa to 29% in Latin America and the Caribbean.[25]

Adolescence in Ethiopia

In the context of Ethiopia, girls tend to marry on average at just past 17 years of age; and age at sexual debut, age at first marriage, and age at first birth are closely linked. Girls typically follow this trajectory from sexual debut to initiation of childbearing all before age 20.[26] Although the revised Family Code of 2000 sets 18 years as the minimum legal age of marriage, according to recent estimates by UNICEF and the Ethiopian Ministry of Women and Children Affairs as of April 2019, nearly 40% of young women in Ethiopia were married or in union before their 18th birthday.[27]

Demand for contraception among married adolescents in Ethiopia is low. Only slightly more than half of married adolescents indicate a desire for contraception, with total unmet need at just over 20%.[26] Yet, adverse outcomes from early childbearing are an acute reality for girls, demonstrated by high levels of maternal and child mortality.[28] This reveals a clear misalignment between girls' reproductive desires and decision-making and the demonstrable health risks posed by too early and too frequent childbearing. For programs wishing to support the health system in addressing this misalignment, understanding the reasons behind girls' desired fertility is therefore paramount.

Over three-quarters of Ethiopian adolescents and youth (aged 10-24) reside in rural areas and rural-urban inequities in access to SRH services are critical and persistent. Rural youth are more likely to be sexually active, driven by high rates of early marriage in rural areas, but less likely to use contraception in comparison to their urban counterparts. Likewise, unmet need for contraception is substantially higher in rural areas, contributing to higher rates of adolescent pregnancy.[26,31]

Within Ethiopia, concerns over resource scarcity have been heightened in previous years. Heavy dependency on agriculture as a primary income source coupled with low farm productivity present major food security challenges for the country.[34] Ethiopia's population is growing at one of the fastest rates in the world, with concerns that at its present rate, Ethiopia's population will double in the next thirty years, significantly increasing demand for limited land, water, energy, food, and other resources.[34]

HEW Responsibilities under the HEP

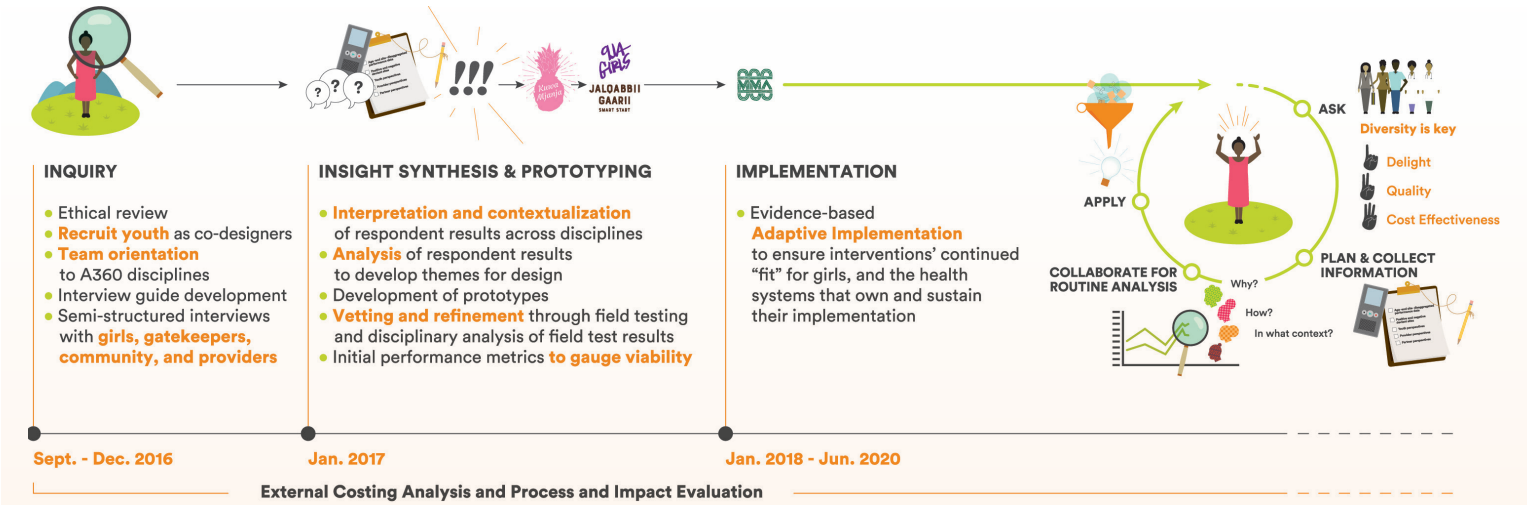
- Under the HEP, services are provided by Health Extension Workers (HEWs), namely trained community members whose health posts form Ethiopia's lowest level of primary care at the community level.
- HEWs spend half their time conducting home visits and outreach activities, with the remaining half at their health post providing basic curative, promotive, and preventive services.
- Two HEWs on average are assigned to each health post, one per kebele. (A kebele is the smallest administrative unit in Ethiopia, similar to a village or neighborhood)
- Five health posts and a health center (or hospital) work in collaboration and together form the primary health care unit (PHCU).
- The essential services offered by HEWs consist of 16 health packages that cover family health, disease prevention and control, personal and environmental hygiene, and health education and promotion.

Health System Context

Within Ethiopia most services are provided through the public health system, with over 80% of contraceptive services accessed through public providers.[26] In the past decade, the Ethiopian Federal Ministry of Health (FMOH) and outside sources have poured resources into expanding the public health system's capacity to reach Ethiopia's vast rural population. The Health Extension Programme (HEP), launched in 2004, aims to accelerate community-based provision of essential health services, including contraception. Since the HEP's inception, Ethiopia has considerably extended coverage of healthcare services, and seen resulting improvements in health outcomes.[35] The progress made through the HEP is challenged by a growing concern over the difficulties facing Health Extension Workers (HEWs) as a result of the size of their average catchment population and of the package of health services that they provide, both of which have continued to grow over time, straining HEW cadres' service provision capacity.[36,37]

In response, the Ethiopian FMOH has worked extensively to design the second generation of this program, the HEP2. Strategic objectives under this second generation include expanding the number and technical capacity of HEWs while also expanding the package of services they provide.[38]

Figure 1: A360 Process & Timeline



Though the HEP has been successful in expanding accessibility and quality of primary care in Ethiopia, adolescents remain an underserved population. Until this point, HEWs have played a limited role in the provision of AYSRH services, with only 5% of rural adolescents indicating that they received contraceptive information from a HEW.[31]

Technical Strategy

Research for Design

A360 brought together a consortium of experts with knowledge and experience in adolescent developmental science, anthropology, and human-centered design (HCD), alongside young people, to complement and challenge its own public health and social marketing expertise, designing the program to follow four phases: 1) inquiry; 2) insight synthesis; 3) prototyping; and 4) adaptive implementation. This structuring allowed for the different disciplines to interrogate and test ideas, maintaining curiosity and a commitment to respond in real-time to the insights that emerged about girls' experiences and desires. For further details see *Pursuing Youth-Powered, Transdisciplinary Programming Across Three Countries: The Case of Kuwa Mjanja*.

Methods

To ensure youth perspectives consistently informed decision-making and intervention design, A360 recruited and trained young people in Ethiopia to work alongside the project's consortium of experts as co-researchers and analysts throughout the project's research for design process. Working together, between 2016 and 2017 multi-disciplinary youth-adult design research teams conducted 294 semi-structured interviews across four representative study locations (Addis Ababa, Afar, Oromia, and Tigray). Respondents included adolescents, their key influencers, community stakeholders, and service providers, with teams employing a variety of supplemental design research methods including photo narratives, trusted sources, storytelling, and direct field observation. Teams conducted data analysis through collaborative theming workshops in which youth-adult teams worked to reach consensus on the meaning and significance of findings. This ensured that resulting synthesized insights reflected both the disciplinary expertise of the project's consortium as well as the perspectives of youth co-designers. Prototypes were iteratively designed, field tested, and revised following similar collaborative analysis and decision-making processes within youth-adult design teams. Reflecting the project's commitment to ethical engagement of young people, Institutional Review Board (IRB) approval was obtained for all design research activities.

Findings – Insight Synthesis

Design research findings painted a clear picture of girls' lives, desires, and needs, reflected in five dominant themes and sub-themes.

Anxiety About the Future

In Ethiopia's rural and agrarian regions, interviewees signaled an acute awareness of changing times, with many community stakeholders voicing an anxiety for girls' and boys' futures. Though marriage, followed by early and frequent childbearing, was no longer perceived as a reliable strategy for achieving future security, they expressed limited confidence in alternative pathways to stability. Alongside this, adolescent girls and boys conveyed anxiety about how to shape and achieve satisfying lives based on more than marriage and early childbearing alone, sharing a sense of urgency to learn how to generate and manage their own money, or become small business owners.

> ***"Moms aspire for their girls to finish school... but getting a job is 'luck'."***
>
> *Parent, Addis Ababa*

> ***"We want to change ourselves to have a better future with lots of money."***
>
> *Unmarried girl, Afar*

Youth Advocacy for Design

Youth voices often proved critical not only in framing research for design from a youth perspective, but also in advocacy with key government stakeholders. In the case of A360, when the FMOH expressed hesitation in the value of waiting for a lengthy design process to conclude before implementation, youth voices were critical in making the case for how a comprehensive design process would yield an intervention that was both effective at scale and ultimately responsive to the needs of young people.

Aspirations

Motherhood as the Achievable Dream

Insight synthesis revealed how this perception of scarcity and mistrust of alternative pathways to stability informed girls' perspectives and prioritization. Though girls recounted having a range of aspirations, many of them perceived these goals as unattainable and even, at times, at odds with one another. This landscape of "competing joys" created the parameters through which girls' and their influencers' perceived and made decisions on which aspirations consistently led to a stable future. Motherhood was held as a central and enduring aspiration. A desire for education as a pathway to stable employment and income, though valued, was counteracted by a perception of educational attainment as unachievable. Even if education was achieved, interviewees were uncertain that it would be sufficient to secure employment. Furthermore, according to respondents, the time and resources required to pursue education could pose a risk to girls' eligibility for marriage by creating a perception of girls as too old, educated, or accomplished for marriage. By contrast, motherhood was viewed as a highly attainable aspiration that could reliably secure both personal joy for girls, as well as good social standing.

> ***"Having the first child is respect. You start to be called by the name of your child."***
>
> *Unmarried girl, Oromia*

> ***"What disturbs our minds is that many of these kids whom we send to school, many end up neither having a good marriage or a good education."***
>
> *Parent, Oromia*

Contraception as Irrelevant and/or a Threat to Girls' Dreams

In many cases, girls saw contraception as a threat to their ultimate dream of motherhood due to myths and misconceptions that reinforce perceived linkages between contraception and future infertility. In this light, use of contraception was viewed by girls as risking their ability to achieve social standing and security. Even in instances where contraception was not an outright threat, its use was frequently portrayed as being misaligned with girls' identities. For unmarried girls, use of contraception connoted sexual promiscuity, and for married girls, pressure and desire to be a willing steward of their family's childbearing goals negated the relevance of contraception. Newly married couples, even when they desired to delay the birth of their first child, experienced pressure to prove fertility. Use of contraception, therefore, represented a threat to their social stability.

> ***"It's a must to have the first baby as soon as possible after marriage."***
>
> *Married girl, Oromia*

> ***"[A girl who uses contraceptives] might age and not get the child when she wants it."***
>
> *Mother of adolescent girl, Tigray*

Isolation and Decision-Making

Girls' sense of urgency, as referenced above, to manage the changing times and secure a stable future, was balanced by their understanding of their own vulnerability and isolation. Married adolescents often found themselves particularly isolated—severing contact with old friends and experiencing limited and supervised social interactions. Girls and their partners actively expressed a desire to counteract this isolation by cultivating meaningful ways of making joint decisions around health, family, and overall wellbeing. However, this desire for joint decision-making was undermined by limited knowledge and agency to do so. Husbands, though keen to learn more, were uninformed about the methods and value of contraception. Simultaneously, girls expressed an eagerness to learn how to initiate and facilitate conversations around these topics with their partners.

> ***"It's good to learn [about contraception] together. I'd want us both to know!"***
>
> *Husband, Oromia*

Intervention Description

Following this period of research synthesis, A360 mapped out a technical strategy in response to the insights generated. This process was supported through an analysis of global literature and incorporated lessons from the multiple disciplines within the A360 consortium (see Table 2 for a summary).

Smart Start Messaging

Smart Start's technical strategy centers on a transformation of the individual client-provider interaction, supporting HEWs to respond with precision to adolescents' social,

Table 2: Summary of Smart Start design research findings

Insights generated during A360's formative research phase underpin Smart Start's technical strategy.

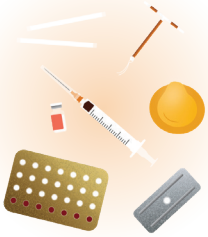
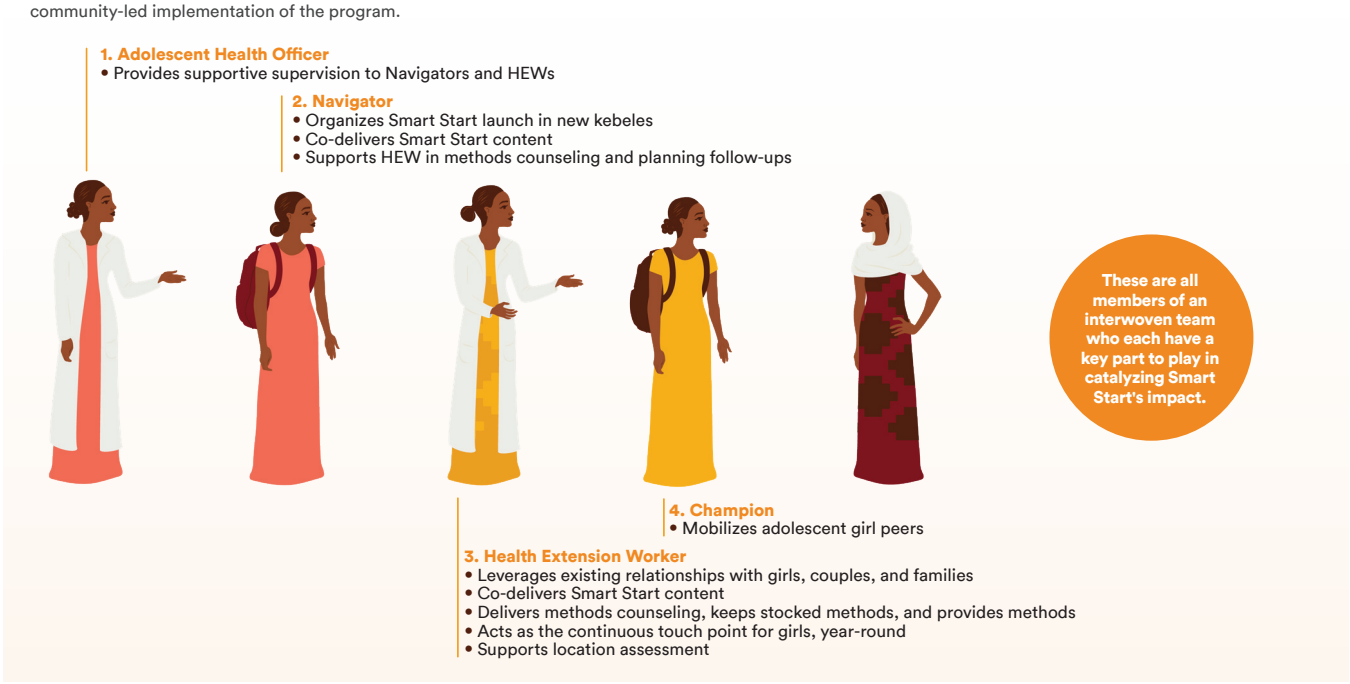
	Insight Synthesis		Technical strategy in response
	**Anxiety over the future**		
	Girls and their influencers both experience anxiety and concern over how to secure a stable future for themselves and their communities. They acknowledge that there is resource scarcity and a shifting economic landscape which requires new ways of living. They have limited confidence in their own capacity to secure a desirable future for self and family.	»	Smart Start supports girls to map out the steps needed to achieve the future financial security that they desire for their families.
	Girls need support to feel a sense of self-efficacy to pursue their goals and shape the lives that they want.	»	Smart Start supports HEWs to begin the conversation by validating girls' aspirations and beginning to sketch out a financial and family plan in pursuit of those aspirations—whether economic, social, or reproductive.
	**Aspirations**		
	Motherhood as the achievable dream Despite a multitude of aspirations early in life, girls' aspirations reduce to those perceived as attainable. Amidst scarcity of opportunities, motherhood is valued as the primary attainable aspiration.	»	Smart Start begins with the affirmation that girls' dreams are valid, and that a wider array of aspirations are attainable and can be pursued—without competing with girls' dreams of motherhood.
	Contraception as irrelevant to girls' dreams Adolescents have a heightened need to feel respected and accorded status, increasing the importance for health interventions to establish trust by demonstrating respect for girls' priorities for their lives—as they define for themselves.[39]	»	Smart Start supports HEWs to build needed trust with adolescent girls by inquiring about girls' and couples' aspirations and supporting them to set financial plans to achieve them, thereby demonstrating respect and legitimating adolescents' power to set their own goals for their lives.
	Expectations for early marriage and childbearing lead to married girls' perception of contraception as irrelevant to their life and aspirations.	»	Smart Start positions contraception as in service of girls' and couples' self-defined aspirations, and as a tool to stay on track to achieve them, protecting her fertility and allowing her and her husband to begin childbearing when they feel it is right for them.
	Adolescents' shifting hormonal surges result in shifting motivations between those for stability (intrinsic motivation) and those for peer recognition and social status (extrinsic motivation).[2] As such, traditional public health messages that appeal only to motivations for positive health outcomes do not consistently align with adolescents' own motivations.	»	Smart Start's messaging resonates with adolescents across the spectrum of shifting motivations. The achievement of financial resources—such as a cow, house, or shade tree—can be perceived both as status symbols (speaking to extrinsic motivation) or ways to pursue stability (speaking to intrinsic motivation).
	**Isolation and Decision-Making**		
	Once married, girls experience isolation from social networks and feel that they have few trusted supports.[17]	»	Part of Smart Start's goal is to enable the HEW to have a foundation for building a relationship with each married girl in their catchment area by starting to build trust based on their inquiry about and support of girls' self-defined dreams for their lives. In this way, they gain a tool to help them bond with girls, chipping away at the isolation that these girls experience.
	Couples voiced that they value shared decision-making but lacked the knowledge and agency to implement this value. Evidence validates the role of shared decision-making in improving health, social and economic outcomes.	»	Husbands are invited to be counseled with wives as part of Smart Start. Even when they are not able to be jointly counseled, Smart Start provides girls with a tool (a "goal card") that can be used to change the decision-making dynamic within her household. Smart Start helps girls to recognize her own agency, prompting her to initiate a conversation with her husband, which goes beyond just joint decision-making, to validating her autonomy.

Figure 2: Makeup of the Smart Start Team

The Smart Start team leverages existing community resources (including the HEW and community youth champions), with targeted outside support to promote community-led implementation of the program.



cognitive, and behavioral place in life. This interaction begins with a conversation about the girl's goals and reinforces that it is feasible to have multiple aspirations without threat to or competition with the goal of motherhood. After being supported to identify these goals, girls and couples are prompted to sketch out their own pathway to success, building a sense of self-efficacy and reinforcing the confidence that these aspirations can be achieved. The HEW, alongside a PSI-employed youth Smart Start Navigator,[1] supports girls and couples to consider the resources that they need to achieve their goals and raise healthy children. This includes broadening the conversation so that the aspiration of having a baby is transformed to one about what it will take to support a family to thrive. Smart Start provides HEWs with one message that allows them to effectively reach girls and couples wherever they are on the spectrum of motivations—whether they are intrinsically motivated to achieve stability or extrinsically motivated to achieve status and recognition. HEWs then introduce contraceptive counseling and services so that they are positioned as being in service of these goals.

Regardless of their decision to accept contraception, girls and couples are provided with a Goal Card to help them track their progress against the life goals they map out in their counseling session. This card also offers an opportunity for girls to initiate a conversation with their husband or family about the relevance of contraception in service of achieving their financial aspirations for their family. In leading with girls' aspirations, Smart Start becomes the entry point for HEWs to establish life-long relationships with adolescents, using the concepts and skills they gained from facilitating Smart Start counseling to connect with girls across the spectrum of health topics and needs.

Service Delivery

Smart Start is delivered by an interconnected web of team members who facilitate community sensitization, outreach, counseling, service delivery, and follow-up in the community. Within this web, the HEW occupies a critical role as the stakeholder who leads, in partnership with A360 and other key community members, the rollout of Smart Start within the kebele. Smart Start's outreach model includes the support of a Smart Start Navigator who assists HEWs to deliver the program. In advance of Smart Start's launch in a kebele, the Navigator supports the HEW to identify and capacitate various stakeholders within the community—leaders, the Women's Development Army (WDA),[2] and adolescents—who they will partner with to deliver Smart Start. A360 offers training and orientation to the HEW and this cadre of community supporters, developing understanding of their roles and responsibilities within the Smart Start team and building literacy with the content of the Smart Start messaging.

When they are ready, Smart Start's launch begins with the community kick-off, convened by A360 but led by the HEW in collaboration with community leaders. During this kick-off, the HEW and other key stakeholders facilitate a dialogue with the goal of building consensus around the relevance of Smart Start to the needs of the community. Community members are prompted to consider their own

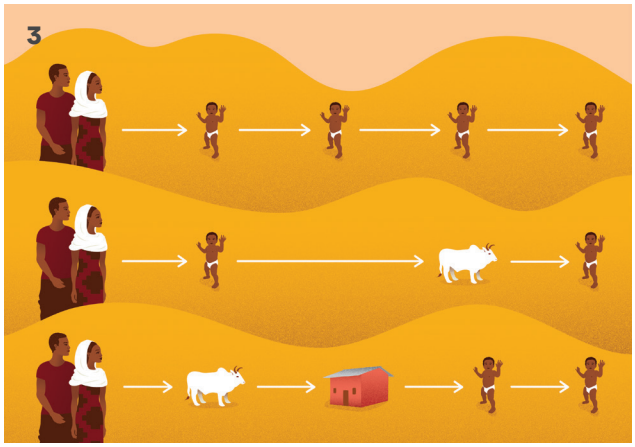
1. Smart Start Navigators are young women, 18-25 years old, who are recruited for their passion for community development and their experience working with adolescent and youth-focused programs.
2. The WDA is an official government cadre of volunteer community members who partner closely with local public health structures to expand the reach of health information within their communities.

Figure 3: Smart Start Discussion Aide

Smart Start's discussion aide is a key tool for HEWs in the delivery of a Smart Start counseling session. The tool provides visual aides for girls and couples to understand the foundational messages behind Smart Start, regardless of their literacy level, and prompts are provided for HEWs alongside these visuals to guide the discussion.

"Think about your future as a family. What do you envision or hope for? Let's figure out what it would take to achieve your goal, given your resources."

"Let's talk about how you could start saving money to put toward achieving your goal."



"What do you understand from what you see here? Everyone has a finite amount of resources. When you space your children out, you'll have more time in between children to accumulate more wealth. If we don't plan our children along with our finances, we are not able to reach our financial goals."

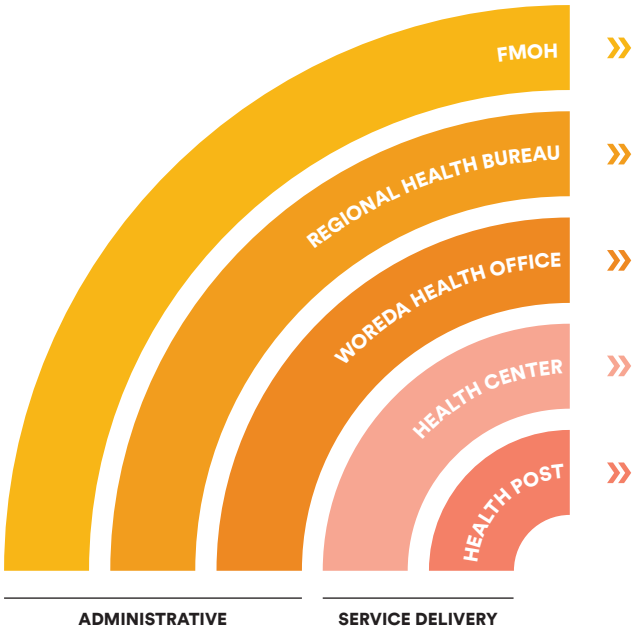
"One thing that young couples find surprising is how much raising children cost! In fact, a child costs more as they grow older."

"Spacing your children is also important for the health of the mom and baby. Spacing births is smart and responsible; it shows that you are taking responsibility for the life and health of you and your family. There are ways that can help you space your births that we can talk about."

"There are many contraceptive methods that you can get from your health service provider. All the methods prevent pregnancy and have different benefits. All the methods are temporary and completely reversible. Would you like to discuss your needs and find out which method might be best for you?"

Figure 4: Smart Start Management Structures for Sustainable Service Delivery

From the beginning of implementation, A360 structured its management and technical assistance to partner with all levels of the government for effective co-implementation of Smart Start.



A full-time staff person is seconded to the FMOH, for Smart Start advocacy and broader focus on AYSRH at a national level. Support and advocacy is also provided by the A360 team and young designers based in Addis.

A360 regional teams have a strong presence in regional technical working groups and orient regional ministries to the work of Smart Start in their communities.

The Adolescent Health Officer (AHO) works closely with an AYSRH focal point at the woreda health office to build support for Smart Start, including using data to help woreda level staff see the value of Smart Start's approach.

The AHO and Navigator work in partnership at the health center, alongside HEW supervisors, for improved focus on AYSRH service provision within supportive supervision.

The Navigator counsels in partnership with the HEWs, supporting their improved fluency with the concepts behind Smart Start and enabling them to continue implementing the intervention once A360 transitions out of the community.

adolescence and the various ways in which their experiences might be disparate from those of the adolescents in their communities today. In much the same way as financial planning is introduced to girls and couples through individual Smart Start counseling sessions, HEWs, with support of the A360 team, prompt community members to collectively identify their shared vision of prosperity for the community, presenting Smart Start's relevance to these goals.

After the kick-off, the HEW and community stakeholders, including the WDA and community youth champions, begin mobilizing girls and couples—referring them for counseling and services. The Navigator and the HEW jointly deliver counseling, with the Navigator orienting the HEW on the concepts presented around financial planning to enable her to facilitate the counseling on her own after A360 exits the community. Smart Start counseling provides a bridge for the HEW to then deliver contraceptive counseling and services in accordance with national protocols and guidelines.

A360's presence in a community continues for an intensive six-week period of support, followed by a transitioning of Smart Start activities fully over to government ownership.

Implementation Experience

In late 2017, with the core intervention components solidified, A360 set the foundation for its adaptive implementation phase, designed to support the project in continually refining the effectiveness of the intervention to optimally deliver for girls, and the health system actors who would ultimately sustain the Smart Start intervention. Among A360's chief aims were to ensure its implementation supported cost-effectiveness, quality, and continuing sensitivity and responsiveness to girls' needs and desires—while doing so in a way that enabled sustainability of the intervention's impact over time.

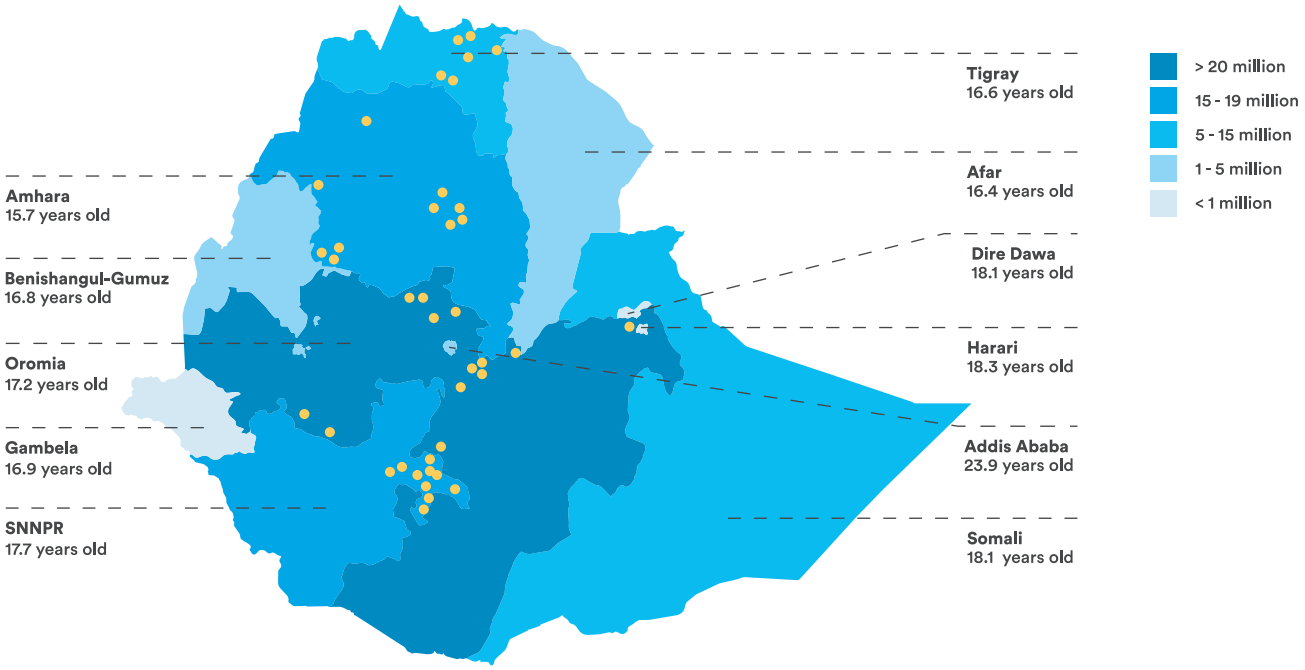
To create a foundation for success in this phase, A360 focused on two key strategies from the outset of implementation. First, to ensure girls remained at the heart of Smart Start implementation, A360 further formalized roles for young people within this new phase—specifically roles around ongoing learning and adaptation, and advocacy with key health system decision-makers for institutionalization of Smart Start. In part as a result of this engagement and advocacy as well as demand for Smart Start among communities and local government, the FMOH approved the intervention for roll out through the HEP in woredas across the Amhara; Tigray; Oromia; and Southern Nations, Nationalities, and Peoples (SNNPR) regions.

Second, to effectively build the capacity of HEP actors to implement and sustain Smart Start into the future, A360 set up its management structure to operate in close partnership with the FMOH at federal, regional, woreda, and PHCU levels (see Figure 4 for further detail). A360 overlaid support onto each level of the health system to ensure a seamless and efficient co-implementation of Smart Start.

With these management structures in place, A360 moved to implement a set of processes to triangulate insights gleaned from routine performance data and learning visits, focusing on variation in performance between sites to identify opportunities for further learning and adaptation. Multi-disciplinary teams work in collaboration to identify areas of potential inquiry for learning visits—for example how to expand and enhance engagement of husbands—which generate qualitative data to pair alongside

Figure 5: Total population (color map), median age at first marriage, and location of Smart Start kebeles (circles), per region, Ethiopia [DHS 2016]

There is significant variation in median age at first marriage regionally in Ethiopia, from nearly 24 years in the capital of Addis Ababa to just shy of 16 years in Amhara. Many of the regions where girls marry, on average, at a younger age are less populous, pastoralist regions, such as Gambela and Afar, where consistent provision of health services highly difficult. A360 has worked to find a balance between scaling to areas where girls are married at younger ages and where the population is greatest to allow for higher impact.



monitoring data, revealing key points at which the two data sources converge and drawing out key themes. Insights from each visit shape the project's broader learning agenda and steer subsequent areas of inquiry, ensuring the project learns continuously and amplifies meaningful evidence generated from program implementation.

Adapting for the HEW as the "User"

Findings from A360's external evaluator, 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 reverted back to the previous practices in which they were originally trained. In response, A360 set out to understand how Smart Start might be further optimized to align 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. These sources of insights revealed key themes which influenced intervention adaptations. 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 maternal newborn and child health (MNCH) tasks whenever possible. The clear inflection point 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.

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.

> ***"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*

> ***"On the training we were resistant to accept and implement the Smart Start program, we mentioned that we were very busy... but later we believed that it was our responsibility to serve the community..."***
>
> *Health Extension Worker, Itad PAR*

Figure 6: Method mix among Smart Start contraceptive users compared to national average

In comparison to national averages, which demonstrate LARC use of only around 18% among married girls 15-19 (DHS 2016), Smart Start's method mix is comprised of 55% LARC methods.

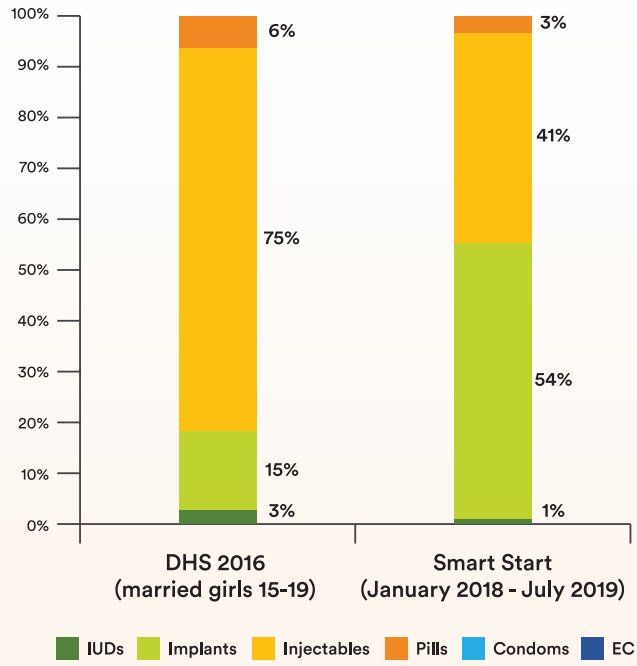
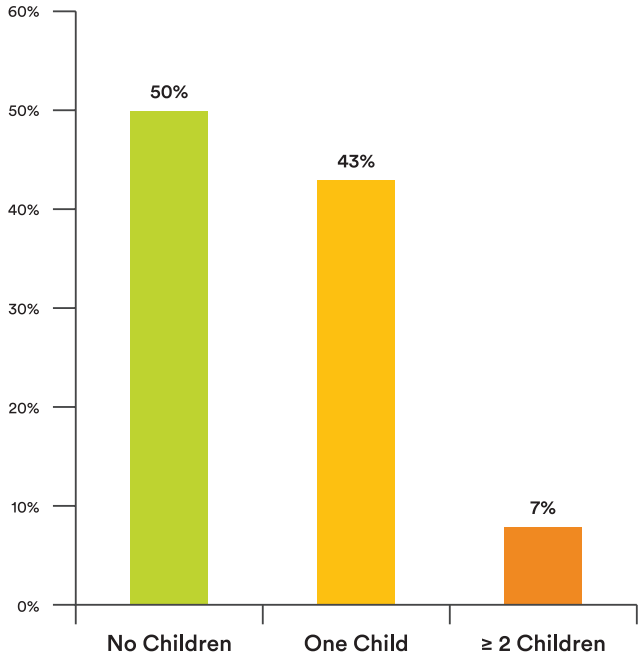


Figure 7: Parity of Smart Start adopters (January 2018 - July 2019)

Half of all girls accepting a modern contraceptive method following a Smart Start counseling session have no children, with the remaining half having one or more children. This points to the resonance of the Smart Start method both for delaying of first birth and spacing of subsequent births.



Adapting for Cost Effectiveness and Outreach Sustainability

A360 also took a critical look at Smart Start's cost-effectiveness, driven by A360's mandate for generating high impact at low cost. This process necessitated a deep dive into key program cost-drivers, as well as intensified scrutiny on program productivity and efficiency, to identify areas where decreasing cost or increasing productivity might lead to a lower overall cost per contraceptive adopter. From a costing analysis, the project quickly identified the Navigator as one of the costliest elements of the program, and tested adaptations to determine whether there was a viable alternative to this position that would continue to reach girls effectively without additional cost burden to the health system should Smart Start be institutionalized.

Based on data from the Itad PAR, in-field work with members of the A360 consortium, and monitoring data, A360 found that the WDA was already referring nearly one third of all girls counseled through Smart Start and that the community thought they could effectively perform the current function of the Navigator. Insights revealed that girls already trusted WDAs to provide financial planning advice. Furthermore, examination of positive deviant sites—those which were particularly high performing—found that involvement of the WDAs in mobilization helped prime girls and couples to understand Smart Start's key concepts prior to being referred to services from the HEW. In some cases, the WDA went as far as to debrief with the HEW after mobilization to support her in tailoring her counseling to each girl's specific needs. As a result, Smart Start also increased the role of the WDA in community kick-off events to give them more credibility as part of the Smart Start program.

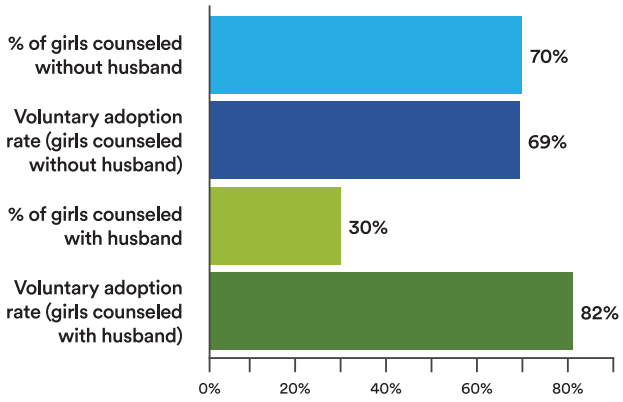
Ongoing learning in these areas has continued to push A360 to improve and refine Smart Start to efficiently and effectively support girls. A360 Ethiopia is currently working to understand how the Smart Start program stays with girls over time and its resulting impacts on continuation of method use.

Performance

Program evidence to date suggests that Smart Start resonates with girls, couples, and key stakeholders which influence girls' decision-making around contraception. Furthermore, by expanding the ability of the public health system to reach adolescent girls and couples in relevant, meaningful ways, Smart Start is viewed by stakeholders at all levels of the Ethiopian FMOH as addressing a critical need for improved programming for adolescents. From January 2018 to July 2019, over 45,000 girls have received counseling through Smart Start. Of the girls eligible for contraceptive adoption (those who were not continuing users or pregnant), nearly 75% voluntarily adopted a modern method of contraception. Over half of these users took up a long-acting and reversible contraceptive method (LARC)—including implants and IUDs. This is significantly higher than the national average for LARC uptake for this population (see Figure 6 for further detail).

Figure 8: Husband engagement and impact on conversion rates for Smart Start (January 2018 - July 2019)

In Smart Start sites, when girls are counseled with their husbands, they are 20% more likely to voluntarily adopt a modern method of contraception. Yet, less than a third of girls are counseled with their husbands, pointing to a critical need to explore ways to further support HEWs to pursue husband engagement in counseling.



Smart Start performance data demonstrates that the intervention has succeeded in supporting the FMOH to reach married girls for both delay of first birth and birth spacing. A full 50% of married girls adopting a method after receiving counseling through Smart Start are nulliparous (having no children), and 43% adopt a method to space after their first birth (see Figure 7 for further detail). Given that the majority of Ethiopian rural adolescent girls begin contraceptive use for the first time only after having had three children, parity among Smart Start adopters demonstrates a significant shift from national averages.[24] Evidence also points to the positive effects of the intervention's engagement of both husbands and wives in joint decision-making around contraception. Compared to girls receiving individual counseling from HEWs, those who are reached and counseled with their husbands voluntarily adopt modern contraceptive methods at a rate nearly 20% higher (see Figure 8 for further detail). Although husband engagement through joint counseling has always been a key component of Smart Start implementation—prompted by insights affirming the desire for joint decision-making among couples—less than a third of counseling sessions are conducted jointly with husbands and wives. In response, A360 has further prioritized strategies to support health posts to make joint counseling and other methods of husband engagement a more consistent part of service delivery.

Lessons Learned and Recommendations

As A360 enters its final year of implementation, the reflections stemming from the project's commitment to learning and partnership offer useful insights for future AYSRH programming targeting married girls and couples.

Complexity in Elevating Youth Voices Throughout the Project Lifecycle

Establishing effective youth-adult partnerships and institutionalizing them into the fabric of program processes has proven valuable to A360, though not without its challenges. In the project's experience, elevation of youth voices—through young people acting as researchers, analysts, advocates, and community-level champions—yielded a variety of benefits. FMOH counterparts reported that presentation of insights to key stakeholders was more compelling and had greater veracity when conveyed through A360's young designers, whom those stakeholders could clearly identify as their constituents. Youth perspectives also reinforced the ability of Smart Start's message to speak directly to what was relevant to girls and couples—specifically through incorporating contextually appropriate examples (such as a cow or a house) that resonated across the spectrum of adolescent motivations and priorities. However, considerably more can be done to ensure meaningful youth engagement (MYE) is done consistently well in A360 and projects like it. To do MYE well, projects must build in time to intentionally develop youth's capacity to successfully contribute to public health programming, building their fluency with content and confidence in active engagement. This engagement is clearly worthwhile, but also requires teams to balance MYE with pursuit of performance efficiency and scale-up.

A360's success in designing and implementing alongside young people—primarily youth leaders—is balanced by a need to do more to bring the voices of representative youth—those closer to our clients—to the forefront. Youth leaders alongside representative youth should serve as co-pilots in program adaptation and quality improvement efforts. This remains a continued area of learning.

Design with the End in Mind: Balancing Design for Users with Design for the Health System

A360's experience reinforces the importance of designing interventions with an eye toward sustainable scale-up from the beginning. In A360's process, an intensive focus on design research to understand girls' desires and aspirations was imperative, but needed to be balanced with a focus on the experience of health system actors, particularly HEWs. These actors warrant attention, not just because they are themselves human and deserve empathy, but because resonance of the intervention with their own intrinsic motivations is critical for the intervention's implementation success.

For A360, adapting to ensure resonance of the intervention to front-line implementers as well as girls provided the critical missing piece in ensuring alignment of support for Smart Start. Smart Start resonated with girls and with government administrators who saw its value to address common challenges faced by their communities. However, refinement of the intervention for fit within the processes and priorities for HEWs as key stakeholders in service delivery was critical for Smart Start's success.

Responsibility to Serve the Whole Adolescent

In recognition that Smart Start's core message bolsters and inspires girls' future aspirations, it follows that A360's responsibility extends beyond supporting girls'

contraceptive journeys to linking them to the types of support that allow them to achieve their goals. Adolescents' needs are naturally integrated across sectors. Therefore partnerships, in particular cross-sectoral collaboration, have an important role to play in ensuring comprehensive programming for adolescents that responds to their interconnected problems with integrated solutions.[7] Challenges remain to such partnerships— including an unconducive competitive landscape, reluctance to test ideas which are not yet evidence-based, mis-matched geographic footprints, and funding restrictions. In this way, creating a conducive ecosystem for this multi-sectoral programming has implications for all levels of development—donor, implementer, government, and civil society.

Male Engagement

A360's performance data in Ethiopia clearly demonstrate that although girls feel more comfortable making decisions around use of contraception with their husbands present, barriers prohibit their attendance at counseling sessions. In the context of rural, agrarian Ethiopia, girls and their husbands expressed a joint desire to have a conversation about their lives and future plans but were unclear where to start. Even in situations where husbands were unable to be present at counseling sessions, A360 found that *the Smart Start goal card*, distributed to every girl counseled through the intervention, has been used proactively by girls to initiate critical shared health and life-planning conversations with their spouses. In the Ethiopian agrarian context, where desire for joint decision-making appears latent among married adolescents, the Smart Start goal card appears to be an effective health system prompt to facilitate this key health behavior. This tool may be useful for other projects in similar contexts.

Next Steps

In its nearly four years of design and implementation, the A360 Smart Start intervention has demonstrated promising results and done so in meaningful partnership with both young people and the Ethiopian FMOH and its implementers at the frontlines.

Under the Roadmap for Integrating Smart Start in Ethiopia (RISE) investment, funded by Children's Investment Fund Foundation (CIFF), PSI/Ethiopia will support the FMOH to institutionalize Smart Start within the HEP and rollout programming nation-wide. As part of this investment, Smart Start will further evolve for implementation fit to Ethiopia's health service context in pastoralist regions, offering renewed opportunity to innovate in how best to reach adolescent girls in hard to reach settings with needed sexual and reproductive health services.

With the support of the Children's Investment Fund Foundation (CIFF), beginning in 2020 the Ethiopian FMOH, A360, and PSI/Ethiopia will begin formal integration of Smart Start into the HEP, triggering national scale-up and expansion of community-level youth friendly contraceptive services to over 500,000 married adolescent girls. This is a testament to the strong partnership between the project, the Ethiopian FMOH, and adolescent girls themselves.

Contributors

Appearing in alphabetic order. Italics indicate authorship.
Recommended Citation: Cutherell M, Cole C. "Supporting Sustainable, Youth-Powered Programming at the Community Level in Ethiopia: The Case of Smart Start." (2019) Washington, D.C.: Population Services International.

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ADOLESCENTS 360

Adolescents 360 (A360) is a four-and-a-half year initiative co-funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF). The project is led by Population Services International (PSI) together with IDEO.org, University of California at Berkeley Center on the Developing Adolescent, the Society for Family Health Nigeria and Triggerise. The project is being delivered in Ethiopia, Nigeria and Tanzania, in partnership with local governments, local organizations, and local technology and marketing firms. In Tanzania, A360 is building on an investment and talent from philanthropist and design thinker Pam Scott.

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